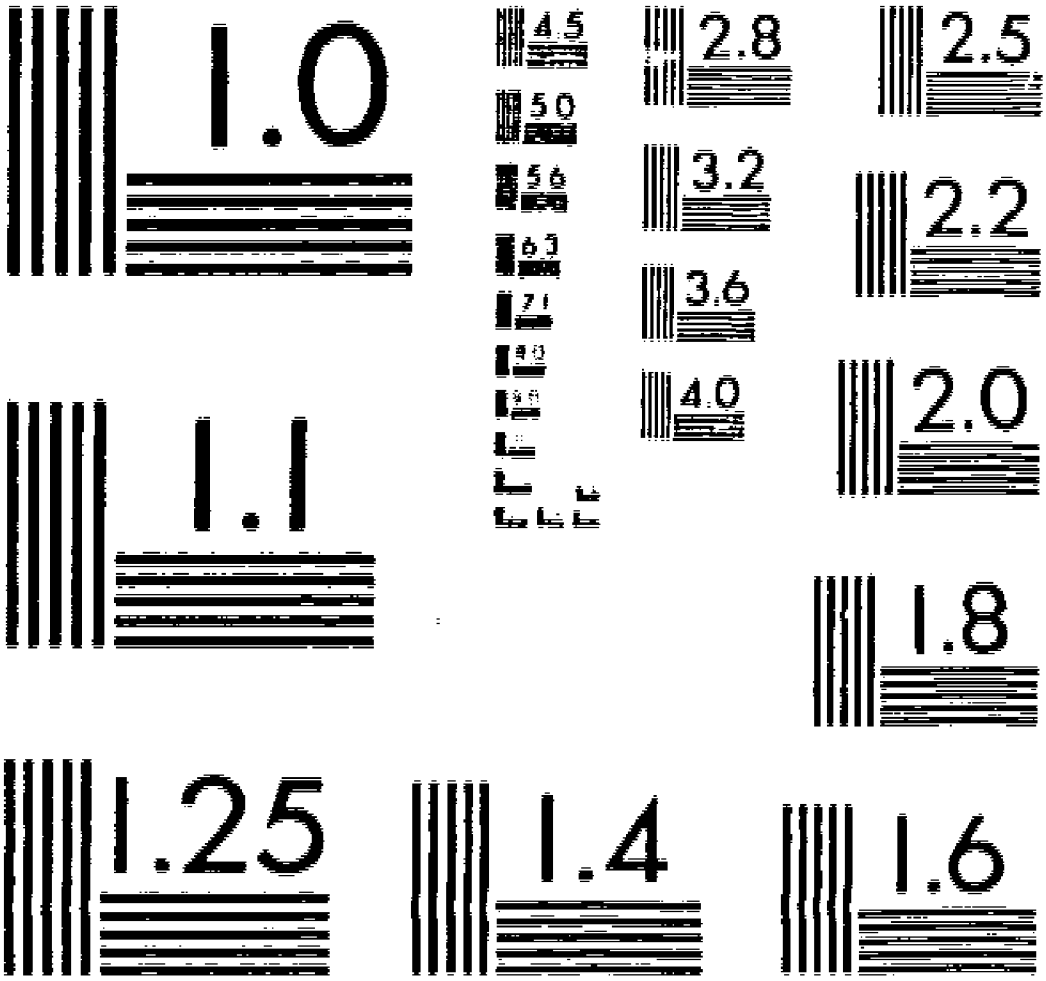

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ABSTRACT

Narrative and statistical data on the Colorado Rural Health Program are presented in this 1970-71 annual report. Objectives of the program were to develop, augment, and improve health care services to rural (including migrant) agricultural workers and their families; to develop, expand, and improve existing programs; and to establish and maintain lines of communication with other agencies involved in the health, education, and welfare of rural workers. Separate sections of the report cover the following areas: interagency commitment, dental services, medical services, environmental health, and nursing services. Some of the major changes in the program for this reporting period included affiliation with the Colorado Migrant Council, extension of the program to include non-migrant rural agricultural workers, and implementation of the "one-roof" concept (the idea of consolidating all services in 1 center). The types and amounts of care given to agricultural workers during the reporting period are presented (by county or region) in both narrative and tabular form. (PS)

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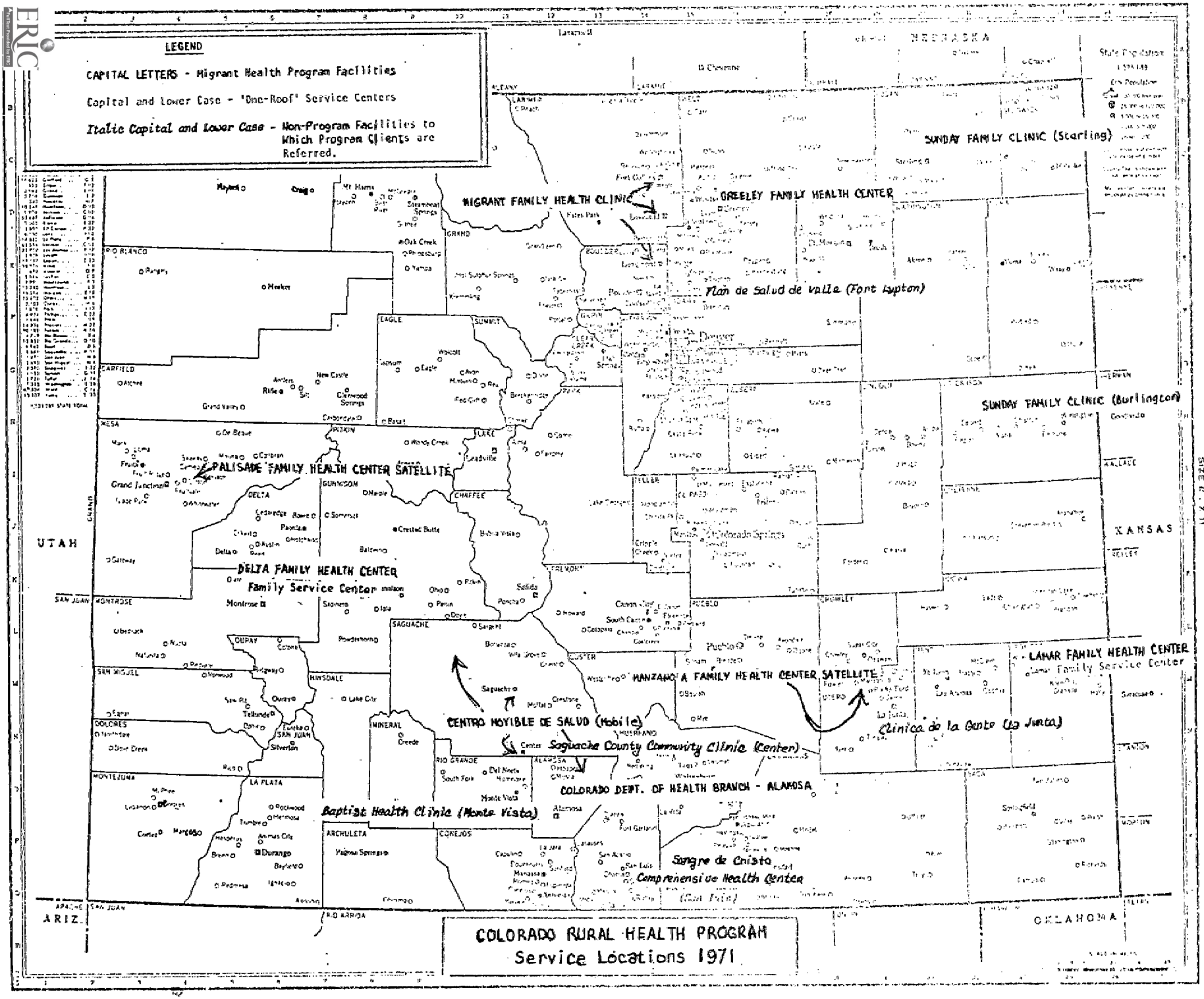
LEGEND
CAPITAL LETTERS - Migrant Health Program Facilities
Capital and Lower Case - 'One-Roof' Service Centers
Italic Capital and Lower Case - Non-Program Facilities to Which Program Clients are Referred.
MIGRANT FAMILY HEALTH CLINIC
GREELEY FAMILY HEALTH CENTER
SUNDAY FAMILY CLINIC (Sterling)
Plan de Salud de Valle (Fort Lupton)
SUNDAY FAMILY CLINIC (Burlington)
PALISADE FAMILY HEALTH CENTER SATELLITE
DELTA FAMILY HEALTH CENTER
Family Service Center
LAMAR FAMILY HEALTH CENTER
Lamar Family Service Center
MANZANOLA FAMILY HEALTH CENTER SATELLITE
Clinica de la Gente (La Junta)
CENTRO MOVIBLE DE SALUD (Mobile)
Saguache County Community Clinic (Center)
COLORADO DEPT. OF HEALTH BRANCH - ALAMOSA
Baptist Health Clinic (Monte Vista)
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Service Locations 1971
CITY-COUNTY STATE MAP
COLORADO

COLORADO DEPARTMENT OF HEALTH
MIGRANT HEALTH PROGRAM

Annual Progress Report
June 1, 1970 - June 1, 1971

INTRODUCTION

I. Reporting Period:

The period covered by this report, June 1, 1970 through June 1, 1971 does not coincide with the fiscal period which is based upon the calendar year. Statistical data for the current season will not have been compiled until early November, 1971. Consequently statistical data will be confined to the reporting period referenced above, while narrative reporting may reflect activities carried out through August 10, 1971.

II. Reporting Format:

The format of this report follows the general instructions outlined in ANNUAL PROGRESS REPORT - Migrant Health Project GPO 873-0 24 Department of Health, Education, and Welfare, Health Services and Mental Health Administration. This outline provides for reporting upon the following subjects:

A. Introduction:

Statistical Data Sheets and Instructions:

- Part I - General project information, population and housing
- Part II - Medical, dental and hospital services
- Part III - Nursing Services
- Part IV - Health Education Services

B. Narrative For Annual Progress Report:

- Summary
- Medical and Dental Services
- Hospital Services
- Nursing Services
- Sanitation Services
- Other Services

Under the heading "Other Services", a section has been included which illustrates inter-agency character of the program, tracing the development of multi-agency funding concepts from their inception in 1967. Included are charts, graphs, and tables which help illustrate program growth and increasing external involvement.

III. Summary:

The content of the summary is confined to those activities presented in the various sections of the report which deal with each c-mponent. Due to the required brevity of this part of the report, it is felt that some of the major changes in program scope and direction ought to be presented in order to relate achievement to the planning commitments which were made at the time our present grant, 08-H-000018-0 was under negotiation.

Accordingly, this information follows in the balance of the introduction, and is concerned with transitional aspects of the program, enlarged scope, new methods of implementing program planning, and general trends, at the time of this report, toward attainment of short-term and long-term objectives.

IV. The Colorado Migrant Health Program Today:

A. A New Commitment:

Prior to the Spring of 1970, the Migrant Health Program was concerned with the domestic migrant agricultural worker and his dependents. Today, a new mandate of Congress and a general increase in concern for the health of the rural poor have broadened the scope of the Colorado program to include seasonal agricultural workers who do not migrate as well as those residents of program areas who are categorized as the 'rural poor'.

Another element in this new commitment has been a dramatic increase in the number of illegal entrants from the Republic of Mexico. While this influx has imposed a burden upon our health care delivery system, care cannot be denied to seriously ill persons, regardless of their national status.

In general, the illnesses found among illegal entrants from Mexico are most serious and often in advanced stages. Consequently, the expense of care is greater as is the potential hazard of disease transmission.

The precise depth of this problem is as yet unknown owing to the difficulty in documenting the actual place of origin of persons whom staff members believe to be from Mexico. While many aliens openly admit their national status, most are secretive and fearful.

Extension of the program's concern to the rural poor has necessarily involved a change in thinking with respect to the ethnic composition of consumer policy boards. Some provision for broader representation will be included in planning for the next calendar year and the years ahead. This new direction will require much delicacy and understanding in order that there will be a clear understanding of motivation.

B. New Ways and Means:

In previous years, the traditional 'clinic' and the "usual and customary fee-for-service" provided the basis of medical care for program patients. While the most of the statistical data presented in this report are still derived from service activities conducted within the older format, program services are being delivered in a far different manner today. Some of these differences are:

1. The personal service contract: Local physicians are contracted with to see all patients referred to them by program nurses. Referrals are made after screening and when the patient's condition does not fall within the scope of the guidelines for treatment of minor conditions. The contract amount is based upon anticipated patient load and is written to cover a specific period of time.

2. The fixed-fee arrangement: In those instances wherein the patient's condition requires a specialists care, or in the event that an appointment cannot be arranged for the patient to see a contract physician, a referral is made to a local physician who has signed an agreement with the program to see patients at a rate of $5 for the first visit and $3 for subsequent visits for the same illness. Charges for injections are limited to $2.

3. Emergency room and out-patient hospital care: In life-threatening emergencies, usual and customary fees are post-authorized for emergency room care in local hospitals. In certain cases, at the discretion of the referring nurse, program patients are seen in out-patient departments of local hospitals. Generally, this is authorized when it is determined by the nurse and the physician that the patient requires the benefit of the more sophisticated diagnostic and laboratory facilities available in hospitals.

4. Greeley Family Health Center: A former store building was rented and remodeled to serve as a family health center. The cooperative nature of this operation is described in detail in "other" of this report. While the older format of hourly fee clinician service is used, a center physician will be employed in October 1971. This physician's services and the continued use of local physicians as part-time clinicians will form the basis of center medical care. The facility contains a reception room, four examining rooms, a conference room, nursing offices, an interview room, two toilets, a drug storage room and a laboratory. Clinic hours are arranged to meet the needs of the target population.

5. The Mobile Health Center: A mobile clinic van was acquired from the Regional Office of the Department of Health Education, and Welfare. This unit, formerly used as a cancer detection unit by the Tri-County District Health Department, has been stationed in the San Luis Valley. Operated and maintained by a program Family Health Worker, responsibility for the placement of the Mobile Health Center rests with the San Luis Va-ley Area Nursing Supervisor. It is staffed by the area program nurses, VISTA supported medical students, and used to augment clinic facilities in the Northern part of the San Luis Valley.

Some categorical medical clinics are conducted in the unit althou h its primary function has been to provide space for nursing clinic: and an appropriate setting for the treatment of minor conditions. The mobile nature of the unit has provided a great deal of flexibility to program operations in the San Luis Valley.

Upon completion of the potato harvest in the San Luis Valley this Fall, the unit will be located in the North Central area as a mobile satellite operation of the Greeley Family Health Center, serving the rural poor in the barrios and colonias in that impact area.

6. Family service centers: In two areas, nursing care and some medical care is given in health centers located in facilities rented by the Colorado Migrant Council. This one-roof idea operated in Lamar (Arkansas Valley Area) and in Delta, (Western Slope Area). Each is equipped with an examining table, clinic refrigerator, hematorit centrifuge, treatment cabinets, scales and other supplies and equipment necessary to a primary treatment facility.

   These two operations are 'home-base' for this program, the family health workers, Colorado Migrant Council staff, VISTA volunteers and staff of the Salud y Justicia program. The Colorado Rural Legal Services, Inc. provides attorneys to counsel center clinics at regularly scheduled times. Welfare and job placement counseling, day care and head start services are provided by the Colorado Migrant Council staff. Hence, the whole person is served, not just the health needs of that person.

7. Community clinics: When appropriate, referrals are made to community clinics operated by other agencies or area consumer groups, some of which are not directly connected to the Migrant Health Program. These are:

   - Plan de Salud del Valle, Fort Lupton, (North Central Area)
   - Sangre de Cristo Neighborhood Health Center, San Luis (San Luis Valley)
   - Baptist Health Center, Monte Vista (San Luis Valley Area)
   - Saguache County Community Clinic, Center (San Luis Valley Area)

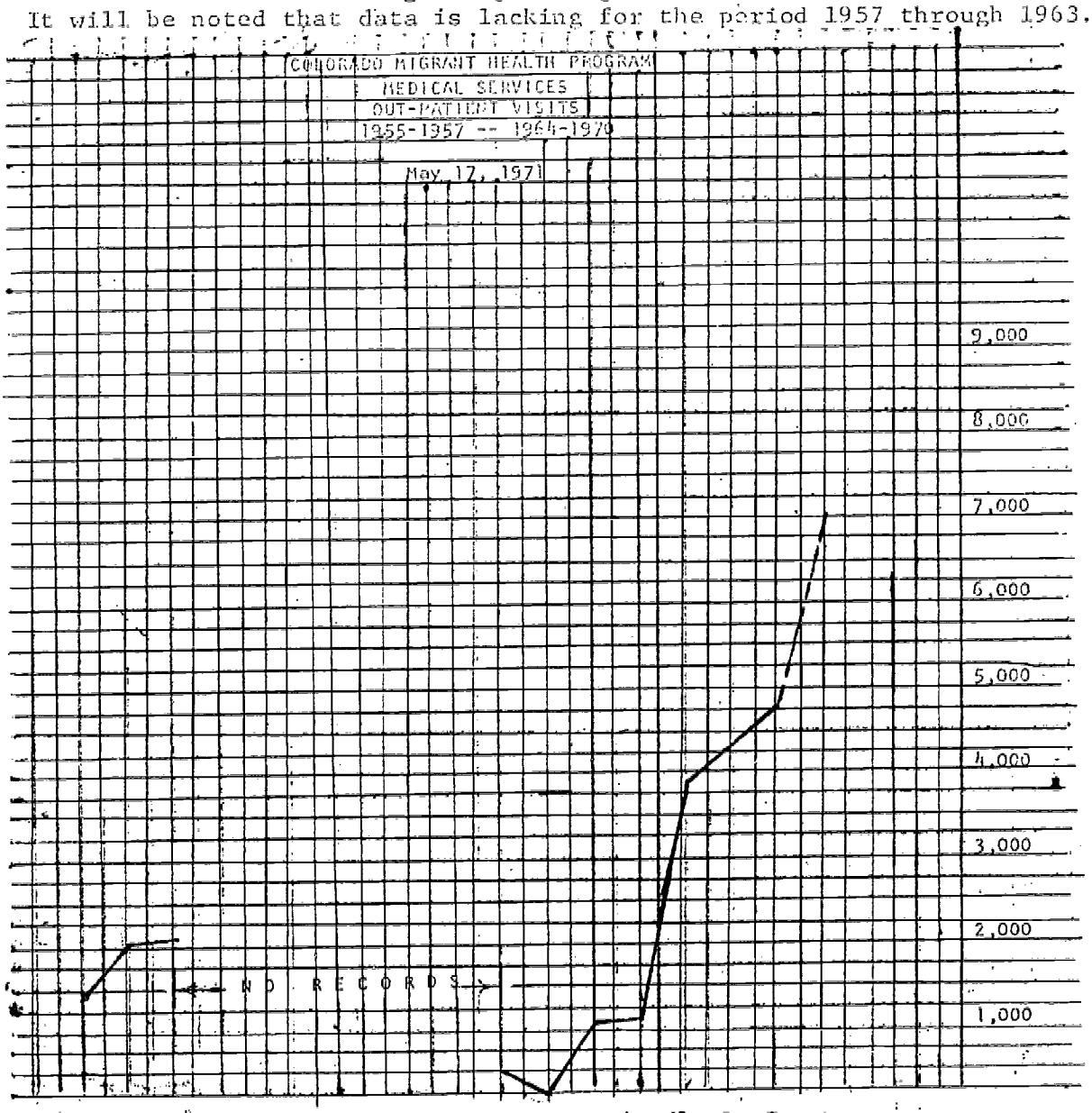
   A new operation, now under consumer policy board assessment, is being organized in La Junta (Arkansas Valley Area). Designated as La Clinica de la Gente, it is thus far a weekend clinic staffed by volunteers from the Boulder-Denver metropolitan area. More evaluation will be needed with respect to determining its place in the inter-agency health care system now being developed. Further reference to these operations are made in the "Other" section of this report.

C. Attainment of Objectives:

For the purpose of measurement, it will be necessary to base comparisons upon the latest migrant population data available to the program. These

data are based upon inter-agency estimates developed after the 1969 season and do not reflect new target population numbers which must include seasonal non-migrant agricultural workers and those classified as the rural poor.

1. The following table is presented to illustrate progress in delivering medical care since the beginning of migrant health programs in 1955. It will be noted that data is lacking for the period 1957 through 1963.



1955 = 1,441	1964 = 840	1968 = 3,871
1956 = 2,010	1965 = 653	1969 = 4,302
1957 = 2,136	1966 = 1,115	1970 = 4,827
1957-1963 = no records	1967 = 1,252	------1971 = 7,000 (projected)

2. Other data relating to progress in the delivery of health care is presented in the section under "Other" in this report.

INTER-AGENCY COMMITMENT

I. The words "Inter-Agency Commitment" are used deliberately to illustrate the difference between the state of affairs today and the largely ineffective concept of inter-agency coordination of former years.

The Colorado rural health endeavor has progressed from strictly limited interests through the stages of concern, involvement, and finally commitment. The change did not come about through some mysterious working of the cosmos. The development has not been automatic, nor has it been unattended by dissension, injured egos, and shattered personal 'master plans.'

The development is the product of a consensus of opinion arrived at only after agonizing trials and errors. Our winters of optimism often became our summers of discontent.

Failures often result from faulty or incomplete planning or, changing situations which make a plan obsolete. More often than not, however, it is a 'people' failure; a failure of people to develop and maintain their dedication no matter what fatigue, disappointments, and ego-shattering developments may occur. The sudden, (and often justifiable) 'souring' of a staff member can affect the cohesion and elan of an entire organization. This phenomenon occurs frequently, and generally stems from believing other persons are either immortal, infa-lible, or both. Disenchantment with a single person is often irrationally allowed to destroy an entire service program, the primary loser being the program client.

At first sight it might seem unwise to begin this section with the pathology of program failure. However, this factor is far too important to be buried or glossed over. The Colorado program as it exists today is a fragile flower, which has been cultivated for many years and has just this year blossomed. We still do not know whether or not it will mature and become the fruit of success. There are many chilling frosts ahead and other as yet unknown dangers to this embryonic rural health program.

The major part of the pessimism out of the way, we can now proceed to the positive aspects of the unique Colorado service delivery system. How did a cohesive program grow from a fragmented, rule and precedent bound, rivallry ridden, multiplicity of conceptual empires? In keeping with human nature, it has been mercifully forgotten how bad the situation really was. Perhaps the key might be found here. Some behavioral psychologists maintain that man, working within his social order, only responds in a committed way when a specific crisis is upon him.

Certainly, however, there were many more elements involved than urgent necessity. One seemingly anomolous factor might be lack of interest! The various small service programs simply did not attract the interest of empire builders, experimenters, and the 'grantsmen' who promote programs for program sake. These are the humanitarians who often have little concern for individual human beings; these are the ones who find the trees invisible but see the forest as their fundamental sphere of interest.

The chaos produced by this approach was convincing enough evidence that some framework had to be built in which conceptual development could take place. Therefore, the first real step toward progress was the point at which Colorado programs discarded the crisis-oriented and subjective approach. From this point, with some unfortunately notable exceptions, a synthesis of ideas began to evolve. Compromise, efforts to avoid re-inventing the wheel and the common courtesy of hearing all ideas and weighing them objectively began to produce order out of chaos.

During this transitional phase many service program staff members began to make reference to the principle that, "There is no limit to what can be done, if no one cares who gets the credit." No genuine commitment can endure if the question of due credit raises its ugly head. Albeit, the beast is still sighted more frequently than is desirable.

II. The Symbiotic Nature of Colorado Service Programs:

An alliance between programs or nation states is rarely an expression of altruism. It is a trade-off, a modus vivendi, which each party generally believes to be essential and reasonably advantageous to its own interests. Such alliances are generally based on urgent need and born of lengthy and tedious compromise, and generally endure only as long as it is mutually advantageous.

Six years ago, the prognosis for success could not have been worse. The need for coordination was known, but the infrequent attempts to achieve cooperation were undermined by suspicion, secretiveness, and jealousy compounded by mutual ignorance. (It is still a widely spread misconception that coordination is something a person or agency does to other persons or agencies.) The concept that coordination is a process of people working together effectively in an atmosphere of trust had still not filtered through to most programs serving migrants in Colorado. Many of the early inter-agency groups became mutual re-crimination societies soon to be disolved and bequeathing their respective residues of cynicsm and apathy to those who tried to begin again. The field would lie fallow for many years.

Another early stumbling block to service unification was the attitudes of local 'Migrant' Councils. These must not be confused with the current idea of a migrant council. The older ones were generally made up of representatives of the power structure of the communities

in which they functioned. (No migrants involved, of course.) Even after due credit is given to the substantial caritas and humanitarianism of these early councils, they were nevertheless, based upon the 'master-servant' relationship. This vestigial remnant of feudalism was often like having the cate care for the canary. These councils did not serve the purpose of consumer advocacy to which principal the Migrant Health Program had now become committed.

A period of alienation followed for the Migrant Health Program. (Then designated as the "Colorado Migrant Plan for Public Health Services". The established local migrant councils were not happy with the turning our attention to the newly developed Colorado Migrant Council. On the other hand, that consumer-based organization viewed the State Program as simply another atrophied arm of the establishment octopus; insensitive, rule-bound, with arteries hardened by inability or willingness to accept the newly found determination of the poor to have a part in determining their own destiny.

The local communities and councils were comprised of anglo's. Acting within the framework of their conditioning, they often had sympathy but seldom empathy. They lacked the personal experience which would have enabled them to understand the indescribable conditions and situations in which migrant farm workers and their families were trapped.

In the mid-60's, a window into a new world was opened. Words like Aztlan, Chicano, Raza -- people named Tejerina, Corky Gonzales, Cesar Chavez, added a new dimension. Inevitable conflict arose between those 'anglo's' who viewed the Chicano community as fellow citizens who had been short-changed, and those who merely reinforced their old attitudes by depersonalizing the poor.

The human resources and ideas which were rediscovered upon the emergence of the Chicano from impotence became assets to the various Colorado service programs. Each program could draw new strength from the others, finding ways to eliminate wasteful duplication of effort marshalling their resources to produce more service.

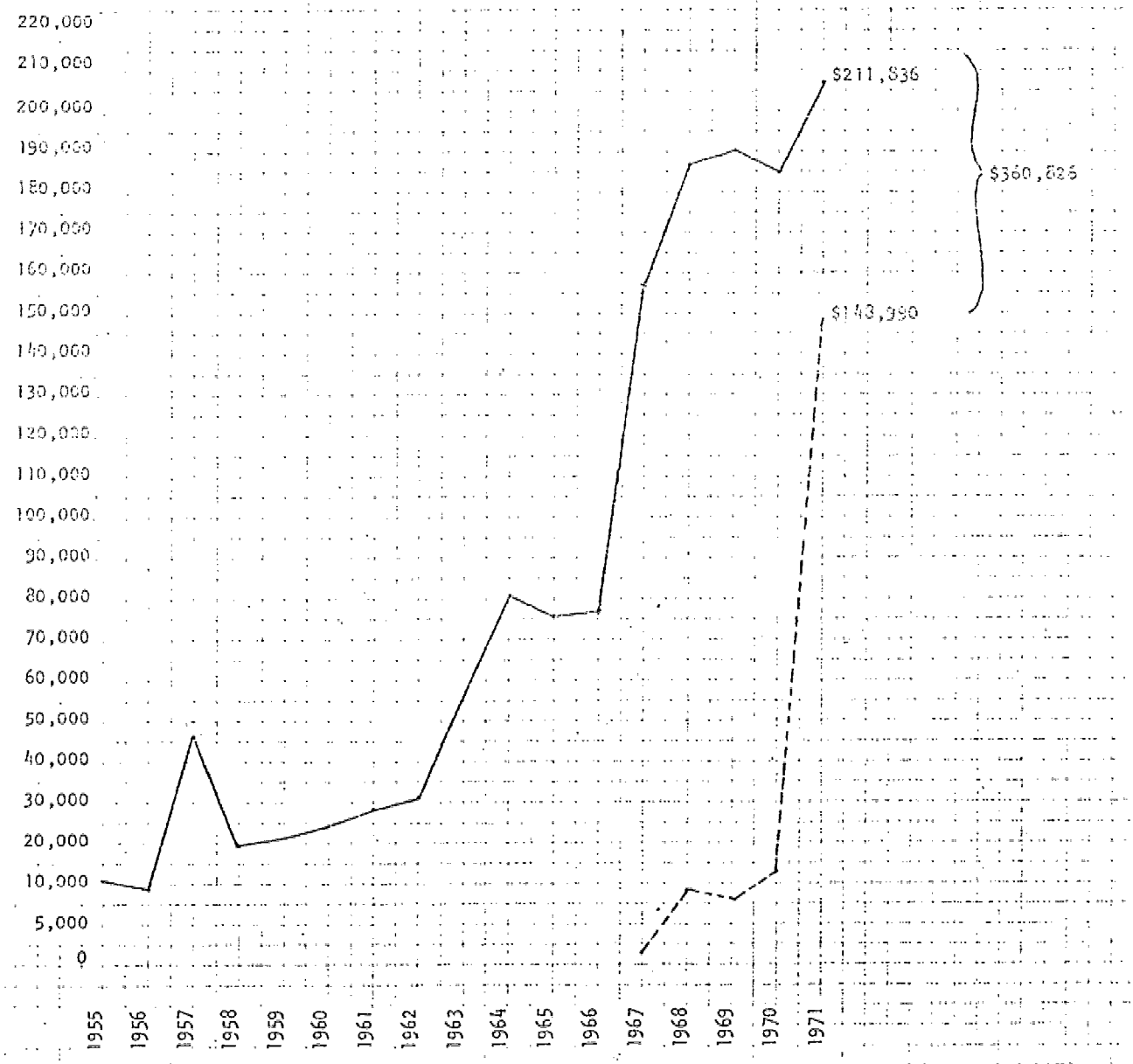
III. Methods:

The methods by which this was brought about fall into several categories:

1. Inter-program personal relationships:

Over the years, many good relationships developed between individual staff members of the various service programs. A common objective of each program was to improve the lot of migrants and seasonal farm workers, and this commonality served to bring people together The good-will and realism of these people meeting together provided a foundation for the more formal agreements which were to follow.

COLORADO MIGRANT HEALTH PROGRAM
16 YEARS
FUNDS ADMINISTERED BY COLORADO DEPARTMENT OF HEALTH
May 17, 1971
(Includes all project costs and services)



H.E.W. OR CHILDREN'S BUREAU FUNDS

COOPERATIVE REIMBURSEMENT AGREEMENTS (other agencies)

	1967	1968	1969	1970	1971
	$3,808	$9,645	$9,392	$11,260	$148,990

2. Reimbursement funding agreements:

The idea of service consolidation through pooling of funding resources was first tried in the area of dental services. The Migrant Health Program negotiated agreements with the Colorado Department of Education Migrant Summer School Program to provide dental care to students enrolled in various migrant schools. These agreements originally made with each school district were largely replaced this season with a blanket agreement providing for medical, dental, and nursing care. A similar dental care agreement with the Colorado Migrant Council formed the basis for a medical-dental care agreement this season.

These precedents played a large part in the Migrant Council's decision to delegate most medical and nursing care aspects of the Salud y Justicia program to the Colorado Migrant Health Program. (A graph and table follow which illustrate the progress of cooperative funding.

SOURCE OF FUNDS: 1971 SEASON

CATEGORY	MIGRANT HEALTH PROGRAM (HEW)	COLORADO MIGRANT COUNCIL (OEO)	SALUD Y JUSTICIA (OEO)	DEPT. OF EDUC. (HEW)	FAMILY PLANNING (HEW)	STATE FUNDS	TOTAL
MEDICAL CARE	$31,500	$13,000	$2,500	$21,000	--	--	$68,000
PRESCRIPTION ITEMS	13,000	--	--	--	$4,000	--	19,000
DENTAL CARE	10,614	5,400	--	28,000	--	--	44,014
NURSING SERVICES	50,548	9,600	36,880	45,000	--	$8,110	150,138
TOTALS:	$107,662	$28,000	$39,380	$94,000	$4,000	$8,110	$281,152

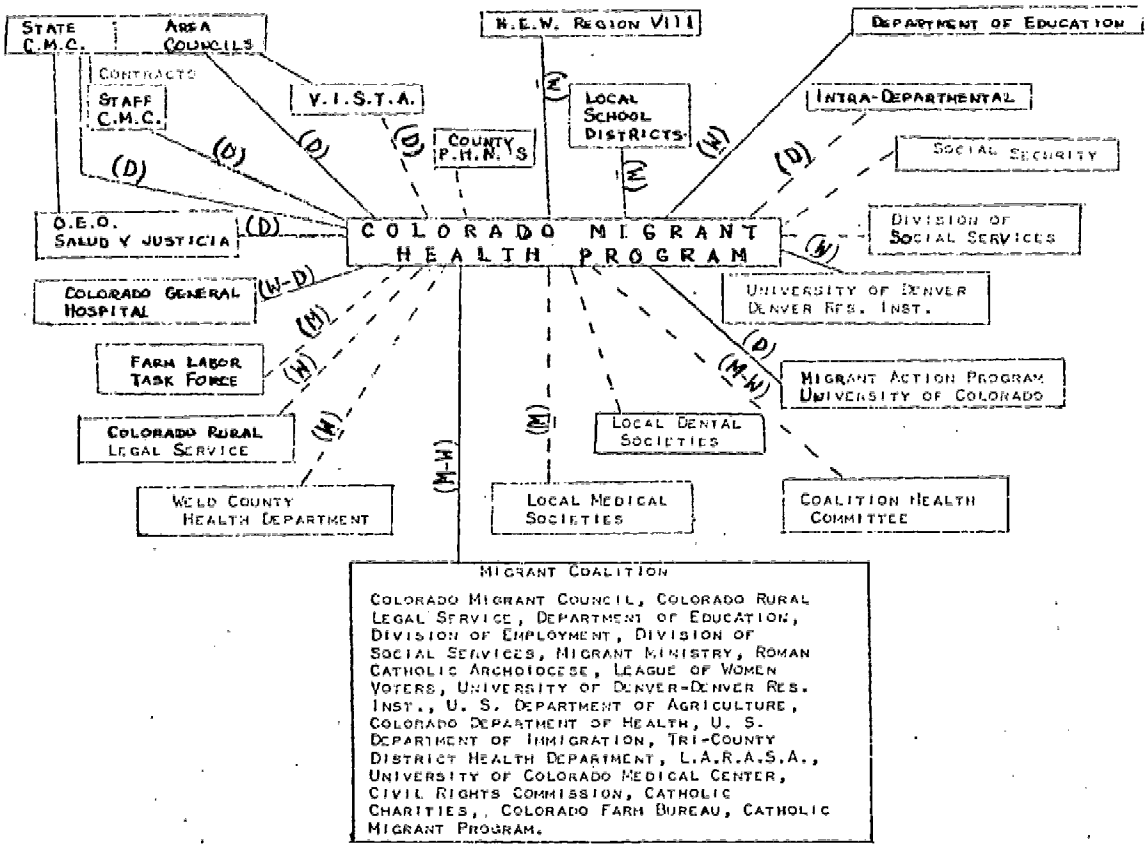
3. Formal affiliation:

In the Fall of 1970, the relationship between this program and the Colorado Migrant Council was formalized in an agreement which designated the Council and its area components as the consumer policy board of the Colorado Migrant Health Program.

Prior to this, in the Spring of 1970, the Migrant Health Program had acted as one of the founding agencies of the Migrant Coalition, a forum and information clearing house for agencies, groups, and individuals concerned with better delivery of service to migrants and seasonal agricultural workers. Through attendance at plenary and committee meetings of this body, all service programs have developed new concepts and a clearer understanding of the complexity and enormity of the problems which must be solved.

Through the media of the Consumer Policy Boards (State and area) and the Migrant Coalition, the program has all but eliminated the older 'informal' lines of communication which so often broke down through simple lack of continuity. The program today has the benefit of the policy direction of the Consumer Boards as well as the advice and counsel available within the Migrant Coalition, all of which takes place within a framework of regular meetings.

The following table shows the contact and depth frequency which now exists with respect to the Migrant Health Program and other groups and agencies serving the target population.



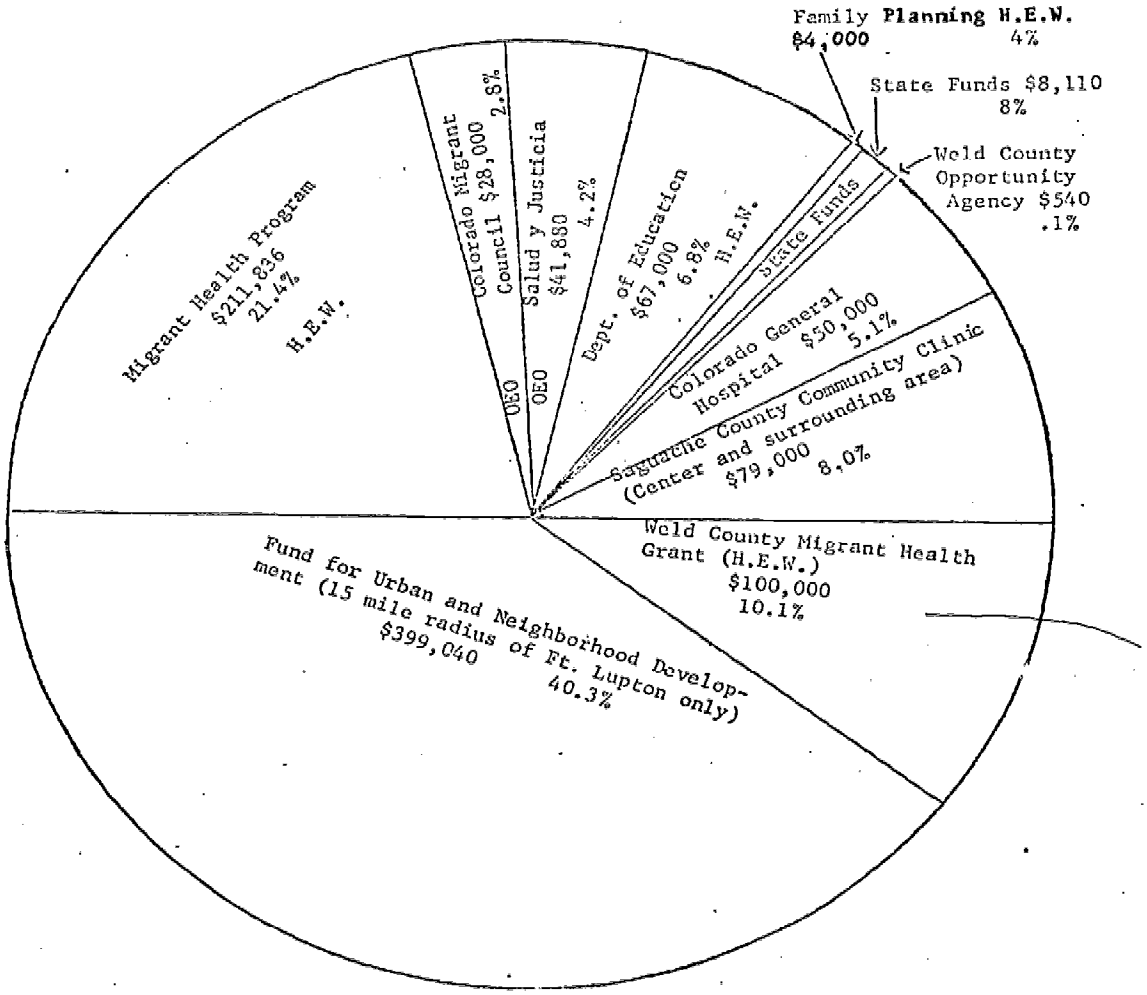
Legend:

========== (Formal)
- - - - - - - - - - (Informal)

D = Daily
W = Weekly
M = Monthly
------ Frequency of contact

Data have been presented which illustrate the progress made in cooperative funding. This system of resource utilization and its evident effectiveness generates a question with respect to the fragmentation of funding which makes this cooperative funding arrangement necessary in the first place. The following graph is presented to help illustrate the splintering which often originates at the Washington level, and which must be replaced subsequently at the local and State levels.

Health Care Resource Distribution
Migrant and Seasonal Agricultural Workers
Based on the 1971 agricultural season



This fragmentation seems to take place in an absence of knowledge of state and area needs and priorities. It also reflects an absence of consultation with the consumer or the deliverer of service. Too often, the distribution seems to result from the selling of an 'inovative' concept or over-selling of a need in areas which no longer experience the migrant labor impact. The popularization of an area name also seems to play too large a part in determining area needs. Unfortunately, the wheel which seems to speak the loudest is not always the one in most dire need of oil.

4. The Family Health Worker:

The use of aides recruited from the target population has provided for new insight to those responsible for program planning and operation. In addition to the out-reach capability, the Family Health Worker has made available, their evaluative capacity has enabled field and headquarters staff to provide and schedule services more exactly tailored to the needs of the consumer.

Criticisms which in the past remained unvoiced are readily expressed to the bi-lingual, bi-cultural aide who cannot only translate language, but also the often more important nuances of emotions. The differences of opinions among representatives of the consumer group can be assessed and weighed more intelligently by the Family Health Worker. This ability to distinguish between grain and chaff was not always found in the 'anglo' health worker. More often, the loudest and most persuasive argument was mistaken for a consensus of consumer opinion.

Family Health Workers provide day-to-day working contact with other area service agencies. This grass-roots level of inter-agency coordination results in the aide becoming a resource person and advocate of the consumer with respect to all aspects of health, welfare, legal aide, and other social services. Hence, the arrangements made at the administrative level are cemented at the consumer contact level, further reinforcing the entire system.

5. The 'one-roof' concept:

Reference was made, in the introduction, to the idea of consolidating all services under 'one-roof'. While the physical implementation of this has begun in only two of the five service areas, the basic concept is practiced in all. This attempt to serve the whole person in a comprehensive manner is a natural overgrowth of the Colorado system of inter-agency combined effort.

The mutual ignorance of program services which existed among agencies and groups in former years has been replaced with an awareness that works to the benefit of the bewildered consumer seeking help. In a certain sense, all program workers, in contact with the consumer, have become social workers, directing clients to resources, following up the results of referrals, and seeking alternatives when normal channels fail.

Program identities often become blurred when this concept is applied, but the partial loss of identity tends to serve the consumer interest in that he no longer has to contend with a confusing array of agency titles, finite specialities and petty differences with which he is usually profoundly unconcerned.

This close cooperation at the local level also tends to foster an atmosphere of cohesiveness among the staffs of the various agencies. The practical application of inter-agency coordination at the central administrative level is paralleled in the areas in that each program activity can draw strength from the others in solving problems.

The principle of staff continuity is also better served by consolidation of services. As personnel changes occur, there is usually a sufficient overlap to provide for the orientation of new permanent staff or seasonal personnel. Those who remain in the area, regardless of their agency sponsorship, are available to assist new staff members in determining area needs, and assessing area situations. Hence, the wheel need not be reinvented each season.

Obviously much of the success of the one-roof concept depends upon the interpersonal relationships which do or do not develop in each area. Staff members must be open to the idea of cooperation in the most practical sense. The selection of area staff, therefore, is a most critical step in the implementation of the one-roof idea. An idea which must be thoroughly understood and accepted by each person involved in its application.

State-wide implementation of the one-roof idea depends upon the extent to which facilities can be acquired in which the various agencies can be housed. It has been more difficult than was anticipated to find structures or relatively adjacent structures which meet the requirements of the participating agencies. Neither the funding strength of the several agencies nor the present state of the economy hold out much hope for the construction of buildings or complexes which would be adequate for the one-roof concept of operation.

6. Other medical care systems:

The Sangre de Cristo Comprehensive Health Center:

This office of Eco-omic Opportunity Agency located in San Luis (Costilla County) formerly served Costilla County (San Luis Valley) and the northern part of Taos County, New Mexico. During the current season, the scope of the clinic's operation was extended into neighboring Conejos County, thus relieving the Program of part of the burden in that Southern San Luis Valley area.

While this facility is well-equipped and staffed under the supervision of the Presbyterian Medical Services of the Southwest, the fact remains that most of the patients with whom this Program is concerned work in or reside in Alamosa, Rio Grande and Saguache Counties in the northern and central parts of the San Luis Valley. The extreme distances between centers of population in the Valley precludes use of the Sangre de Cristo facility by many. Additionally, local political factors have made it difficult for the Sangre de Cristo unit to plan satellites in these other areas of the Valley. In fact, it is still not certain as to what extent the San Luis-based health center will be able to operate in Conejos County.

The Saguache County Community Clinic:

This clinic operation, beginning from a base of zero assets, has grown from a weekend, volunteer staffed effort to a week-day clinic, partially staffed by paid personnel. The Clinic is consumer controlled and has served not only as a health facility but as a focal point for community involvement as well. Some of the agencies and organizations supporting the Clinic or proposing support are:

- Office of Economic Opportunity
- Freedom From Hunger Foundation
- Presbyterian Medical Services of the Southwest
- County Public Health Nursing Services
- Colorado Department of Health
- United States Army Medical Corps
- Department of Housing and Urban Development

Originally, the Clinic was proposed as a supportive facility of the Dicho y Hecho organization which was later to become a branch of the United Farmworkers Organizing Committee. Most of the community consumer board as well as some union officials felt that the union-affiliation of the clinic might detract seriously from potential support. Accordingly, direct communication with the United Farmworkers Organizing Committee was severed in the early stages of development. The Migrant Health Program contributed some drugs and medicines, biologicals, and small equipment items.

Physicians from the Denver-Boulder metropolitan area contributed professional time as did nurses and lab technicians. The only physician in the county gave assistance through his support of the concept and the use of some of his diagnostic and laboratory equipment. The County Public Health Nurse gave time as did the Nursing Coordinator for this program. One departmental physician, a pediatrician also contributed some professional time.

These early developments, which took place during the winter months of 1971 were followed by more formalized efforts by local supporters to secure sources of funding. Some severe differences of opinion and understanding detracted from progress during this time, but the consumer board was able to clarify their wishes, and many of the elements of confusion as to purpose and direction have subsequently disappeared or have been minimized.

The Migrant Health Program has used its mobile health center (Centro Movible de Salud) to augment clinic facilities, and program staff have extended their cooperation to clinic personnel. The program has also made a commitment to provide for the utilities hookup of a large trailer lent to the clinic by the Presbyterian Medical Services. This trailer will be used until a permanent clinic facility can be built.

Program patients are regularly referred to this clinic, and it is hoped that the future will bring a greater degree of program development in the support of this community endeavour. However, the extent of this involvement will depend upon resources available to the program upon the wishes of the consumer group governing the operation, the wishes of this Programs' area policy board and finally, upon the intended geographical scope of operation of the Clinic.

There is strong sentiment for a more comprehensive geographical commitment which will extend services and satellite operations beyond Saguache County to meet the needs of the rural poor in Alamosa and Rio Grande County areas adjacent to Saguache County.

The Baptist Health Center:

This clinic facility, operated by the Baptist Church in the barrio of Lariet, situated on the southern edge of Monte Vista, (Rio Grande County) in the San Luis Valley has served the rural poor for a number of years. A local physician in private practice serves as the clinician. In years past, not too many migrant patients availed themselves of the clinic services. Recently, however, this number has increased.

There has been some objection voiced among area consumers that there is an undue amount of proselytism involved in the operation of the clinic facility. While this allegation remains undocumented, the question seems to arise during most discussions of the clinic with respect to external support.

A significant amount of support has been made available to the clinic over the years by the Maternal and Child Health Section of the Colorado Department of Health. Further support, by this Program, would depend upon the viewpoint of the area consumer policy board, the wishes of the director of the Baptist Health Center, and upon arrangements made with respect to the Saguache County Community Clinic with which this Program seems to have more open lines of communication.

Plan de Salud de Valle:

Opereted by the Fund for Urban and Neighborhood Development, this facility is located in Fort Lupton (Weld County) in the North Central area. The ultimate goal seems to be the creation of a comprehensive health center. Unfortunately this operation is not deeply involved in the inter-agency communication effort that is so much a part of other Co-orado service programs. Little is known with respect to the extent to which the consumer board affects clinic policy nor to what extent that board actually represents the consumers in the Fort Lupton area.

Patients are referred by Migrant Health Program nurses to the Plan de Salud de Valle Clinic. Sufficient data with respect to numbers, ages, and sex distribution will hopefully be available toward the close of the current season.

No positive commitment with respect to geographical scope of operation has been made available thus far. It is the current understanding of the staff of this Program and that of the Colorado Migrant Council that this scope covers an area within a 15-mile radius of Fort Lupton.

The Plan de Salud de Valle operation is funded by the Department of Health, Education, and Welfare through the Migrant Health Act.

La Gente Clinic:

La Clinica de la Gente is a volunteer-staffed primary care center located in La Junta, (Otero County) in the Arkansas Valley. The building in which the facility is presented located is rented by the Colorado Migrant Council. Originally, the site was to have been used as a 'half-way house' for newly-arrived migrant families who found themselves without shelter. The 'Nosotros' group, composed of local people and outside volunteers developed the idea of a peoples free clinic. Again, volunteer physicians and other professional persons from the Boulder-Denver area manned the clinic on weekends.

As with all new concepts, a certain amount of controversy has attended efforts to establish this clinic. While the nature of the controversy bears similarity to that which surrounded the Saguache County operation, most of the circumstances were greatly different.

The La Junta Clinic is located in a well populated town in which a relatively large number of physicians practice. It is also located in a county which has a local health department. The initial level of support of this operation by the Colorado Department of Health was limited due to the reluctance of the Colorado Migrant Council area director to endorse the operation. It was his feeling that the clinic offered a low quality of medical care, alienated patients from established relationships with local physicians. He made this assessment upon the basis of his own observations and those of the Migrant Health Program nurses to whom he interprets area policy board wishes.

This same reluctance to endorse the clinic was voiced by a physician employed by the Otero County Health Department. Her objections were based upon what she felt to be poor follow-up of clinic findings and an overlapping of effort with respect to the following of patients by county public health nurses. Many of these patients were already enrolled in maternal and child health type programs for the treatment of chronic conditions.

In recent weeks, however, some of the controversial elements have been resolved, and a new assessment of this operation will have to be made. A problem relatively impossible to solve will remain however in the La Junta location of the clinic. It is felt by the area director of the Colorado Migrant Council and by Migrant Health Program staff that such a clinic is needed more toward the west -- Rocky Ford or Manzanola. However, the fact that the clinic is a La Junta community effort seems to preclude its physical removal to another area.

The full import of this organizational effort will not be known for many months. The extent to which local and state agencies and groups feel inclined to support the clinic will determine its ultimate success or failure.

7. Community and volunteer clinics:

It is hoped that far more utilization of community clinics and various volunteered staffed efforts will have been made during the present 1971 season. During the 1970 season, migrant attendance at the Sangre de Cristo and Monte Vista operations was minimal:

Sangre de Cristo Comprehensive Health Center -- 84 patients
Baptist Health Center, Monte Vista -- 25 patients

The increased use of these facilities tend to reduce the amount of dollars needed for each patient's care. Dur-ng the 1970 season, considerable use was made of volunteer physicians in the San Luis Valley. These doctors, from the University of Colorado Medical School, staffed weekend clinics sponsored by the Migrant Health Program during the potato harvest in the San Luis Valley. While the average cost per patient throughout all areas was $8.90 per visit, the cost in the San Luis Valley was only $6.63. Increased minor condition care by nurses and better screening is expected to further reduce the cost per patient during the 1971 season.

These questions and others relating specifically to medical care are dealt with in more detail in the Medical Care Section of this report.

DENTAL HEALTH NARRATIVE REPORT

MIGRANT HEALTH PROGRAM

1971

For the purpose of presenting a complete and up-to-date accounting of the migrant dental health program, this report includes an over-all picture of the 1970 migrant season, an interim report covering the current season, and recommendations for the 1972 program.

1970-71 SUMMER PROGRAM

I. BACKGROUND

The Migrant Dental Health Program provided dental health education and dental care for the migrant laborer and his family. A dental hygienist is employed full-time on the project. The project is concentrated into five regions of the state: North Central, Northeast, Arkansas Valley, San Luis Valley, and Western Slope. Counties included were: Adams, Delta, Kit Carson, Larimer, Morgan, Otero, Weld, Baca, Bent, Mesa, Logan, Saguache, Sedgwick, Prowers, Phillips, Yuma, Pueblo, Boulder, Conejos, Montrose and Saguache. The Migrant Project Dental Hygienist of the Colorado Department of Health, in a cooperative program with the Colorado Department of Education and Colorado Migrant Council, provided limited dental health services to the children enrolled in these programs.

Prior to the beginning of the migrant season the Project Dental Hygienist contacted other agencies involved in migrant programs. Included were: personnel with the Colorado Department of Health, Colorado Department of Education, Department of Social Services, Colorado Migrant Council, Migrant Ministry, and local migrant councils. In each participating county contact was made with migrant school principals, County Public Health Nurses and local dentists to integrate the migrant dental health program for that county.

Packets were distributed to each school and center including explanation of the program, sample forms, and dental health educational materials. Toothbrushes were distributed to schools and centers. A teacher's guide entitled "Dental Health Education in Migrant Schools" was made available to all staff members.

The Project Dental Hygienist visited the schools and conducted a dental inspection on each child. A second dental hygienist was employed by the project for six weeks to assist with the program. Those children in need of dental care were referred by the dental hygienists to local private dentists for dental treatment in their offices. The dentists had set aside blocks of time for the migrant children prior to the migrant season. The dentists were reimbursed on a fee-for-treatment basis.

Again this year the preventive program of "Brush-Ins" was conducted in the centers. A zirconium silicate toothpaste with a high concentration (9%) of fluoride was used by each child in the "Brush-Ins". The paste was developed for self-application by mass segments of the population. Documented studies have shown it to be effective in reducing dental caries by from 40 percent to 95 percent in both adults and children. The paste is effective for approximately six months.

The "Brush-Ins" were conducted in each classroom. Toothbrushes, prventive toothpaste, disposable aprons and cups were distributed to each child. The proper toothbrushing technique was first demonstrated and practiced by the children. Then, each child brushed his teeth with the preventive paste. The effectiveness of the application depends upon a thorough and systematic brushing of all surfaces of every tooth. Teachers, aides, nurses and volunteers assisted with the brushing.

All supplies for the program were furnished by the Colorado Department of Health. Approximately 2,240 school children participated. This was twice as many children as the previous year.

A card was developed and used in conjunction with the dental screening. The card contained a dental health message and what was found during the screenings. The children were given a card to take home. The purpose of the card was to inform the parents of the dental inspection, the condition of their child's teeth, and to relate dental health facts. The card was a bright cherry color and was printed in both English and Spanish.

Reimbursement agreements were signed with the Colorado Migrant Council and twelve of the school districts. The specified funds were to be spent for dental care. These agreements augmented the funds of the Colorado Department of Health's program.

Following are reports of the total school and pre-school dental health programs, regional programs and evening dental clinic statistics. Reports are presented in this manner to show scope of each phase of the program. Totals are included in the statistics section of the Annual Report.

II. SCHOOL AND PRE-SCHOOL PROGRAM

A. 1970 PROGRAM

A total of 28 summer migrant schools and 26 Colorado Migrant Council pre-school centers were included in the program. A total of 2,699 children were given a dental screening. 593 were children enrolled in Colorado Migrant Council Head Start Centers and 2,106 were children enrolled in Migrant Schools. They ranged in age from one to sixteen years.

As a result of the dental screenings, the children were classified, according to dental needs, into the following four categories: (1) those with no discernible dental defects, (2) those requiring routine dental treatment, (3) those requiring immediate treatment, (4) those with dental defects but not recommended for treatment at present.

44.1 percent of the children were in need of dental care. 13.1 percent were in need of emergency care. The percent of children needing dental care remained almost the same as in 1969 (43.5%). But, there was a 3.2 percent drop in those in need of emergency treatment.

The children were surveyed this year in respect to previous dental experiences. The verbal answers were unrelaible so note was made only of those children with visible signs of having had professional dental care, i.e., restorations. 695 of the children had been to a dentist. This was 25.8 percent of the total number examined. 43.6 percent of these children need further dental care.

During the dental screening, a record was kept of all children who exhibited fluorosis of the dental enamel. Variance was from mild fluorosis to mottled enamel. It has been a common belief that one reason for the lower decay rate in these children was that they come from the Southwestern United States where adequate amount of natural fluoride are frequently found in the water.

500 of the children examined were found to have fluorosis. This is 19 percent of those included in the program. 134 or 27 percent of these children needed dental care.

The OHI-S (Oral Hygiene Index - Simplified) was included in the dental screenings this year. The OHI-S was used to determine the amounts of retained food debris and calculus on the teeth. Results of this index provided information regarding home and professional dental care practices of the migrant children. The debris (DI-S) component was interpreted as an indication of the toothbrushing practices of the children. The calculus (CI-S) component was interpreted as an indication of the level of professional oral hygiene care.

DI-S and CI-S values range from zero to three. The OHI-S is the sum of the two components (DI-S and CI-S) with a numerical range of zero to six.

A base line OHI-S survey was done in 1967. Migrant children enrolled in summer school programs were included both years. The examiner was the same for both surveys.

The following Table indicates the average OHI-S rates per pupil in 1967 and 1970.

TABLE 1: AVERAGE OHI-S PER PUPIL

Year	Number Pupils	DI-S Ave./pupil	CI-S Ave./pupil	OHI-S Ave./pupil
1967	1,133	1.16	0.53	1.69
1970	468	.97	.37	1.34

It is difficult to conduct a controlled study because of the mobility of the target group. However, there is little doubt the OHI-S averages in 1970 were significantly lower. This is interpreted by the examiner as indicating a higher level of personal and professional oral hygiene care in 1970. Hopefully, Colorado's Migrant Dental Health Program and that of other states are contributing factors to the increase in improved oral hygiene practices of the migrant children.

This year an attempt was made again to estimate the total cost of dental treatment. At the time of the dental screening, an estimate was made for each child and recorded. Figures are used as a basis for request of future funds.

Total estimate of treatment costs for 1970 was $47,547.00. Based upon this figure, approximately $17.50 is needed for dental care for each child examined.

702 children and 104 adults received dental care. (Again, those children and adults examined and receiving treatment through evening and weekend clinics are not included in these figures.) This was 67.7% of those who were found to be in need of dental care. Total cost of this care was $35,015.00. An average of $44.00 per child was spent for the 702 children receiving treatment. An additional 127 children were authorized to receive dental care but moved or failed appointments.

6,854 direct care services were completed for these children and adults including x-rays, prophylaxis, extractions, amalgam restorations, crowns, and partial and full dentures.

B. COMPARISON OF 1970 WITH PAST SCHOOL AND PRE-SCHOOL PROGRAMS

TABLE 2: NUMBER EXAMINED; PERCENT NEEDING TREATMENT; PERCENT RECEIVING TREATMENT (OF THOSE NEEDING TREATMENT)

Year	Number Examined	Percent Needing Treatment	Percent Receiving Treatment
1967	1,799	56.5	49.5
1968	2,397	53.1	62.2
1969	2,880	43.5	56.2
1970	2,803	44.1	67.7

III. REGIONAL PROGRAMS

A. NORTH CENTRAL REGION (does not include clinics)

1. 1970 PROGRAM

A total of 1,095 children were examined in the summer migrant schools and pre-school centers in Greeley, Gilcrest, Ault, Fort Lupton, Eaton, Windsor, Fort Collins, Brighton, and Longmont. They ranged in age from two to sixteen years. 41.2 percent were in need of dental care. 311 of the children had previously been to a dentist for treatment. 124 needed further dental care.

278 children and adults received dental care for a total cost of $13,506.00. Twenty-eight of these were pre-school children, 247 were school children, and three were adults. Ninety-five of these school children received their care through contracts signed with six of the school districts totaling $4,300.00. Forty-nine additional children were authorized to receive care but moved or failed appointments. Estimated treatment costs were $17,632.00.

A total of 2,858 dental services were completed for the patients, including x-rays, prophylaxis, extractions and restorations.

2. BREAKDOWN BY AGE GROUP

TABLE 3: DATA BY AGE GROUP

Group	Number Examined	Number Receiving Treatment	Cost of Treatment	Number of Services
Pre-school	184	28	1,378.00	284
School Children	911	247	12,044.00	2,560
Adults	3	3	84.00	14

3. COMPARISON OF 1970 WITH PAST PROGRAMS

TABLE 4: NUMBER EXAMINED; PERCENT NEEDING TREATMENT; PERCENT RECEIVING TREATMENT (OF THOSE NEEDING TREATMENT)

Year	Number Examined	Percent Needing Treatment	Percent Receiving Treatment
1966	611	51.2	36.4
1967	871	55.7	29.7
1968	990	54.3	46.8
1969	1062	45.4	45.2
1970	1098	41.2	61.6

B. NORTHEASTERN COLORADO REGION PROGRAM

1. A total of 1,035 children were examined in the summer migrant schools and pre-school centers in Wiggins, Holyoke, Brush, Fort Morgan, Sterling, Ovid, Wray, Yuma, Weldona and Burlington. They ranged in age from one to sixteen years. 46.1 percent were in need of dental care. 227 of the children had previously been to a dentist for treatment. 109 needed further dental care.

   353 children and adults received dental care for a total cost of $13,272.00. Thirty-six of these were pre-school children, 240 were school children, and seventy-seven were adults. Seventy-nine of these school children received their care through contracts signed with five of the school districts totaling $2,510.00. Twenty-six additional children were authorized to receive care but moved or failed appointments. Estimated treatment costs were $19,235.00.

   A total of 2,449 dental services were completed for the patients, including x-rays, prophylaxis, extractions, restorations, crowns and dentures.

2. BREAKDOWN BY AGE GROUP

TABLE 5: DATA BY AGE GROUP

Group	Number Examined	Number Receiving Treatment	Cost of Treatment	Number of Services
Pre-school	230	36	1,636.00	328
School Children	805	240	8,880.00	1,753
Adults	77	77	2,756.00	368

3. COMPARISON OF 1970 WITH PAST PROGRAMS

TABLE 6: NUMBER EXAMINED; PERCENT NEEDING TREATMENT; PERCENT RECEIVING TREATMENT (OF THOSE NEEDING TREATMENT)

Year	Number Examined	Percent Needing Treatment	Percent Receiving Treatment
1967	513	54.8	94.7
1968	973	49.7	82.4
1969	1,197	42.4	65.7
1970	1,112	46.1	74.0

C. ARKANSAS VALLEY REGION PROGRAM

1. 1970 PROGRAM

A total of 305 children were examined in the summer migrant schools and pre-school centers in Manzanola, Rocky Ford, Las Animas, Walsh, Lamar, Granada and Vineland. They ranged in age from three to sixteen years. 38.4 percent were in need of dental care. Eighty-one of the children had previously been to a dentist for treatment. Thirty-three needed further dental care.

Sixty-seven children and adults received dental care for a total cost of $3,105.00. Four of these were pre-school children, fifty-two were school children, and eleven were adults. Five of these school children received their care through contracts signed with one of the school districts totaling $250.00. Twenty-eight additional children were authorized to receive care but moved or failed appointments. Estimated treatment costs were $3,975.00.

A total of 635 dental services were completed for the patients, including x-rays, prophylaxis, extractions and restorations.

2. BREAKDOWN BY AGE GROUP

TABLE 7: DATA BY AGE GROUP

Group	Number Examined	Number Receiving Treatment	Cost of Treatment	Number of Services
Pre-school	54	4	$ 165.00	39
School Children	251	52	2,129.00	507
Adults	11	11	811.00	89

3. COMPARISON OF 1970 WITH PAST PROGRAMS

TABLE 8: NUMBER EXAMINED; PERCENT NEEDING TREATMENT; PERCENT RECEIVING TREATMENT (OF THOSE NEEDING TREATMENT)

Year	Number Examined	Percent Needing Treatment	Percent Receiving Treatment
1966	52	65.4	58.8
1967	197	57.4	58.4
1968	287	50.9	64.3
1969	264	40.9	75.0
1970	316	38.4	57.3

D. SAN LUIS VALLEY REGION PROGRAM

1. 1970 PROGRAM

A total of 163 children were examined in the summer migrant schools and pre-school centers in Center, Blanca and Fort Garland. They ranged in age from two to thirteen years. 56.4 percent were in need of dental care. Sixty of the children had previously been to a dentist for treatment. Thirty-seven needed further dental care.

Forty-six children and adults received dental care for a total cost of $2,869.00. Forty-one of these were pre-school and school children, and five were adults. Thirteen additional children were authorized to receive care but moved or failed appointments. Estimated treatment costs were $4,285.00.

A total of 538 dental services were completed for the patients, including x-rays, prophylaxis, extractions, and restorations.

2. BREAKDOWN BY AGE GROUP

TABLE 9: DATA BY AGE GROUP

Group	Number Examined	Number Receiving Treatment	Cost of Treatment	Number of Services
Pre-school	61	(Pd. by D.H. funds)	-	-
School Children	102	41	$2,803.00	523
Adults	5	5	66.00	15

3. COMPARISON OF 1970 WITH PAST PROGRAMS

TABLE 10: NUMBER EXAMINED; PERCENT NEEDING TREATMENT; PERCENT RECEIVING TREATMENT (OF THOSE NEEDING TREATMENT)

Year	Number Examined	Percent Needing Treatment	Percent Receiving Treatment
1967	137	67.9	10.8
1968	66	54.6	19.4
1969	258	41.9	25.0
1970	168	56.4	50.0

E. WESTERN SLOPE REGION PROGRAM

1. 1970 PROGRAM

A total of 101 children were examined in the summer migrant school and pre-school centers in Grand Junction, Fruita, Delta and Montrose. They ranged in age from two to thirteen years. 53.5 percent were in need of dental care. Sixteen of the children had previously been to a dentist for treatment.

Sixty-two children and adults received dental care for a total cost of $2,263.00. Fifteen of these were pre-school children, thirty-nine were school children, and eight were adults. Eleven additional children were authorized to receive care but moved or failed appointments. Estimated treatment costs were $2,420.00.

A total of 374 dental services were completed for the patients, including x-rays, prophylaxis, extractions and restorations.

2. BREAKDOWN BY AGE GROUP

TABLE 11: DATA BY AGE GROUP

Group	Number Examined	Number Receiving Treatment	Cost of Treatment	Number of Services
Pre-school	64	15	$1,021.00	152
School Children	37	39	1,080.00	207
Adults	8	8	162.00	15

3. COMPARISON OF 1970 WITH PAST PROGRAMS

TABLE 12: NUMBER EXAMINED; PERCENT NEEDING TREATMENT; PERCENT RECEIVING TREATMENT (OF THOSE NEEDING TREATMENT)

Year	Number Examined	Percent Needing Treatment	Percent Receiving Treatment
1966	14	57.1	12.5
1967	81	54.3	38.6
1968	81	55.6	55.6
1969	99	46.7	93.5
1970	109	53.5	75.9

IV. MIGRANT DENTAL CLINICS

A. NORTH CENTRAL REGION - 1970

Migrant Dental Clinics were only held in the North Central Region this year. They were scheduled evenings and weekends in conjunction with Migrant Family Health Clinics. In 1970, fourteen clinics were held in Greeley, Brighton, Fort Lupton, Keenesburg, and Frederick.

One of the Project Dental Hygienists or Tri-County Health Department Dental Hygienists were in attendance at the clinics. Existing dental clinics or portable equipment was used. Services offered included: dental health education, dental examination, prophylaxis (on a limited basis) and referral for treatment.

Patients were seen from the surrounding area. They came to the clinics of their own accord or were referred by public health nurses, physicians, and family health workers. Interpreters were available if needed.

Dental health education was individually given to each patient seen in the clinic. Toothbrushes were given to each patient. The public health nurse contacted the patients in regard to dental appointments and conducted follow-up care when necessary Volunteers provided transportation to and from the dental offices.

Migrant school and preschool dental health programs are conducted through June and July. The Project Dental Hygienists are not available to begin evening and weekend clinics until the end of July. Clinics had to be discontinued early this year due to a lack of dental care monies.

Table 13 illustrates the number of patients examined in the clinics according to age group and sex.

TABLE 13 - PATIENTS EXAMINED ACCORDING TO AGE AND SEX

	1-13 Years	14 Years & Older	Total
Male	18	28	46
Female	34	43	77
TOTAL	52	71	123

A total of 123 patients were seen: 42.3 percent of the patients were under fourteen years of age and 57.7 percent were fourteen years or older; 37.4 percent were male and 62.6 percent were female.

76.4 percent of the patients examined needed dental care.

Patients who needed dental treatment were referred to local dentists in Adams, Weld, Boulder and Larimer Counties. Care was provided in the private dentist's office. Reimbursement was on a fee-for-service basis. Referrals were made by the dental hygienist and the migrant nurses.

105 children and adults received dental care for a total of $6,854.00. Thirty-two additional patients authorized to receive care failed to keep their appointments.

Table 14 illustrates the number of patients receiving care in each age group.

TABLE 14 - PATIENTS RECEIVING CARE ACCORDING TO AGE AND SEX

	1-13 Years	14 Years & Older	TOTAL
Male	10	25	35
Female	16	54	70
TOTAL	26	79	105

Of the patients receiving care, 24.8 percent were under fourteen years of age; and 75.2 percent were fourteen years or older. 33.3 percent were male and 66.7 percent were female.

A total of 1,045 dental services were completed for these patients.

Table 15 illustrated the dental services provided according to age group.

TABLE 15 - SERVICES PROVIDED BY AGE GROUPS

Services	1-13 Years	14 Years & Older	TOTAL
Examination	11	35	46
Prophylaxis & Periodontal Treatment	10	42	52
Fluoride	1	1	2
X-rays	33	268	301
Restorations	93	359	452
Extractions	22	124	146
Pulpotomy	8	-	8
Crowns	12	1	13
Partials-Dentures	-	11	11
Other	4	10	14

TABLE 16 - COMPARISON OF 1970 WITH PAST CLINIC PROGRAMS

Year	No. Clinic Locations	No. Clinics	No. Patients Seen	No. Patients Receiving Care
1965	1	7	44	4
1966	1	10	28	14
1967	1	10	71	18
1968	3	23	128	58
1969	2	30	150	99
1970	5	14	123	105

B. BRIGHTON DENTAL CLINIC - 1970

Seven evening dental clinics were held in Brighton in conjunction with Family Health Clinics. They were staffed by the Project Dental Hygienists and the Tri-County Dental Hygienists.

The dental clinics totaled 62 patient visits (some patients were seen more than once) - 27 males and 35 females. They ranged in age from two to seventy years. Twenty-five of those seen were under fourteen years of age and thirty-seven were over fourteen. Thirteen of the patients seen did not need dental care. Eight patients received a partial or complete prophylaxis in the clinics.

Sixteen children (under fourteen years) and thirty-two adults received dental care for a total of $2,537.00. The patients were referred to local dentists by the dental hygienists and migrant nurses. Sixteen additional patients were authorized to receive care but failed their appointments.

A total of 386 dental services were completed for these patients including x-rays, prophylaxis, restorations, extractions, crowns, periodontal treatment and dentures.

C. FORT LUPTON DENTAL CLINIC - 1970

The Project Dental Hygienist attended one evening migrant clinic in Fort Lupton. Conflicting scheduling and low clinic attendance were responsible for minimal dental services in this area. No patients were referred to the dental hygienist during the one clinic.

D. FREDERICK DENTAL CLINIC - 1970

One evening nursing clinic in Frederick was staffed by the Project Dental Hygienist. Migrants left the area and the nursing clinics were discontinued before more dental clinics could be scheduled.

Fifteen patients were examined by the dental hygienist - six males and nine females. They ranged in age from three to fifty-four years. Seven of those examined were under fourteen years of age and eight were over fourteen. All but three of the children needed dental care.

Five children (under fourteen years) and thirty adults received dental treatment for a total cost of $3,565.00. These patients were referred to local dentists by the dental hygienist and the migrant nurses. Two additional patients were authorized to receive care but failed appointments.

A total of 536 dental services were completed for these patients including x-rays, prophylaxis, restorations, extractions, periodontal treatment, crowns, root canal treatment, and dentures.

E. GREELEY DENTAL CLINIC - 1970

Three evening dental clinics were held in Greeley in conjunction with Family Health Clinics. Fifteen patients were examined by the Project Dental Hygienists - three males and twelve females. They ranged in age from three to thirty-nine years. Eight of those examined were under fourteen years of age and seven were over fourteen. Eight of those examined did not need dental care.

Two children (under fourteen years) and eleven adults received dental care for a total cost of $617.00. The patients were referred to local dentists by the dental hygienists and the migrant nurse. Five additional patients authorized to receive care failed to keep their appointments.

A total of seventy-six services were completed for these patients including x-rays, prophylaxis, restorations, extractions, and dentures.

F. KEENESBURG DENTAL CLINIC - 1970

One Sunday afternoon dental clinic was held in Keenesburg in conjunction with the Migrant Family Health Clinic. The Project Dental Hygienist examined patients in the Marycrest Health Van after they had seen the attending physician.

Thirty-one patients were given a dental screening - ten males and twenty-one females. They ranged in age from five to sixty-four years. Twelve of those seen were under fourteen years of age and nineteen were over fourteen. All but five of the patients examined needed dental treatment.

Three children (under fourteen years) and six adults received dental care for a total cost of $207.00. Nine additional patients were authorized to receive care but failed appointments.

A total of forty-seven services were completed for these patients including x-rays, prophylaxis, restorations, and extractions.

1970-71 SPRING PROGRAM AND 1971 SUMMER PROGRAM

I. INTRODUCTION

Spring is the time of planning and implementing for the Project staff. This section will include plans and objectives for the 1971-72 season with a brief description of accomplishments to date.

II. GENERAL OBJECTIVES

A. An integrated, comprehensive system for delivery of dental care:

It must be dynamic and continually improving and expanding. It must be responsive to the changing needs of the population it is to serve and the changing directions of the project.

B. Education, Prevention, and Treatment:

The number one area of concern for the migrant as well as the total population is dental. Dental problems are: universal in nature (affect almost everyone); irreparable in nature (tooth enamel cannot repair itself like other tissues of the body); is continuous in nature (decay and periodontal disease affect people all their lives).

C. Expansion of program to include seasonal and rural poor.

III. PROGRAM PLANNING - ACTIVITIES

A. Inter-Agency Coordination:

Considerable time was spent in dialogue with other agencies directly and indirectly involved with the migrant and rural poor. Project Hygienist directly participated in meetings of Migrant Coalition, Health Committee of Migrant Coalition, Legislative Action Group, Colorado Dental Association, local dental societies, Colorado Dental Hygienists' Association, and regional staff and Policy Board meetings.

B. Training and Orientation:

1. Provided extensive training with all pre-school personnel of Colorado Migrant Council Northern Region.

2. Provided training to Family Health Workers.

3. Provided training to dental aides.

4. Provided training to Project nursing staff.

5. Provided in-service training to migrant school personnel.

6. Involved Migrant Ministry, VISTAs, school and volunteers in providing dental outreach, follow-up and transportation.

C. Location of Other Dental Resources:

1. Several alternative plans to direct fee-for-service payment were discussed at length with Colorado Dental Association, local dental societies and individual dentists. Funds currently are not available for setting up a dental clinic with salaried dental personnel in one or all of the regional Migrant Centers. Most plans were discarded as not feasible this year. However, it should be noted that one dentist did agree to provide dental care for all migrant adults in his area for a fixed total cost. To date, he has provided services totaling approximately twice the set fee. Initial exploration with the dental societies in regard to personal contracts and fixed-fee arrangements should provide new systems of dental care delivery in 1972. There has been a marked increase in the use of dental specialists.

2. Dental care monies budgeted in 1971 grant are 1/3 of that budgeted the previous year. Colorado Migrant Council increased the amount contracted to us for dental care this year to help cover all dental costs for children enrolled in their programs. The Colorado Department of Education for the first time this year contracted dental monies on a state-wide basis in the amount of $21,000.00. This is a tremendous achievement in terms of inter-agency cooperation and coordination. Without these funds, the current year's dental care program could not have even provided emergency care to all who needed it.

3. Use of existing dental clinics:

a. Sangre de Cristo Clinic in San Luis, Colorado provided, at no cost to this project, all needed dental care for migrants in Costilla County.

b. Initial planning was carried out with the Center Community Clinic. However, the dental component is not in full-time operation at this time.

c. Salud del Valle in Ft. Lupton provided, at no cost to the project, dental care for migrant children in their target area referred by the project dental hygienist. Additional suggestion for coordination of programs and personnel unfortunately were not followed through by Salud del Valle. These suggestions and report on efforts for inter-project coordination follow. (Fort Lupton and Surrounding Area - Presented to Salud del Valle; Report on Salud del Valle to Project Director from Dental Hygienist; Supplemental Report on Salud del Valle; Dental Family Health Workers).

MIGRANT DENTAL HEALTH PROGRAM

FORT LUPTON AND SURROUNDING AREA - PRESENTED TO SALUD DEL VALLE

May 25, 1971

1970 Migrant Dental Health Program:

1. Dental screening on all children in Summer Migrant Schools and pre-school centers.

2. "Brush-Ins" Preventive Fluoride program for children in above programs.

3. Dental Health education in schools and pre-school centers, educational materials available to programs.

4. Arrangement and delivery of dental treatment with local dentists.

5. Adults seen in evening and weekend clinic in North Central Colorado.

6. Some patients given prophylaxis by project dental hygienists in evening clinics.

7. Dental Health education given for all seen in clinic.

8. Limited care provided to those seen in clinic. Care received in private dental offices.

9. Dental care was paid under a fee-for-service arrangement.

1971 Migrant Dental Health Program:

1. I will provide the migrant schools and pre-school centers in Ft. Lupton and Gilcrest with educational materials, training, toothbrush kits for all children.

2. I will conduct a dental screening on the above children on July 2nd and 7th (see enclosed green schedule)

3. I have checked with Mr. Joe Stockton, the migrant school director at Gilcrest, as to his school's boundaries. They are central Weld County, Keenesburg, Hudson, and Prospect. He felt that all of the migrant children in his school would be from your target area.

4. Projected needs: (see enclosed reports from last year)
   1970: Ft. Lupton - 59 children given a dental screening (total enrollment over 100)
   30% needed dental treatment - estimated cost $875.00.
   19 children received care (100% of those in need) - $1,392.00.
   20 - estimated man hours of local dentists' time to provide 19 children with dental treatment.

Gilcrest - 155 children screened (total enrollment 300)
38% in need of dental treatment - estimated cost - $1,055.00
33 - estimated man hours of local dentists' time to provide 35 children with dental treatment

1971: Ft. Lupton - 150 estimated enrollment
45-50 will need care
30 - estimated man hours needed (if all work completed)
Gilcrest - 301 estimated enrollment
75 estimated number in need of care
65 - estimated man hours needed (if all work completed)

5. Treatment Schedule: I have enclosed the treatment schedule from the Brighton Weld County dentists who will be providing the care for the other Weld County migrant schools. As you can see, blocks of time have been set aside in mornings following the dental screening. Mornings are the best time to fit into the school's schedule, for finding volunteer drivers to provide transportation to and from the clinic, and for the children who are not so tired and upset. The school will have permission slips signed by parents on all children for dental care.

   We discussed setting aside some mornings at the clinic if you have the available dental manpower for providing care for the migrant children. I will make referrals based upon the findings of the dental screening and the availability of your time and resources.

   If time is to be set aside for these children, I must inform the school directors as soon as possible so that drivers can be lined-up and field trips scheduled around the treatment time. If you are unable to provide care, I must begin locating other resources immediately.

6. There will be two Family Health Workers in the dental program this summer, who will be conducting:

   a. Fluoride program "Brush-Ins"
   b. Limited testing of children for dental knowledge and attitude
   c. Outreach work - survey of home dental habits - see enclosed procedures. (Perhaps Family Health Worker could spend some time with outreach workers in conducting the survey.)

7. The Dental Hygienist will hold evening clinics in North Central Colorado in July, August, and September. No schedule has been set at this time. Enclosed is a report of last year's clinics. It is hoped that referrals can be made to physicians for treatment, especially adults.

8. Perhaps you could make use of the Family Health Workers in your dental clinics, during the season. Both know dental assisting. The Dental Hygienist will also be available in lat summer to help in any way she can.

REPORT ON SALUD DEL VALLE - TO PROJECT DIRECTOR
August 1971

April 7 Met with Doctor Tappan at clinic. He introduced me to staff. Discussion with Sam Burns, Frank Woertman and Doctor Abeyta about program cooperation was favorable.

April 19 Wrote a letter (copy attached) to Sam Burns requesting follow-up meeting. No response to letter.

April 29 Trish Teed and I went to clinic. Sam Burns walked out as we went in. Talked a while to Doctor Tappan. He asked Frank Woertman to talk to us. After waiting 30 minutes, we sent back where Frank was repairing some equipment and presented ideas (attached). His response was favorable and requested further information. He felt he could commit the clinic to dental treatment of migrant children.

May 25 Hand delivered letter and information to clinic (attached). Frank was not there, so left it with receptionist. No response to this material.

July 2 Called clinic from Gilcrest School after screening. Talked to Emma - gave her information on number of children in need of care. Told her I needed to know that day if they could provide treatment. No response.

July 5. Authorized Gilcrest children to receive treatment by private dentists.

July 6. Jerry Sandoval called me at Greeley School. Had found letter I sent to Frank Woertman. Requested meeting.

July 7 and 8 Met with Doctor Dawson, Jerry Sandoval and Doctor Abeyta several times to work out details of treatment. Spent long hours in evenings reauthorizing these children and others from surrounding schools to private dentists. (See attached schedule and list for treatment).

The supplemental report attached from the two dental aides will give you an idea of what followed that involved them. The clinic has completed work on the Gilcrest School children and is now providing treatment for Fort Lupton school children.

I appreciate the cooperation received in regard to dental care. I feel a great deal needs to be done in areas of outreach and patient education. The two dental assistants could have provided much in these areas. Discussion and planning must be done previous to the season. The many hours spent redoing paper work, last minute meetings scheduled in already busy days, and the uncertainty of not knowing if the clinic would cooperate was

completely unnecessary. I have hopes that next year's program will provide better services to the migrant through closer inter-project cooperation.

SUPPLEMENTAL REPORT ON SALUD DEL VALLE FROM DENTAL FAMILY HEALTH WORKERS

At the end of July, the Project Dental Hygienist set up a meeting with Mr. Jerry Sandoval of the Fort Lupton Clinic. She wanted to see if the dental assistants could work out of the clinic doing home visits and some dental backup work. The dental assistants could also train their staff in this aspect. Mr. Sandoval forgot about the meeting.

During the end of July and beginning of August, the dental assistants stopped in at the clinic whenever they were in the area hoping to run into Mr. Sandoval. They did, finally, and set up a meeting with their staff to discuss what could be done.

At this meeting the dental assistants were introduced and Mr. Sandoval explained what they would like to do. One of the social workers thought it would be best to discuss this in more detail after the staff meeting. The Project Dental Hygienist was called to attend this later discussion.

After two days of sitting around and doing paper work, the dental assistants decided to give up the work in the clinic. They informed Doctor Abeyta, the clinic dentist, he could contact them if he wanted home visits done. He asked the dental assistants to come back on the next Tuesday and his assistant would have a list of homes to visit and that the assistant would come along for some training.

The dental assistants arrived at 10 a.m. on Tuesday morning and sat around until lunch time. After lunch they visited the one home the assistant could find to visit. Everyone's main worry seemed to be who would continue with home visits after the dental assistants were terminated.

D. Regionalization of Dental Program:

Regional migrant nurses have been given authority for the dental program in their area. This includes direct authorization of dental services. Dental clinics in Family Health Centers are held by project dental staff. Orientation and training of center staff in all phases of the dental program are in progress. Funds for dental care will be available through the end of the calendar year in each of the five regions. There are continuous efforts toward inclusion of a dental clinic in each regional center.

E. Use of Paraprofessional Personnel:

Much discussion and thought was given to the past practice of hiring a part-time dental hygienist during the peak season. Final decision was to hire two paraprofessionals to function directly within the dental program. To date, the results could not be more successful. A dental hygiene student and a Chicano dental assistant were hired. Both have dental background training. One of them, a dental assistant with Denver's Neighborhood Health Centers, was employed under a cooperative training program. She is now returning to Denver Health and Hospital Services in a new position in the career ladder. She will plan, organize, and implement a preventive "Brush-in" program in Denver, including training of other paraprofessionals.

1. Preliminary Plans for Dental Paraprofessionals:

a. Purpose: To provide migrant, seasonal and rural poor families with expanded dental health services.

b. Definition: A Family Health Worker under the supervision of the Project Dental Hygienist assists in providing dental hygiene education and preventive services to the migrant families in Colorado.

c. Qualifications:
- Mature in attitudes, ideas and approach to solving problems.
- Bilingual in English and Spanish preferred.
- Previous training or background in the dental field.
- Ability to communicate and build rapport with others.
- Have empathy for all cultures and social classes.
- Ability to take responsibility and work independently as assigned.
- Possess valid driver's license.

d. Employment and Salary: Two Family Health Workers - Dental: To be hired for two to three months each. Employment runs May 25 to August 20. Salary is $400 per month plus reimbursement for travel (10 cents per mile), and per diem ($14 per day maximum).

e. Duties:
- Shall be trained to assume all duties of general Family Health Workers (see attached "Migrant Family Health Worker - Qualifications and Duties, February 1970").

- Assist in conducting a program of self-application of fluoride preventive dentistry paste in the migrant schools and preschool centers, under the supervision of the Project Dental Hygienist, following training.
- Prepare and present dental hygiene educational talks to migrant families in the schools, preschool centers, clinics, and homes.
- Assist Project Dental Hygienist and project staff in developing and evaluating appropriate visual aides.
- Provide education, follow-up, and data on home habits by outreach work in the camps.
- Assist in gathering data in selected knowledge and attitudes by testing in schools (Questionnaire developed by Project Dental Hygienist and staff).
- Assist in collection and correlation of data at end of season to provide program direction for following year.

f. Orientation and Training: Provided by Project Dental Hygienist, Project Staff, and Dental Hygienist Consultant.

- Tentative Schedule:

May 25-28	Orientation week for Family Health Workers - Boulder.
June 1-4	Orientation at State Health Department to Migrant Dental Program. Accompany Project Dental Hygienist.
June 6-7	If possible, attend Colorado University workshop on Guidelines for Dental Health Education materials for use with Chicano people, Grant, Colorado.
June 10, 11, 14-18	Field training under supervision of Family Health Worker Coordinator, and Migrant Health Program nurse for the North Central area.
June 21-July 30	Conduct preventive "Brush-In" programs and dental hygiene educational programs in all summer migrant schools and pre-school centers.
August	Assist in migrant family service centers and clinics, make home visit, become involved in community organization and data collection through surveys in camps and schools.

2. The training and experience of the dental aides now qualify her to assume new duties in the following areas:

a. Brush-Ins
- Order all necessary supplies and materials for school, community and Head Start programs.
- Train dentists, teachers, nurses, aides, assistants in the techniques of "brush-ins".
- Orient those people listed above and others who assist during "brush-ins".
- Organize, set-up and carry out complete community "brush-in" programs for groups of various size and age.

b. Migrant Schools:
- Besides "brush-ins", has provided dental health education in the classroom.
- Provided dental health education to teachers and other school personnel.
- Surveyed the school children in regard to dental knowledge, attitudes, and practices. Has altered and improved on original survey questionnaire as the situation called for.

c. Outreach:
- Has gone into the migrant camps and homes to inform population of program and available resources.
- Provided dental health education in the homes.
- Oriented nurses and family health workers in ways of reaching the migrant with dental health information.
- Completed a survey of migrant families as to dental health practices and needs.

d. Clinics:
- Attended evening family health clinics.
- Provided education, screening and referral services to patients.

e. Collation of Data:
- Collated and compiled data from school and home surveys.
- Assisted in compiling statistical information for the Project Annual Report.
- Assisted in providing guidelines for future program directions based upon surveys and experience.

3. Dental Family Health Workers: - Activity Report for June 1 - August 19, 1971

2,579 children participated in preventive fluoride "brush-in" programs.
22 migrant schools included in programs.
27 surveys in migrant homes.
145 school children surveyed in eight migrant schools.
2 evening Migrant Health Clinics attended to date.
10 families surveyed in clinics.
11 patients seen in clinics.
4 days spent at Fort Lupton Clinic - Salud del Valle (time completely wasted due to lack of staff cooperation)

remainder of time spent in data collation.

4. Consumer Involvement:

An extensive effort will be made this year to contact directly the migrant and rural poor to identify their dental needs as they perceive them. This Spring, a home survey questionnaire was developed to determine the migrants' needs and practices. Two questionnaires were developed for use with school children. Results should show practices, knowledge and attitude of the target group. Information when tabulated will be invaluable in assessing the current dental program and providing future program directions. Questionnaire and procedures follow.

MIGRANT DENTAL HEALTH SURVEY - 1971

I. PURPOSE: To determine dental health practices and areas of need among the migrant population.

II. OBJECTIVES:

A. To obtain:

1. Family unit - number of members, sex and age distribution, permanent residence.

2. Dental practices:
- If they seek care - where and why.
- If they have toothbrushes and paste.
- Frequency of toothbrushing.

3. Knowledge of existing dental programs in schools including feed-back on program acceptability and effectiveness.

4. Specific dental needs of family group - especially adults.

B. To provide basic dental health education to family unit.

C. To determine future program direction to better meet educational treatment needs of the group.

III. PROCEDURES:

A. Development of a survey questionnaire.

B. Dental Family Health Workers conduct survey - working with Family Health Worker Coordinator, Migrant Nurses, Migrant Action Program students, and VISTA workers.

C. North Central region selected because of geographical accessibility and population concentration.

D. An initial target number of 50 family households to be contacted.

E. Dental health education to be combined with survey - distribution of toothbrushes, brushing instructions, nutritional information, basic dental health facts.

IV. CONCLUSIONS:

Findings to be correlated with caries experience found during clinic and school examinations and test on dental knowledge, attitudes and practices to be given in North Central region migrant schools.

MIGRANT DENTAL HEALTH SURVEY - 1971

1. Head of Household: Name _____
   Last First Middle

2. Descent: A C N O (circle one)

3. Number (by age):

	M	F
0-5 Years	____	____
5-15 Years	____	____
15 + Years	____	____

4. Permanent Residence (STATE): _____

5. How many have been to a DDS (by age): to a MD? To DDS in last year?

0-15 Years	____	____	____
15 + Years	____	____	____

6. Reason: Extraction_____ Fillings_____ Checkup_____ Other_____

7. Where (State): Instream?_____ Texas or home base?_____ Mexico?_____

8. Of those who had care in Colorado - how many by age:

	Under Migrant Health Program	On Their Own
0-15 Years	____	____
15 + Years	____	____

9. Toothbrushing: (a) How many own a brush?_____ (b) How many don't brush?____
   (c) How many brush once a day?_____ (d) How many brush twice a day?_____
   (e) How many brush more than twice?_____

10. Do parents encourage their children to brush?_____

11. Do they use toothpaste?_____ What?_____

12. Do parents know migrant school dental programs?_____

13. Which migrant school and comments on program?_____
    _____
    _____

14. How many of the children have participated in "Brush-Ins"?_____
    In Colorado?_____

15. Special dental needs or problems:_____
    _____
    _____

Date_____ Town_____
Interviewer_____ School district_____
County_____

MIGRANT DENTAL HEALTH PROGRAM - 1971

QUESTIONNAIRE I (6-7 YEAR OLDS)

NAME _____ DATE _____

AGE _____ INTERVIEWER _____

PERMANENT RESIDENCE (STATE) _____ SCHOOL _____

1. Why do we need our teeth?

For chewing [ ]

For good appearance [ ]

For correct speech [ ]

Other response [ ]

2. How do you take care of your teeth?

Brush them [ ]

Good diet [ ]

Visit the dentist [ ]

Other [ ]

3. How often should your teeth be brushed?

_____

4. In what direction should we brush our teeth?

_____

5. Do you have a toothbrush at home?

Yes [ ]

No [ ]

Do your parents remind you to brush?

Yes [ ]

No [ ]

6. Do your gums bleed when you brush your teeth?

Yes [ ]

No [ ]

7. If you had your choice of one snack after school, which would it be?

Apple [ ]

Candy bar [ ]

Fruit juice [ ]

Pop [ ]

Other [ ]

8. How often should you go to the dentist?

_____

9. If you have a cavity in your tooth, can the dentist usually repair it?

Yes [ ]

No [ ]

QUESTIONNAIRE I (cont.)

10. Have you ever been to a dentist?

Yes ☐

No ☐

For what reason?

Toothache ☐

Check-up ☐

Other ☐

11. Do you think it is necessary for a person to lose his teeth when he gets old?

Yes ☐

No ☐

12. How often do you eat candy?

Every day ☐

More than twice a week ☐

Less than twice a week ☐

Don't ☐

13. What kind of care do you think you give your teeth?

Very good ☐

Good ☐

Fair ☐

Poor ☐

14. How do you feel about going to the dentist?

Like it ☐

Don't mind it ☐

Don't like it ☐

Other ☐

15. Where do you think you learned most about dental health?

Home base school ☐

This school ☐

Parents ☐

Friends ☐

Television ☐

Dentist ☐

Other ☐

MIGRANT DENTAL HEALTH PROGRAM - 1971

QUESTIONNAIRE II (10-12 YEAR OLDS)

NAME _____ DATE _____

AGE _____ INTERVIEWER _____

PERMANENT RESIDENCE (STATE) _____ SCHOOL _____

1. Why do we need our teeth?

   For chewing [ ]

   For good appearance [ ]

   For correct speech [ ]

   Other response [ ]

2. How do you take care of your teeth?

   Brush them [ ]

   Good diet [ ]

   Visit the dentist [ ]

   Other [ ]

3. How often should your teeth be brushed?

   _____

4. In what direction should we brush our teeth?

   _____

5. Do you have a toothbrush at home?

   Yes [ ]

   No [ ]

   Do your parents remind you to brush?

   Yes [ ]

   [ ]

6. Do your gums bleed when you brush your teeth?

   Yes [ ]

   No [ ]

7. Do many people suffer from tooth decay?

   Yes [ ]

   No [ ]

8. What causes tooth decay?

   Eating sweets [ ]

   Failure to brush regularly [ ]

   Both [ ]

   Other _____

9. If you had your choice of one snack after school, which would it be?

   Apple [ ]

   Candy bar [ ]

   Fruit juice [ ]

   Pop [ ]

   Other [ ]

Do decayed teeth affect your general health?

Yes ☐

No ☐

If so, how? _____

How often should you go to the dentist?

_____

If you have a cavity in your tooth, can the dentist usually repair it?

Yes ☐

No ☐

Have you ever been to a dentist?

Yes ☐

No ☐

For what reason?

Toothache ☐

Check-up ☐

Other ☐

Why is it necessary for a dentist to X-ray your teeth?

_____

_____

Do you think it is necessary for a person to lose his teeth when he gets old?

_____

How often do you eat candy?

Every day ☐

More than twice a week ☐

Less than twice a week ☐

Don't ☐

17. What kind of care do you think you give your teeth?

Very good ☐

Good ☐

Fair ☐

Poor ☐

18. How do you feel about going to the dentist?

Like it ☐

Don't mind it ☐

Don't like it ☐

Other ☐

19. What are the parts of a tooth?

Crown ☐

Root ☐

Enamel ☐

Cementum ☐

Dentin ☐

Pulp ☐

20. Where do you think you learned most about dental health?

Home base school ☐

This school ☐

Parents ☐

Friends ☐

Television ☐

Dentist ☐

Other ☐

ACCOMPLISHMENT TO DATE OF GOALS AS SET FORTH IN THE 1971 PLAN FOR MIGRANT DENTAL HEALTH

Goals:	Accomplishments (to date):
1. Provide 8,500 dental services	1. 8,345 services provided
2. Include 3,100 children in fluoride program	2. 2,980 children in fluoride program
3. Survey 200 migrant homes	3. 52 homes surveyed
4. Survey 500 school children	4. 150 children surveyed

RECOMMENDATIONS FOR 1972 PROGRAM

I. Increased Use of Paraprofessionals.

This summer's practice of using dental aides in place of a second part-time hygienist should be continued. Direct services to migrants were greatly increased as a result. One dental aide should be employed for each of the five regions. Employment should be a year-round basis. They would work out of the regional health centers. Direct supervision would be given by the Project Dental Hygienist.

Areas of activity would include:

A. Preventive "Brush-In" programs for school and preschool children.

B. Direct dental health education in classrooms.

C. Direct patient education in clinics.

D. Gross screening of children for referral to local dental resources.

E. Outreach in the community.

F. Year-round dental programs with rural poor population.

II. Funds:

A. Increased grant funds for adult target population.

B. Increased use of local dental resources.

C. New ways for delivery of dental care.

III. Health Education:

A. Development of materials for target population.

B. Increased education programs with professionals and rural population groups.

Patients receiving dental services: COUNTY: STATEWIDE

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	2,926	2,751	175
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	1,438	1,247	191
Cases completed	911	728	183
Cases partially completed	NOT AVAILABLE		
Cases not started	527	519	8
c. Services provided: total	7,899	6,554	1,345
Preventive	423	340	83
Corrective	7,486	6,224	1,262
Extraction	850	532	318
Other	6,636	5,692	944
d. Patient visits: total	1,605	1,337	268

Patients receiving dental services: COUNTY: NORTH CENTRAL

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	1,211	1,147	74
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	555	483	72
Cases completed	365	301	64
Cases partially completed	NOT AVAILABLE		
Cases not started	190	182	8
c. Services provided: total	3,903	3,048	855
Preventive	197	148	49
Corrective	3,706	2,900	806
Extraction	347	226	121
Other	3,359	2,674	685
d. Patient visits: total	767	632	135

Patients receiving dental services: COUNTY: ADAMS

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	166	129	37
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	83	47	36
Cases completed	71	39	32
Cases partially completed	NOT AVAILABLE		
Cases not started	12	8	4
c. Services provided: total	649	401	248
Preventive	42	20	22
Corrective	607	381	226
Extraction	71	36	35
Other	536	345	191
d. Patient visits: total	118	77	41

Patients receiving dental services:

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	100	92	8
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	42	38	8
Cases completed	42	38	8
Cases partially completed	NOT AVAILABLE		
Cases not started	—	—	
c. Services provided: total	1,063	568	495
Preventive	42	26	16
Corrective	1,021	542	479
Extraction	102	36	66
Other	919	506	413
d. Patient visits: total	138	70	68

Patients receiving dental services: COUNTY: LARIMER

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	111	108	3
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	58	55	3
Cases completed	36	33	3
Cases partially completed	NOT AVAILABLE		
Cases not started	22	22	-
c. Services provided: total	392	378	14
Preventive	52	50	2
Corrective	340	328	12
Extraction	17	16	1
Other	323	312	11
d. Patient visits: total	71	67	4

Patients receiving dental services: COUNTY: WELD

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	844	818	26
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	364	343	21
Cases completed	208	191	17
Cases partially completed	NOT AVAILABLE		
Cases not started	156	152	4
c. Services provided: total	1,799	1,701	98
Preventive	61	52	9
Corrective	1,738	1,649	89
Extraction	157	138	19
Other	1,581	1,511	70
d. Patient visits: total	440	418	22

Patients receiving dental services: COUNTY: NORTH EAST

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	1,112	1,035	77
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	556	479	77
Cases completed	353	276	77
Cases partially completed	NOT AVAILABLE		
Cases not started	203	203	-
c. Services provided: total	2,449	2,078	371
Preventive	94	65	29
Corrective	2,355	2,013	342
Extraction	357	201	156
Other	1,998	1,812	186
d. Patient visits: total	551	451	100

Patients receiving dental services: COUNTY: KIT CARSON

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	302	247	55
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	171	116	55
Cases completed	112	57	55
Cases partially completed	NOT AVAILABLE		
Cases not started	59	59	-
c. Services provided: total	592	377	215
Preventive	34	7	27
Corrective	558	370	188
Extraction	142	54	88
Other	416	316	100
d. Patient visits: total	158	87	71

Patients receiving dental services: COUNTY: LOGAN

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	97	95	2
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	46	44	2
Cases completed	25	23	2
Cases partially completed	NOT AVAILABLE		
Cases not started	21	21	-
c. Services provided: total	153	149	4
Preventive	12	12	-
Corrective	141	137	4
Extraction	27	23	4
Other	114	114	-
(Patient visits: Total)	35	33	2

Patients receiving dental services: COUNTY: MORGAN

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	353	347	6
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	141	135	6
Cases completed	115	109	6
Cases partially completed	NOT AVAILABLE		
Cases not started	26	26	-
c. Services provided: total	852	793	59
Preventive	38	37	1
Corrective	814	756	58
Extraction	69	45	24
Other	745	711	34
d. Patient visits: total	178	169	9

Patients receiving dental services: COUNTY: PHILLIPS

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	119	114	5
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	56	51	5
Cases completed	27	22	5
Cases partially completed	NOT AVAILABLE		
Cases not started	29	29	-
c. Services provided: total	196	188	8
Preventive	3	3	-
Corrective	193	185	8
Extraction	41	36	5
Other	152	149	3
d. Patient visits: total	43	38	5

Patients receiving dental services: COUNTY: SEDGWICK

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	76	76	-
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	38	38	-
Cases completed	16	16	-
Cases partially completed	NOT AVAILABLE		
Cases not started	22	22	-
c. Services provided: total	88	88	-
Preventive	3	3	-
Corrective	85	85	-
Extraction	9	9	-
Other	76	76	-
d. Patient visits: total	23	23	-

Patients receiving dental services: COUNTY: TOTAL

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	165	156	9
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	104	95	9
Cases completed	58	49	9
Cases partially completed	NOT AVAILABLE		
Cases not started	46	46	-
c. Services provided: total	568	483	85
Preventive	4	3	1
Corrective	564	480	84
Extraction	69	34	35
Other	495	446	49
d. Patient visits: total	114	101	13

Patients receiving dental services: COUNTY: ARKANSAS VALLEY

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	316	305	11
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	134	123	11
Cases completed	67	56	11
Cases partially completed	NOT AVAILABLE		
Cases not started	77	77	-
c. Services provided: total	635	546	89
Preventive	93	90	3
Corrective	552	466	86
Extraction	71	38	33
Other	481	428	53
d. Patient visits: total	112	93	19

Patients receiving dental services: COUNTY: BACA

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	53	51	2
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	30	28	2
Cases completed	12	10	2
Cases partially completed	NOT AVAILABLE		
Cases not started	18	18	-
c. Services provided: total	102	97	5
Preventive	20	20	-
Corrective	82	77	5
Extraction	9	4	5
Other	73	73	-
d. Patient visits: total	19	17	2

Patients receiving dental services: COUNTY: BENT

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	23	23	-
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	9	9	-
Cases completed	9	9	-
Cases partially completed	NOT AVAILABLE		
Cases not started	-	-	
c. Services provided: total	41	41	-
Preventive	7	7	-
Corrective	34	34	-
Extraction	2	2	-
Other	32	32	-
d. Patient visits: total	10	10	-

Patients receiving dental services: COUNTY: OTERO

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	126	120	6
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	50	44	6
Cases completed	16	10	6
Cases partially completed	NOT AVAILABLE		
Cases not started	34	34	-
c. Services provided: total	161	105	56
Preventive	16	15	1
Corrective	145	90	55
Extraction	37	9	28
Other	108	81	27
d. Patient visits: total	28	18	10

Patients receiving dental services: COUNTY: PROWERS

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	91	90	1
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	31	30	1
Cases completed	16	15	1
Cases partially completed	NOT AVAILABLE		
Cases not started	15	15	-
c. Services provided: total	135	134	1
Preventive	26	26	-
Corrective	119	118	1
Extraction	10	10	-
Other	109	108	1
d. Patient visits: total	24	23	1

Patients receiving dental services: COUNTY: PUEBLO

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	23	21	2
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	14	12	2
Cases completed	14	12	2
Cases partially completed	NOT AVAILABLE		
Cases not started	—	—	
c. Services provided: total	196	169	27
Preventive	24	22	2
Corrective	172	147	25
Extraction	13	13	-
Other	159	134	25
d. Patient visits: total	31	25	6

Patients receiving dental services: COUNTY: SAN LUIS VALLEY

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	168	163	5
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	96	91	5
Cases completed	46	41	5
Cases partially completed	NOT AVAILABLE		
Cases not started	50	50	-
c. Services provided: total	538	523	15
Preventive	34	34	-
Corrective	504	489	15
Extraction	67	60	7
Other	437	429	8
d. Patient visits: total	94	89	5

Patients receiving dental services: COUNTY: COSTILLA

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	45	43	2
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	21	19	2
Cases completed	9	7	2
Cases partially completed	NOT AVAILABLE		
Cases not started	12	12	-
c. Services provided: total	109	100	9
Preventive	6	6	-
Corrective	103	94	9
Extraction	7	4	3
Other	96	90	6
	24	22	2

Patients receiving dental services: COUNTY: SAGUACHE

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	123	120	3
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	75	72	3
Cases completed	37	34	3
Cases partially completed	NOT AVAILABLE		
Cases not started	38	38	-
c. Services provided: total	429	423	6
Preventive	28	28	-
Corrective	401	395	6
Extraction	60	56	4
Other	341	339	2
d. Patient visits: total	70	67	3

Patients receiving dental services: COUNTY: WESTERN SLOPE

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	109	101	8
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	79	71	8
Cases completed	62	54	8
Cases partially completed	NOT AVAILABLE		
Cases not started	17	17	-
c. Services provided: total	374	359	15
Preventive	5	3	2
Corrective	369	356	13
Extraction	8	7	1
Other	361	349	12
d. Patient visits: total	81	72	9

Patients receiving dental services: COUNTY: DELTA

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	67	61	6
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	60	54	6
Cases completed	56	50	6
Cases partially completed	NOT AVAILABLE		
Cases not started	4	4	-
c. Services provided: total	324	311	13
Preventive	4	2	2
Corrective	320	309	11
Extraction	7	7	-
Other	313	302	11
d. Patient visits: total	71	64	7

Patients receiving dental services: COUNTY: TESA

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	16	14	2
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	6	4	2
Cases completed	3	1	2
Cases partially completed	NOT AVAILABLE		
Cases not started	3	3	-
c. Services provided: total	4	2	2
Preventive	1	1	-
Corrective	3	1	2
Extraction	1	-	1
Other	2	1	1
d. Patient visits: total	3	1	2

Patients receiving dental services: COUNTY: MONTROSE

Item	Total	Under 15	15 & Older
a. Number of migrants examined: total	26	26	-
Number of decayed, missing, filled teeth	NOT AVAILABLE		
Average DMF per person	NOT AVAILABLE		
b. Individuals requiring services: total	13	13	-
Cases completed	3	3	-
Cases partially completed	NOT AVAILABLE		
Cases not started	10	10	-
c. Services provided: total	46	46	-
Preventive	—	—	—
Corrective	46	46	-
Extraction	—	—	—
Other	46	46	-
d. Patient visits: total	7	7	-

ENVIRONMENTAL HEALTH NARRATIVE REPORT

MIGRANT HEALTH PROGRAM

June 1, 1970 - June 1, 1971

SANITATION SERVICES:

I. A. The objectives of this component were to provide for the physical well-being of migrant and local residents through improvement of their living and working environment in rural areas. Methods used include:

1. Inspections of housing facilities to determine conformance with department "Standards and Regulations for Labor Camps".

2. Surveys of slum transient housing facilities and substandard rentals based on compliance with applicable standards or public health statutes relating to health and safety hazards or nuisance conditions.

3. Notices to operators and owners ordering correction of deficiencies within a stipulated period or condemnation of housing for purposes of habitation with ensuing legal action initiated upon non-compliance.

4. Promotion of construction of new housing in communities having severe housing shortages for permanent and transient residents; particularly in those areas with a large influx of migrant labor competing with permanent residents for the limited amount of decent available housing. Promotional efforts consist of community block environmental surveys, public meetings, organizing local citizens' improvement groups, consultation with Federal funding agencies and with county commissioners, town boards, city council and other local officials to develop appropriate codes and to develop low cost housing facilities.

B. The level of service and program accomplishment has been conditional upon staffing for field activities. Field personnel on the state level has been insufficient to effectively conduct the program activities which have been restricted to complaint response and requests for service. Staffing for this report period is noted as follows:

1. Weld County: One full-time sanitary aide employed by county for part-time activities in migrant housing.

2. Boulder County: Part-time migrant housing activities by a county sanitarian.

3. Otero County: Complete program functions relating to housing and field sanitation by county health department director and one sanitary aide. No significant efforts made by any other county health department in the state.

4. Two full-time housing consultants employed by the Colorado Department of Health. One assigned to Denver office and one stationed in San Luis Valley to cover balance of state including departmental direct service counties and those county or district health departments not providing service.

C. Major on-going and functioning relationships have been continued with the following:

1. U. S. Labor Department, Colorado Employment Department, coordination of survey findings and program requirements for the provision of adequate housing and field sanitation facilities.

2. Colorado Division of Housing, Farmers Home Administration, H.U.D. Local Housing Authorities, County and Town Officials. Water Pollution Commission, consult, participate, and assist as indicated in promoting development and production of low cost and subsidized housing in agricultural communities.

3. Colorado Migrant Council, Colorado Rural Legal Services, Salud y Justicia, Dicho y Hecho, Colorado Migrant Ministry, Local Council of Chicano Citizens, VISTA, Community Action Program groups and other government and private service organizations by providing information about improper environmental conditions and about local groups interested in the development and implementation of plans for housing and improvements in living and working conditions.

4. University of Colorado: Assisting by orienting VISTA trainees and health aides in the basics of sanitation.

5. University of Denver (Denver Research Institute): Metro Fair Housing Inc., Colorado Housing Inc., Colorado Housing Development Inc., and Great Western United Foundation Consultation and assistance in planning construction of individual dwellings and community-type housing developments.

6. Great Western, Holly, and American Crystal Sugar Companies, Kuner Empson, Western Canning and other food processing companies: Additionally, beet growers association chapters, grower co-ops, onion and potato growers associations, and other produce and and fruit growers groups. Cooperation of above agriculture groups in providing information about program requirements and stimulating grower interest in compliance, through growers meetings and information in the organizations news releases.

II. Table A, Part IV reflects total number of family and single type housing facilities in the state that are or have been used. The figures do not indicate housing numbers inspected this report period because severe staffing shortages prevented extensive housing survey activities. The statistical summary of Environmental Health Activities indicates statewide and by county the numbers of inspections, re-inspections, conducted and the numbers of deficiencies and corrections by type. The numbers do not reflect all the poor housing in a county or counties having migrants or substantial migrant housing problems.

A. Most migrant housing now in Colorado consists of on farm single family or 2-8 unit multiple family occupancies. They are located in old farm houses, in buildings of standard construction, or in dual purpose utility buildings. Also an increasing number of mobile homes individually or centrally located in on farm mobile home type parks. The latter range up to 45 mobile homes in one location. Barracks type facilities for single workers are provided as noted in the population and housing data section for counties in Arkansas Valley, San Luis Valley, and Western Colorado. Large family type camps are being abandoned and there is a heavy increased use of slum rentals in agricultural area communities because of program pressures.

B. There is no requirement for permits in Colorado and enforcement criteria are departmental "Standards and Regulations for Labor Camps" adopted by the Colorado Board of Health on June 18, 1968. They are comprehensive in scope to adequately cover sanitation deficiencies common to such housing. They are limited in areas of application relating to (slum) rentals, converted store buildings, etc.. Statutory is also provided for abatement of public health nuisances in Chapter 66, Article 1, Colorado Revised Statutes as amended 1969 and there are applicable departmental regulations for control of improper environmental conditions in Public or transient housing accommodations.

C. The major factor contributing to the improvement in housing conditions has been a strict enforcement program. However, some adverse side effects have resulted, such as attempts by growers to circumvent requirements by continuing to:

1. House migrants in slum rentals, substandard hotels, motels, etc. or by not providing housing and compelling migrants to seek out their housing in farming area towns.

2. House migrants in adjacent state border towns, particularly along Colorado-Kansas boundary.

3. Hide illegal Mexican Nationals (single and family groups) in abandoned shacks, truck bodies, cellars, barns, chicken houses, etc. to avoid detection. There is extremely sharp increase in the use of this labor source over past several years. It is estimated approximately 2,500 of these workers were employed

in the fields during 1970. This does not indicate total numbers since most are employed in construction, industrial, and manufacturing activities in urban areas. Accordingly, it has been necessary to broaden the scope of migrant housing activities into a more generalized environmental health program.

D. Table B, Part IV. All sanitation categories were considered during inspections conducted at each location. (Refer to "Statistical Summary of Environmental Health Activities"). The number of corrections with respect of total numbers of inspection and numbers of defects found, is not numerically or accurately illustrated since many camps were vacated and closed to further use upon order. Program efforts have been directed, during the past year, to complaints of substandard housing conditions. Therefore, most camps were ordered closed and corrections were not made. Housing, other than in camps or on farms, is not specifically identified because of coding system limitations and changes of system are not indicated, since the program is being deemphasized as a result of a lack of funding for staffing.

E. Insufficient staffing levels have permitted only limited attention to sanitary facilities for field and shed workers. Such efforts have been confined to requiring produce growers and shippers to provide water, toilet and hand washing facilities in the Arkansas and San Luis Valley and have been reasonably successful. However, these sanitary facilities are lacking in balance of agricultural areas of the state.

F. Principle difficulties in achieving program goals continue to be:

1. Insufficient field staffing.

2. Inherent antagonisms and oppositions to a housing enforcement program.

3. Limited numbers of proprietary farm operators. Most farming acreages in the state which require field labor are absentee owned. The percentages from 60 to 80 percent. The land is held in estates, owned by retired farmers, widows, or by speculative groups for investment purposes. Their interest is not in rehabilitating or maintaining dilapidated labor housing for tenant farmers operating on an annual contractual basis.

4. Failure of operators to provide or maintain labor housing. Operators are reluctant and often financially unable to repair or improve housing on farms not owned by them and rented only for the agricultural season.

5. Tremendous influx of illegal Mexican aliens, and natural tendency of the farmer employer to hide them in barns, cellars, chicken houses, etc., since the location of labor housing is usually more conspicuous.

6. Provision of labor housing not always economically feasible. Many crops require labor for short seasonal periods, e.g., peach, cherry, pear, harvest one to two weeks; potato harvest 4 weeks; sugar beet cultivation 4 to 6 weeks. The short term occupant use periods and the decreasing costs of mechanization and herbicide use permitting increased use of same make it economically unfeasible to build, repair, or otherwise maintain farm labor housing. Additional factors are real property taxes and upkeep costs resulting from some vandalism damaged caused by migrants or local delinquents.

7. Financial limitations; cost-profit margin compaction, increased fixed costs; interest, taxes, repairs, labor and a decreased return on the investment does not provide sufficient money for capital improvements, especially by tenant farmers.

8. Seasonal crop losses: Colorado is generally considered high risk growing areas because of variable adverse climatic conditions. However, excessively heavy crop losses have been experienced over past two years and financial repercussions continue and acreages devoted this year to some of these high priced, high risk labor crops have continue to decrease.

G. The continued trend is toward:

1. Production of feed crops to serve needs of increasing numbers of feed lot operations.

2. Increased mechanization to eliminate labor and need for housing.

3. Reliance on various kinds of slum rental housing in the agricultural area communities for their farm labor.

4. Increased use of illegal Mexican Nationals, singles and families.

5. Increased use of locals to obviate the cost of housing and collateral costs of using migrant labor. At present local workers provide more than one-half of the agricultural seasonal labor needed in the state. The number is increasing because of higher unemployment rates, opportunities for women and students to secure part-time work, and a higher settling out rate of migrants. The migrants are so intermingled with the local agricultural seasonal workers in slum sections of some agricultural areas that solutions to sanitation problems must now be considered on a community-wide basis to serve all residents.

H. The transitional trends makes necessary, continuing evaluations and applications of program approaches to achieve maximum accomplishment and effectiveness in providing an adequate level of environmental health services to the rural poor of Colorado. However, existent budget problems that relate to personnel employment severely limit efforts in this regard.

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

ANNUAL PROGRESS REPORT - MIGRANT HEALTH PROJECT

DATE SUBMITTED

PERIOD COVERED BY THIS REPORT

FROM	THROUGH

PART I - GENERAL PROJECT INFORMATION

1. PROJECT TITLE

2. GRANT NUMBER (Use number shown on the last Grant Award Notice)

3. GRANTEE ORGANIZATION (Name & address)

4. PROJECT DIRECTOR

SUMMARY OF POPULATION AND HOUSING DATA FOR TOTAL PROJECT AREA

5. POPULATION DATA - MIGRANTS (Workers and dependents)

a. NUMBER OF MIGRANTS BY MONTH

MONTH	TOTAL	IN-MIGRANTS	OUT-MIGRANTS
JAN.			
FEB.			
MAR.			
1971 APRIL	794	794	N.A.
1971 MAY	2,588	2,588	
1970 JUNE	14,478	14,478	
o1970 JULY	10,288	10,288	
o1970 AUG.	9,524	9,524	
+1970 SEPT.	6,040	6,040	
1970 OCT.	4,674	4,674	
NOV.	440	440	
DEC.			
TOTALS	48,826	48,826	

b. NUMBER OF MIGRANTS DURING PEAK MONTH

	TOTAL	MALE	FEMALE
(1) OUT-MIGRANTS:			
TOTAL	N.A.		
UNDER 1 YEAR			
1 - 4 YEARS			
5 - 14 YEARS			
15 - 44 YEARS			
45 - 64 YEARS			
65 AND OLDER			
(2) IN-MIGRANTS:			
TOTAL			
UNDER 1 YEAR			
1 - 4 YEARS			
5 - 14 YEARS			
15 - 44 YEARS			
45 - 64 YEARS			
65 AND OLDER			

7239 workers 14 yrs. and over
Approx. same number of non-wo
ing dependents. Information
categorizing age not availabl
Peak month is June with crop
activities primarily beet cul
vation. Workers consist prima
of Span.-Amer. locals and mig
family workers. This is the o
month that numbers of out of
state migrant labor exceeds t
number of local laborers.

c. AVERAGE STAY OF MIGRANTS IN PROJECT AREA

	NO. OF WEEKS	FROM (MO.)	THROUGH (MO.)
OUT-MIGRANTS	22	5-1	10-15
IN-MIGRANTS			

d. (1) INDICATE SOURCES OF INFORMATION AND/OR BASIS OF ESTIMATES FOR 5a.

1. Sugar processors: Great Western, Holly, and American Crystal.
2. Food Processors: H.J. Heinz, Kuner Empson, Western Canning Co.
3. Local Co-op and Grower Associations: Potato, Lettuce, Onion, Peach, Apple & Labor Contractors
4. Government Agencies: Colo. Employment Dept., U.S. Labor, U.S. Immigration.

Includes following Single Workers; Does not include approx. 2500 illegal Mex. Nationals.
* 500 in Peach harvest + 100 in Broom Corn harvest
o 500 in Lettuce harvest

6. HOUSING ACCOMMODATIONS

a. CAMPS

MAXIMUM CAPACITY	NUMBER	OCCUPANCY (PEAK)
LESS THAN 10 PERSONS		
10 - 25 PERSONS		
26 - 50 PERSONS		
51 - 100 PERSONS		
MORE THAN 100 PERSONS		
TOTAL*		

REFER TO NEXT PAGE

b. OTHER HOUSING ACCOMMODATIONS

LOCATION (Specify):	NUMBER	OCCUPANCY (PEAK)
TOTAL*		

*NOTE: The combined occupancy totals for "a" and "b" should equal approximately the total peak migrant population for the year.

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OF PROJECT AREA - Append map showing location of camps, roads, clinics, and other places important to project.

HOUSING ACCOMMODATIONS a. CAMPS MAXIMUM CAPACITY	F NUMBER	F OCCUPANCY (PEAK)	F D.U.	S NUMBER	S OCCUPANCY (PEAK)	S D.U.
LESS THAN 10 PERSONS	1,732	11,684	1,732	6	40	3
10 - 25 PERSONS	674	12,876	1,752	32	570	32
26 - 50 PERSONS	98	3,526	536	29	1,053	29
51 - 100 PERSONS	18	1,288	212	15	1,325	15
MORE THAN 100 PERSONS	9	2,658	360	3	450	3
TOTAL*	2,531	32,032	4,592	85	3,438	85

b. OTHER HOUSING ACCOMMODATIONS LOCATION (Specify)	F NUMBER	F OCCUPANCY (PEAK)	F D.U.	S NUMBER	S OCCUPANCY (PEAK)	S D.U.
Less than 10 pers.	106	716	106	0	0	0
10-25 persons	41	738	109	1	20	1
26-50 persons	18	414	63	7	266	7
51-100 persons	3	216	35	5	372	5
More than 100 pers.	0	0	0		0	0
TOTAL*	168	2,084	313	13	658	13

* Capacities only. Total occupant loads not determined because all housing occupied by migrants not surveyed. Occupant data for inspected dwellings noted in "Statistical Summary" of Environmental Health Services.

F = Family
S = Singles

PART IV - SANITATION SERVICES

GRANT NUMBER

TABLE A. SURVEY OF HOUSING ACCOMMODATIONS

HOUSING ACCOMMODATIONS *F = Family *S = Singles	TOTAL NUMBER	TOTAL MAXIMUM CAPACITY	COVERED BY PERMITS NUMBER	COVERED BY PERMITS MAXIMUM CAPACITY
CAMPS	2,531 85	32,032 3,438		
OTHER LOCATIONS	168 13	2,084 658		
HOUSING UNITS - Family:				
IN CAMPS	4,592	32,032		
IN OTHER LOCATIONS	313	2,084	No permit provisions in Colorado	
HOUSING UNITS - Single				
IN CAMPS	85	3,438		
IN OTHER LOCATIONS	13	658		

TABLE B. INSPECTION OF LIVING AND WORKING ENVIRONMENT OF MIGRANTS

ITEM	NUMBER OF LOCATIONS INSPECTED*		TOTAL NUMBER OF INSPECTIONS		NUMBER OF DEFECTS FOUND		NUMBER OF CORRECTIONS MADE	
LIVING ENVIRONMENT:	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHE
a. WATER	273	477			168		30	
b. SEWAGE	273	477			260		38	
c. GARBAGE AND REFUSE	273	477			157		22	
d. HOUSING	273	477			261		21	
e. SAFETY	273	477			64		17	
f. FOOD HANDLING	273	477			84		18	
g. INSECTS AND RODENTS	273	477			118		23	
h. RECREATIONAL FACILITIES	Not within survey scope							
WORKING ENVIRONMENT:								
a. WATER	xxxx		xxxx		xxxx		xxxx	
b. TOILET FACILITIES	xxxx		xxxx		xxxx		xxxx	
c. OTHER	xxxx		xxxx		xxxx		xxxx	

*Detailed info. in "Statistical Summery of Environmental Health Activities". Camps and other locations not individually categorized.

* Locations – camps or other locations where migrants work or are housed.

PART V - HEALTH EDUCATION SERVICES (By type of service, personnel involved, and number of sessions.)

TYPE OF HEALTH EDUCATION SERVICE	NUMBER OF SESSIONS: HEALTH EDUCATION STAFF	PHYSICIANS	NURSES	SANITARIANS	AIDES (other than Health Ed.)	OTHER (Spec
A. SERVICES TO MIGRANTS.						
(1) Individual counselling				86		
(2) Group counselling						
B. SERVICES TO OTHER PROJECT STAFF:						
(1) Consultation						
(2) Direct services						
C. SERVICES TO GROWERS						
(1) Individual counselling				108		
(2) Group counselling				* 4 G, 240 P		
+D. SERVICES TO OTHER AGENCIES OR ORGANIZATIONS:						
(1) Consultation with individuals				396		
(2) Consultation with groups				* 59 G, 1244 P		
(3) Direct services				60		
E. HEALTH EDUCATION MEETINGS						

* G=Groups * P=Persons

\+ Number is disportionate but results from tremendous increase service requests, i.e., information, materials, miscellaneous inquiries, speeches and panel participation at meetings, training, field trips, etc., by the proliferating Federal Grant Program agencies servicing migrants.

POPULATION AND HOUSING DATA

FOR SAN JUAN BASIN, DOLORES-MONTEZUMA COUNTIES

GRANT NUMBER

INSTRUCTIONS: Projects involving more than one county will complete a continuation sheet (page 1 ___) for each county and summarize all the county data for total project area on page 1. Projects covering only one county will report population and housing on page 1.

E. POPULATION DATA - MIGRANTS (*Workers and dependents*)

a. NUMBER OF MIGRANTS BY MONTH

MONTH	TOTAL	IN-MIGRANTS	OUT-MIGRANTS
JAN.			
FEB.			
MAR.			
APRIL	80	80	N.A.
MAY	160	160	
JUNE	200	200	
JULY	500	500	
AUG.	400	400	
SEPT.	250	250	
OCT.	200	200	
NOV.			
DEC.			
TOTALS			

b. NUMBER OF MIGRANTS DURING PEAK MONTH

	TOTAL	MALE	FEMALE
(1) OUT-MIGRANTS:			
TOTAL			
UNDER 1 YEAR			
1 - 4 YEARS		N.A.	
5 - 14 YEARS			
15 - 44 YEARS			
45 - 64 YEARS			
65 AND OLDER			
(2) IN-MIGRANTS:			
TOTAL			
UNDER 1 YEAR			
1 - 4 YEARS	250 workers and		
5 - 14 YEARS	250 non-working dependents		
15 - 44 YEARS			
45 - 64 YEARS			
65 AND OLDER			

c. AVERAGE STAY OF MIGRANTS IN COUNTY

	NO. OF WEEKS	FROM (MO.)	THROUGH (MO.)
OUT-MIGRANTS			
IN-MIGRANTS	8 (dry bean)	8-1	9-1

6. HOUSING ACCOMMODATIONS

a. CAMPS

MAXIMUM CAPACITY	D.U.	NUMBER	OCCUPANCY (*Peak*)
LESS THAN 10 PERSONS	12	12	68
10 - 25 PERSONS	3	1	18
26 - 50 PERSONS			
51 - 100 PERSONS			
MORE THAN 100 PERSONS			
Total*	15	13F	86F

b. OTHER HOUSING ACCOMMODATIONS

LOCATION (*Specify*)	NUMBER	OCCUPANCY (*Peak*)
0	N.A.	
TOTAL*		

*NOTE: *The combined occupancy total for "a" and "b" should equal approximately the total peak migrant population for the year.*

REMARKS

F = Family
S = Singles

Above housing condemned and vacated but not demolished. Acceptable housing for Navajo Indian families cultivating and harvesting pinto beans virtually non-existent. No program activities this reporting period.

PH RE (PAGE 1 ___)

(CONTINUATION PAGE FOR PART I)

POPULATION AND HOUSING DATA
FOR WESTERN SLOPE ~~COUNTY~~

GRANT NUMBER

INSTRUCTIONS: Projects involving more than one county will complete a continuation sheet (page 1 ___) for each county and summa all the county data for total project area on page 1. Projects covering only one county will report population and hou on page 1.

5. POPULATION DATA - MIGRANTS (*Workers and dependents*)

a. NUMBER OF MIGRANTS BY MONTH

MONTH	TOTAL	IN-MIGRANTS	OUT-MIGRANTS
JAN.			
FEB.			
MAR.			
71 APRIL	14	14	N.A.
71 MAY	8	8	
70 JUNE	210	210	
70 JULY	240	240	
70 AUG.	710	710	
70 SEPT.	860	860	
70 OCT.	250	250	
70 NOV.			
70 DEC.			
TOTALS	2,292	2,292	

b. NUMBER OF MIGRANTS DURING PEAK MONTH

	TOTAL	MALE	FEMALE
(1) OUT-MIGRANTS:			
TOTAL	N.A.		
UNDER 1 YEAR			
1 - 4 YEARS			
5 - 14 YEARS			
15 - 44 YEARS			
45 - 64 YEARS			
65 AND OLDER			
(2) IN-MIGRANTS:	680 workers and 180 non-working dependents Does not accurately reflec numbers of dependents for other seasonal periods because of large influx of single people harvesters from Aug. 15 to Sept. 15.		
TOTAL			
UNDER 1 YEAR			
1 - 4 YEARS			
5 - 14 YEARS			
15 - 44 YEARS			
45 - 64 YEARS			
65 AND OLDER			

c. AVERAGE STAY OF MIGRANTS IN COUNTY

	NO. OF WEEKS	FROM (MO.)	THROUGH (MO.)
OUT-MIGRANTS	6 (beets) 4 peaches	June 1 August 15	July 15 Sept. 15
IN-MIGRANTS	8 apples		

6. HOUSING ACCOMMODATIONS

a. CAMPS

MAXIMUM CAPACITY	NUMBER	OCCUPANCY (*Peak*)
LESS THAN 10 PERSONS		REFER TO NEXT PAGE
10 - 25 PERSONS		
26 - 50 PERSONS		
51 - 100 PERSONS		
MORE THAN 100 PERSONS		
TOTAL*		

b. OTHER HOUSING ACCOMMODATIONS

LOCATION (*Specify*)	NUMBER	OCCUPANCY (*Peak*)
TOTAL*		

NOTE: *The combined occupancy totals for "a" and "b" should equal approximately the total peak migrant population for the year.*

REMARKS

* Beet cultivation in Mesa, Delta, and Montrose Counties
** Peach harvest in Mesa County and apple harvest in Delta County

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(CONTINUATION PAGE FOR PART I)

WESTERN SLOPE

6. HOUSING ACCOMMODATIONS a. CAMPS	F	F	F	S	S	S
MAXIMUM CAPACITY**	NUMBER	OCCUPANCY (PEAK)	D.U.	NUMBER	OCCUPANCY (PEAK)	D.U.
LESS THAN 10 PERSONS	84	567	84			
10 - 25 PERSONS	83	1,494	221			
26 - 50 PERSONS	6	216	45	13	468	13
51 - 100 PERSONS	1	72	19	8	576	8
MORE THAN 100 PERSONS	1	250	50			
TOTAL*	175	2,599	419	21	1,044	21

b. OTHER HOUSING ACCOMMODATIONS	F	F	F	S	S	S
LOCATION (Specify)	NUMBER	OCCUPANCY (PEAK)	D.U.	NUMBER	OCCUPANCY (PEAK)	D.U.
N.A.						
TOTAL*						

* Summary only. Population data not indicated for individual counties in Western Slope region because of Inter-county shifting of migrants within the area.

** Capacities of existent housing facilities. Occupant data relating to dwellings surveyed during report period are noted in "Statistical Summary of Environmental Health Activities".

MESA COUNTY

6. HOUSING ACCOMMODATIONS a. CAMPS	F	F	F	S	S	
MAXIMUM CAPACITY	NUMBER	OCCUPANCY (PEAK)	D.U.	NUMBER	OCCUPANCY (PEAK)	D
LESS THAN 10 PERSONS	44	297	44			
10 - 25 PERSONS	50	900	133			
26 - 50 PERSONS			13	13	468	
51 - 100 PERSONS			8	8	576	
MORE THAN 100 PERSONS						
TOTAL*	94	1,197	198	21	1,044	

b. OTHER HOUSING ACCOMMODATIONS	F	F	F	S	S	S
LOCATION (Specify)	NUMBER	OCCUPANCY (PEAK)	D.U.	NUMBER	OCCUPANCY (PEAK)	D.
		UNKNOWN				
TOTAL*						

S = Singles
F = Family
SF = Family housing also used by single workers.

* Maximum occupant loads. Much housing not used because of recent mechanization in beet cultivation and tomato harvest. Also because of variable peach production from year to year. Health Department has not assumed program and there have been no housing improvement activities in 1970.

DELTA COUNTY

6. HOUSING ACCOMMODATIONS a. CAMPS	F	F	F	S	S	S
MAXIMUM CAPACITY	NUMBER	OCCUPANCY (PEAK)	D.U.	NUMBER	OCCUPANCY (PEAK)	D.U.
LESS THAN 10 PERSONS	19 SF	128	19			
10 - 25 PERSONS	28 SF	504	75			
26 - 50 PERSONS	6 SF	216	32			
51 - 100 PERSONS	1 SF	72	11			
MORE THAN 100 PERSONS	1 F	250	50			
TOTAL*	55	1,170	187			

b. OTHER HOUSING ACCOMMODATIONS	F	F	F	S	S	S
LOCATION (Specify):	NUMBER	OCCUPANCY (PEAK)	D.U.	NUMBER	OCCUPANCY (PEAK)	D.U.
TOTAL*						

F = Family
S = Singles
SF = Occupancy by either family or single workers.

Most camps are designated to accommodate either single or family workers with few dependents, in beet cultivating and fruit harvest. The latter primarily apple harvest. Housing consists mostly of multiple dwelling units in the camps. No Health Department and no program activities in 1970.

MONTROSE COUNTY

6. HOUSING ACCOMMODATIONS a. CAMPS	F	F	F	S	S	
MAXIMUM CAPACITY	NUMBER	OCCUPANCY (PEAK)	D.U.	NUMBER	OCCUPANCY (PEAK)	D
LESS THAN 10 PERSONS	21	142	21			
10 - 25 PERSONS	5	90	13			
26 - 50 PERSONS						
51 - 100 PERSONS						
MORE THAN 100 PERSONS						
TOTAL*	26	232	34			

b. OTHER HOUSING ACCOMMODATIONS	F	F	F	S	S	
LOCATION (Specify):	NUMBER	OCCUPANCY (PEAK)	D.U.	NUMBER	OCCUPANCY (PEAK)	D
TOTAL*						

F = Family

No Health Department and no program activities conducted this reporting period.

POPULATION AND HOUSING DATA
SAN LUIS VALLEY
FOR _____ ~~COUNTY~~.

GRANT NUMBER

INSTRUCTIONS: Projects involving more than one county will complete a continuation sheet (page 1 ___) for each county and summarize all the county data for total project area on page 1. Projects covering only one county will report population and houses on page 1.

5. POPULATION DATA - MIGRANTS (*Workers and dependents*)

a. NUMBER OF MIGRANTS BY MONTH

MONTH	TOTAL	IN-MIGRANTS	OUT-MIGRANTS
JAN.			
FEB.			
MAR.			
APRIL	72	72	N.A.
MAY	192	192	
JUNE	670	670	
JULY	1,392	1,392	
AUG.	1,140	1,140	
SEPT.	460	460	
OCT.	2,140	2,140	
NOV.			
DEC.			
TOTALS	6,066	6,066	

b. NUMBER OF MIGRANTS DURING PEAK MONTH

	TOTAL	MALE	FEMALE
(1) OUT-MIGRANTS:			
TOTAL	N.A.		
UNDER 1 YEAR			
1 - 4 YEARS			
5 - 14 YEARS			
15 - 44 YEARS			
45 - 64 YEARS			
65 AND OLDER			
(2) IN-MIGRANTS:	1,070 workers; balance non-working dependents.		
TOTAL			
UNDER 1 YEAR			
1 - 4 YEARS			
5 - 14 YEARS			
15 - 44 YEARS			
45 - 64 YEARS			
65 AND OLDER			

c. AVERAGE STAY OF MIGRANTS IN COUNTY

	NO. OF WEEKS	FROM (MO.)	THROUGH (MO.)
OUT-MIGRANTS			
IN-MIGRANTS	12 Lettuce 4 potato	June 15 Sept. 15	Sept. 15 Oct. 15

6. HOUSING ACCOMMODATIONS

a. CAMPS

MAX[illegible]ITY	NUMBER	[illegible]UPANCY (Peak)
LESS THAN 10 PERSONS		REFER TO NEXT PAGE
10 - 25 PERSONS		
26 - 50 PERSONS		
51 - 100 PERSONS		
MORE THAN 100 PERSONS		
TOTAL*		

b. OTHER HOUSING ACCOMMODATIONS

LOCATION (Specify)	NUMBER	OCCUPANCY (Peak)
TOTAL*		

*NOTE: The combined occupancy totals for "a" and "b" should equal approximately the total peak migrant population for the year.

REMARKS

* Higher labor needs from good potato harvest field. 1969 potato harvest poor because of adverse climatic conditions.

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(CONTINUATION PAGE FOR PART I)

SAN LUIS VALLEY

6. HOUSING ACCOMMODATIONS a. CAMPS	F	F	F	S	S	S
MAXIMUM CAPACITY	NUMBER	OCCUPANCY (PEAK)	D.U.	NUMBER	OCCUPANCY (PEAK)	D
** LESS THAN 10 PERSONS	37	256	37			
10 - 25 PERSONS	207	4,546	610			
26 - 50 PERSONS	11	396	59	1	45	1
51 - 100 PERSONS	3	216	33	4	323	4
MORE THAN 100 PERSONS				3	450	3
TOTAL*	258	5,414	739	8	818	8

b. OTHER HOUSING ACCOMMODATIONS	F	F	F	S	S	S
LOCATION (Specify)	NUMBER	OCCUPANCY (PEAK)	D.U.	NUMBER	OCCUPANCY (PEAK)	D.
Less than 10 pers.	57	386	57			
10-25 persons	34	612	90	1	20	1
26-50 persons	14	270	40	5	194	5
51-100 persons				4	300	4
More than 100 pers.						
TOTAL*	105	1,268	187	10	514	10

* Summary only. Population data not indicated for individual counties because of inter-county shifting of migrants in San Luis Valley geographical area.

** Capacities of existent housing. Occupant data relating to dwellings surveyed during report period noted in "Statistical Summary of Environmental Health Activities".

ALAMOSA COUNTY

6. HOUSING ACCOMMODATIONS a. CAMPS MAXIMUM CAPACITY	F NUMBER	F OCCUPANCY (PEAK)	F D.U.	S NUMBER	S OCCUPANCY (PEAK)	S D.U.
LESS THAN 10 PERSONS						
10 - 25 PERSONS						
26 - 50 PERSONS				1	45	1
51 - 100 PERSONS						
MORE THAN 100 PERSONS						
TOTAL*				1	45	1

b. OTHER HOUSING ACCOMMODATIONS LOCATION (Specify)	F NUMBER	F OCCUPANCY (PEAK)	F D.U.	S NUMBER	S OCCUPANCY (PEAK)	S D.U.
Less than 10 pers.	42	284	42			
*10-25 persons	15 SF	270	40			
26-50 persons				3	114	3
51-100 persons				4	300	4
Slum rental houses, hotels & one motel.						
TOTAL*	57	554	82	7	414	7

F = Family
S = Singles

* Family housing used by single workers.

CONEJOS COUNTY

6. HOUSING ACCOMMODATIONS a. CAMPS	F	F	F	S	S	
MAXIMUM CAPACITY	NUMBER	OCCUPANCY (PEAK)	D.U.	NUMBER	OCCUPANCY (PEAK)	D.
LESS THAN 10 PERSONS	10	68	10			
10 - 25 PERSONS	8	184	21			
26 - 50 PERSONS	5 SF	180	27			
51 - 100 PERSONS	1	72	11	2	179	2
MORE THAN 100 PERSONS						
TOTAL*	24	504	69	2	179	2

b. OTHER HOUSING ACCOMMODATIONS	F	F	F	S	S	S
LOCATION (Specify)	NUMBER	OCCUPANCY (PEAK)	D.U.	NUMBER	OCCUPANCY (PEAK)	D.
Less than 10 persons	1	7	1			
* 10-25 persons	5 SF	90	13			
Slum rentals						
TOTAL*	6	97	14			

F = Family
S = Singles

* Family housing occupied by single workers

COSTILLA COUNTY

5. HOUSING ACCOMMODATIONS a. CAMPS	F	F	F	S	S	S
MAXIMUM CAPACITY	NUMBER	OCCUPANCY (PEAK)	D.U.	NUMBER	OCCUPANCY (PEAK)	D.U.
LESS THAN 10 PERSONS						
10 - 25 PERSONS	43 SF	774	115			
26 - 50 PERSONS	5 SF	180	27			
51 - 100 PERSONS						
MORE THAN 100 PERSONS				2	150	2
TOTAL*	48	954	142	2	150	2

b. OTHER HOUSING ACCOMMODATIONS	F	F	F	S	S	S
LOCATION (Specify)	NUMBER	OCCUPANCY (PEAK)	D.U.	NUMBER	OCCUPANCY (PEAK)	D.U.
10-25 persons	14	252	37			
Slum rentals, old						
store buildings.						
TOTAL*	14	252	37			

F = Family
S = Singles
SF = Family housing occupied periodically by single

RIO GRANDE COUNTY

6. HOUSING ACCOMMODATIONS a. CAMPS MAXIMUM CAPACITY	F NUMBER	F OCCUPANCY (PEAK)	F D.U.	S NUMBER	S OCCUPANCY (PEAK)	S D.
LESS THAN 10 PERSONS	5	40	5			
* 10 - 25 PERSONS	130 FS	3,120	405			
26 - 50 PERSONS						
51 - 100 PERSONS	1 FS	72	11			
MORE THAN 100 PERSONS						
TOTAL*	136	3,232	421			

b. OTHER HOUSING ACCOMMODATIONS LOCATION (Specify)	F NUMBER	F OCCUPANCY (PEAK)	F D.U.	S NUMBER	S OCCUPANCY (PEAK)	S D.
26-50 persons	1 FS	36	5			
Slum cabin court						
in Del Norte						
TOTAL*	1	36				

F = Family
S = Singles

* Most are not currently used.

SAGUACHE COUNTY

a. HOUSING ACCOMMODATIONS a. CAMPS MAXIMUM CAPACITY	F NUMBER	F OCCUPANCY (PEAK)	F D.U.	S NUMBER	S OCCUPANCY (PEAK)	S D.U.
LESS THAN 10 PERSONS	22	148	22			
10 - 25 PERSONS	26	468	69			
26 - 50 PERSONS	1	36	5			
51 - 100 PERSONS	1	72	11	2	144	
MORE THAN 100 PE.	0	0		1	300	
TOTAL*	50	724	107	3	444	3

b. OTHER HOUSING ACCOMMODATIONS LOCATION (Specify)	F NUMBER	F OCCUPANCY (PEAK)	F D.U.	S NUMBER	S OCCUPANCY (PEAK)	S D.U.
Less than 10 persons	14	95	14			
10-25 persons				1	20	1
26-50 persons	13	234	35	2	80	2
51-100 persons						
TOTAL*	27	329	49	3	100	3

F = Family
S = Singles

POPULATION AND HOUSING DATA
FOR ARKANSAS VALLEY ~~COUNTY~~.

GRANT NUMBER

INSTRUCTIONS: Projects involving more than one county will complete a continuation sheet (page 1 ___) for each county and summarize all the county data for total project area on page 1. Projects covering only one county will report population and housing on page 1.

5. POPULATION DATA - MIGRANTS (*Workers and dependents*)

a. NUMBER OF MIGRANTS BY MONTH

MONTH	TOTAL	IN-MIGRANTS	OUT-MIGRANTS
JAN.			
FEB.			
MAR.			
APRIL	168	168	N.A.
MAY	380	380	
JUNE	1,934	1,934	
JULY	1,800	1,800	
AUG.	1,206	1,206	
SEPT.	1,352	1,352	
OCT.	596	596	
NOV.	100	100	
DEC.			
TOTALS	7,536	7,536	

b. NUMBER OF MIGRANTS DURING PEAK MONTH

	TOTAL	MALE	FEMALE
(1) OUT-MIGRANTS:			
TOTAL			
UNDER 1 YEAR			
1 - 4 YEARS			
5 - 14 YEARS			
15 - 44 YEARS			
45 - 64 YEARS			
65 AND OLDER			
(2) IN-MIGRANTS:	967 workers; balance non-working dependents.		
TOTAL			
UNDER 1 YEAR			
1 - 4 YEARS			
5 - 14 YEARS			
15 - 44 YEARS			
45 - 64 YEARS			
65 AND OLDER			

c. AVERAGE STAY OF MIGRANTS IN COUNTY

	NO. OF WEEKS	FROM (MO.)	THROUGH (MO.)
OUT-MIGRANTS *	4 beets	May 15	July 15
**	20 produce	May 15	Oct. 15
IN-MIGRANTS ***	6 broomcorn	Sept. 1	Oct. 15

6. HOUSING ACCOMMODATIONS

a. CAMPS

MAXIMUM CAPACITY	NUMBER	OCCUPANCY (*Peak*)
LESS THAN 10 PERSONS		REFER TO NEXT PAGE
10 - 25 PERSONS		
26 - 50 PERSONS		
51 - 100 PERSONS		
MORE THAN 100 PERSONS		
TOTAL*		

b. OTHER HOUSING ACCOMMODATIONS

LOCATION (*Specify*)	NUMBER	OCCUPANCY (*Peak*)
TOTAL*		

*NOTE: *The combined occupancy totals for "a" and "b" should equal approximately the total peak migrant population for the year.*

REMARKS

* Small demand for labor because of poor broom corn harvest resulting from adverse climatic conditions.

* cultivation throughout the Arkansas Valley

* Produce cultivation and harvest: Pueblo, Otero, Bent and Prowers Counties e.g., lettuce, peppers, tomatoes, potatoes, onions, etc.

*** Broomcorn harvest in Baca County.

ARKANSAS VALLEY

. HOUSING ACCOMMODATIONS a. CAMPS MAXIMUM CAPACITY	F NUMBER	F OCCUPANCY (PEAK)	F D.U.	S NUMBER	S OCCUPANCY (PEAK)	S D.U.
LESS THAN 10 PERSONS	130	876	130	6	40	6
10 - 25 PERSONS	34	612	43	32	570	32
26 - 50 PERSONS	16	585	87	15	540	15
51 - 100 PERSONS	5	360	64	3	426	3
MORE THAN 100 PERSONS	4	1,364	143			
TOTAL**	189	3,797	467	56	1,576	56

. OTHER HOUSING ACCOMMODATIONS LOCATION (Specify)	F NUMBER	F OCCUPANCY (PEAK)	F D.U.	S NUMBER	S OCCUPANCY (PEAK)	S D.U.
Less than 10 persons	39	263	39			
10-25 persons	2	36	6			
26-50 persons	3	108	18	2	72	2
51-100 persons	2	144	24	1	72	1
More than 100 pers.						
TOTAL*	46	551	87	3	144	3

F = Family
S = Singles

* Summary for Arkansas Valley. Population data not indicated for individual counties. Population densities not subject to accurate determination because of inter-county shifting within area.

** Capacities of existent housing. Occupant data relating to dwellings surveyed during report period noted in "Statistical Summary of Environmental Health Activities". One 50-unit camp, capacity 50, demolished.

PUEBLO COUNTY

E. HOUSING ACCOMMODATIONS a. CAMPS MAXIMUM CAPACITY	F NUMBER	F OCCUPANCY (PEAK)	F D.U.	S NUMBER	S OCCUPANCY (PEAK)	S D.
LESS THAN 10 PERSONS	47	317	47			
10 - 25 PERSONS	13	234		1	12	1
26 - 50 PERSONS	1	36	5	1	36	1
51 - 100 PERSONS						
MORE THAN 100 PERSONS						
TOTAL*	61	587	52	2	48	2

b. OTHER HOUSING ACCOMMODATIONS LOCATION (Specify):	F NUMBER	F OCCUPANCY (PEAK)	F D.U.	S NUMBER	S OCCUPANCY (PEAK)	S D.
TOTAL*						

F = Family
S = Singles

No program activities conducted this reporting period. Local Health has not indicated willingness to conduct program.

OTERO COUNTY

6. HOUSING ACCOMMODATIONS a. CAMPS MAXIMUM CAPACITY	F NUMBER	F OCCUPANCY (PEAK)	F D.U.	S NUMBER	S OCCUPANCY (PEAK)	S D.U.
LESS THAN 10 PERSONS	32	216	32			
10 - 25 PERSONS	7	126	19			
26 - 50 PERSONS	8	288	43			
51 - 100 PERSONS	3	216	32			
*MORE THAN 100 PERSONS	2	500	50			
TOTAL*	52	1,346	176			

b. OTHER HOUSING ACCOMMODATIONS LOCATION (Specify):	F NUMBER	F OCCUPANCY (PEAK)	F D.U.	S NUMBER	S OCCUPANCY (PEAK)	S D.U.
Less than 10, slum rental	16	108	16			
26-50, slum motel	1	36	8			
51-100 slum multiple rental	2	144	24			
TOTAL*	19	288	48			

F = Family

* Except for Manzanola Camp (fifty 3-room units, capacity 350) constructed in 1967 much of the labor housing closed by order or not used by grower choice. However, substantial numbers of migrants are housed in slum rentals located in the communities and are not readily identifiable.

** Motel closed by court action. Local Health Department has assumed responsibility for migrant housing program.

BENT COUNTY

6. HOUSING ACCOMMODATIONS c. CAMPS	F	F	F	S	S	S
MAXIMUM CAPACITY	NUMBER	OCCUPANCY (PEAK)	D.U.	NUMBER	OCCUPANCY (PEAK)	D.
LESS THAN 10 PERSONS	15	101	15			
11 - 25 PERSONS	4	72	11			
* 26 - 50 PERSONS	2	95	17			
51 - 100 PERSONS						
MORE THAN 100 PERSONS						
TOTAL*	21	268	43			

b. OTHER HOUSING ACCOMMODATIONS	F	F	F	S	S	S
LOCATION (Specify)	NUMBER	OCCUPANCY (PEAK)	D.U.	NUMBER	OCCUPANCY (PEAK)	D.U.
TOTAL*						

F = Family

* Not currently used. No program activities conducted this reporting period. No local health department.

PROWERS COUNTY

a. HOUSING ACCOMMODATIONS a. CAMPS MAXIMUM CAPACITY	F NUMBER	F OCCUPANCY (PEAK)	F D.U.	S NUMBER	S OCCUPANCY (PEAK)	S D.U.
LESS THAN 10 PERSONS	22	148	22			
10 - 25 PERSONS	2	36	5			
+ 26 - 50 PERSONS	2	58	6			
51 - 100 PERSONS	1	72	21			
* MORE THAN 100 PERSONS	1	720	72			
TOTAL*	28	1,034	130			

b. OTHER HOUSING ACCOMMODATIONS LOCATION (Specify)	F NUMBER	F OCCUPANCY (PEAK)	F D.U.	S NUMBER	S OCCUPANCY (PEAK)	S D.U.
Less than 10 persons	8	54	8			
Slum rentals						
10-25 persons-motel	1	18	3			
26-50 persons-multi-	1	36	5			
ple slum rental units						
TOTAL*	10	108	16			

F = Family

* Granada Camp, seventy-two 3-bedroom units, constructed in 1967. No local health department.

+ 10-unit camp at Bristol demolished.

MIGRANT HEALTH PROGRAM
June 1970 to June 1971

)UNTY	# of Initial Insps.	# of Living Units	Max. Capcy.	Violations		S	U	Re-Insps.	Occ. Load	Violations		Corrections		S	U	F.S. W	F.S. T	I	Conf. G	Conf. P
ESTERN LOPE																				
ielta	1	40	200	Yard	1		1	1		Yard	0	Yard	0	1				6	1	8
				Water	0					Water	0	Water	0							
				Sewage	0					Sewage	0	Sewage	0							
				Refuse	1					Refuse	0	Refuse	0							
				Vector	1					Vector	0	Vector	0							
				Housing	1					Housing	1	Housing	1							
				Food	1					Food	0	Food	0							
				San. Fac.	1					San. Fac.	0	San. Fac.	0							
				Misc.	1					Misc.	0	Misc.	0							
AN LUIS ALLEY																				
lamosa	6	6	42	Yard	3	3	3	24	12	Yard	0	Yard	0	14	7					
				Water	3					Water	20	Water	7							
				Sewage	2					Sewage	18	Sewage	13							
				Refuse	3					Refuse	3	Refuse	2							
				Vector	3					Vector	1	Vector	0							
				Housing	6					Housing	1	Housing	0							
				Food	2					Food	0	Food	0							
				San. Fac.	3					San. Fac.	0	San. Fac.	0							
				Misc.	1					Misc.	0	Misc.	0							
												Vacated		3						
onejos	1	3	150	Yard	0	1		15		Yard	0	Yard	0	10	3			11		
				Water	0					Water	4	Water	4							
				Sewage	0					Sewage	4	Sewage	4							
				Refuse	1					Refuse	1	Refuse	0							
				Vector	0					Vector	0	Vector	0							
				Housing	1					Housing	0	Housing	0							
				Food	0					Food	0	Food	0							
				San. Fac.	0					San. Fac.	0	San. Fac.	0							
				Misc.	0					Misc.	0	Misc.	0							
												Vacated			2					

STATISTICAL SUMMARY OF ENVIRONMENTAL HEALTH ACTIVITIES
MIGRANT HEALTH PROGRAM
June 1970 to June 1971

COUNTY	# of Initial Insps.	# of Living Units	Max. Capcy.	Violations		S	U	Re-Insps.	Occ. Load	Violations		Corrections		S	U	F.S. W	F.S. T	I	Conf. G	Conf. P
Costilla	7 F 3 S	10 4	46 156	Yard Water Sewage Refuse Vector Housing Food San. Fac. Misc.	10 2 8 9 7 9 7 7 6		10	19	289	Yard Water Sewage Refuse Vector Housing Food San. Fac. Misc.	10 2 3 7 5 10 4 5 4	Yard Water Sewage Refuse Vector Housing Food San. Fac. Misc. Vacated	1 1 2 3 5 3 1 2 1	8 3	6 2			10		
Rio Grande	14	29	176	Yard Water Sewage Refuse Vector Housing Food San. Fac. Misc.	13 5 5 13 5 12 6 6 3	6	8	37	130	Yard Water Sewage Refuse Vector Housing Food San. Fac. Misc.	15 9 6 15 0 13 4 8 4	Yard Water Sewage Refuse Vector Housing Food San. Fac. Misc. Vacated	0 3 0 0 0 0 0 0 0	8 17	3 9			40	1	3
Saguache	10 F 1 S	31 1	247 150	Yard Water Sewage Refuse Vector Housing Food San. Fac. Misc.	6 4 7 10 3 10 5 6 3	4	7	19	61	Yard Water Sewage Refuse Vector Housing Food San. Fac. Misc.	7 7 13 15 6 15 12 12 3	Yard Water Sewage Refuse Vector Housing Food San. Fac. Misc.	1 1 3 1 2 1 1 1 0	5	14			21	1	80

COUNTY	# of Initial Insps.	# of Living Units	Max. Capcy.	Violations	S	U	Re-Insps.	Occ. Load	Violations	Corrections	S	U	F.S. W	F.S. T	I	Conf. G	Conf. P
ARKANSAS VALLEY																	
Otero	22	73	292	Yard 21 Water 13 Sewage 19 Refuse 22 Vector 19 Housing 22 Food 14 San. Fac. 17 Misc. 6	1	21	39	27	Yard 8 Water 5 Sewage 22 Refuse 24 Vector 19 Housing 28 Food 7 San. Fac. 20 Misc. 8	Yard 6 Water 6 Sewage 6 Refuse 6 Vector 6 Housing 6 Food 6 San. Fac. 6 Misc. 6 Vacated	15 5	4 15	65	65	23	3 91	180
Prowers	*3	78	779	Yard 1 Water 0 Sewage 1 Refuse 1 Vector 1 Housing 1 Food 1 San. Fac. 1 Misc. 1	1	2	9	27	Yard 5 Water 4 Sewage 5 Refuse 5 Vector 5 Housing 5 Food 5 San. Fac. 6 Misc. 6	Yard 4 Water 4 Sewage 4 Refuse 4 Vector 4 Housing 4 Food 4 San. Fac. 4 Misc. 4	3	6			9	1	10
* Granada Camp - Capacity 750																	
Baca	3	3	23	Yard 3 Water 1 Sewage 3 Refuse 3 Vector 3 Housing 3 Food 1 San. Fac. 3 Misc. 1		3	35	60	Yard 12 Water 4 Sewage 8 Refuse 12 Vector 12 Housing 12 Food 7 San. Fac. 8 Misc. 8	Yard 6 Water 4 Sewage 6 Refuse 6 Vector 6 Housing 6 Food 6 San. Fac. 6 Misc. 6 Vacated	13	6 16			10		

STATISTICAL SUMMARY OF ENVIRONMENTAL HEALTH ACTIVITIES
MIGRANT HEALTH PROGRAM
June 1970 to June 1971

COUNTY	# of Initial Insps.	# of Living Units	Max. Capcy.	Violations		S	U	Re-Insps.	Occ. Load	Violations	Corrections	S	U	F.S. W	F.S. T	I	Con G
NORTHERN COLORADO																	
Boulder	3	3	27	Yard	1		3									3	2
				Water	3												
				Sewage	0												
				Refuse	1												
				Vector	0												
				Housing	2												
				Food	0												
				San. Fac.	1												
				Misc.	0												
Larimer	19	27	136	Yard	15	5	8									4	
				Water	8												
				Sewage	6												
				Refuse	7												
				Vector	7												
				Housing	12												
				Food	2												
				San. Fac.	13												
				Misc.	0												
				Vacant		6											
Weld	180	246	1160	Yard	5		15										1
				*Water	68												
				*Sewage	124												
				Refuse	5												
				Vector	5												
				*Housing	97												
				Food	0												
				San. Fac.	5												
				Misc.	4												

* Conducted by Weld County Health Department. Survey conducted to above three categories. State Health inspected 5 unfit premises. Ten cases filed by Weld County Health Department with District Attorney. Five of the cases are pending and five have been resolved. Condition of balance of camps (165) unknown.

COUNTY	# of Initial Insps.	# of Living Units	Max. Capcy.	Violations	S	U	Re-Insps.	Occ. Load	Violations	Corrections	S	U	F.S. W	F.S. T	I	Conf. G	Conf. P
Kit Carson							6	28	Yard 6 Water 6 Sewage 6 Refuse 6 Vector 6 Housing 6 Food 6 San. Fac. 6 Misc. 6	Vacated		2 4			2		
Denver Area															364	48	1145

F = Family
S = Singles

S = Satisfactory
U = Unsatisfactory

Field Sanitation
W = Water
T = Toilets

Conferences
I = Individuals
G = Groups
P = Persons

MEDICAL SERVICES NARRATIVE REPORT

I. OBJECTIVES:

In accordance with the experience of the previous season, preseason evaluation and planning program staff concurred in the following objectives for the 1970 season.

A. Stronger medical care orientation within the program.
B. An increased role of the consumer in determining health care priorities.
C. Increased availability of outside professional advice.
D. Increase in care throughout the five project areas.
E. An increase in the number of Family Health and Clinics and categorical clinics.
F. In-patient care for migrants.

II. PROGRESS and PROBLEMS:

A. Project Medical Care Orientation:

During the previous reporting period, a program medical advisor was appointed by the Project Director to assist staff in providing more emphasis upon the medical care aspects of the program, and to represent the program and the department in the newly formed Migrant Coalition. In mid-September, 1970, this orientation was strengthened by the appointment of a physician as Program Director. The previous medical advisor continued as the program's Migrant Coalition Representative, serving as the chairman of that organization's health committee.

B. The Consumer's Role in Determining Health Care Priorities:

During the early part of the 1970 season, explorative steps were taken with respect to formalizing the relationships between this program and the Colorado Migrant Council, both at the area and State levels. As a result of this, the Colorado Migrant Council agreed to serve as the program's state-level consumer policy board during the early part of September, 1970. It was later arranged that the four area councils serve as consumer boards. This arrangement yielded the maximum balance in representation of area interests viewed in the light of state-wide priorities as to the locations of facilities and their hours of operation.

It was felt that in general, this Board and its area components have exercised good judgement in setting priorities. Available funds, area needs and anticipated patient load were taken into account in the decision-making process undertaken by the Council. Later, during the reporting period, the State Policy Board (Board of Directors of the Colorado Migrant Council) appointed a three-member

health committee composed of representatives of the resident rural poor, inter-state migrants and the Migrant Council central staff.

C. Professional Advice:

In years past, there was no orderly method to assure an on-going source of professional medical advice. The appointment of a medical advisor, and the subsequent appointment of a physician as program director opened up new avenues of communication with the medical community. Some of the more concrete results were the volunteer-staffed weekend clinics held in Rio Grande County (San Luis Valley) during the 1970 potato harvest, and Sunday clinics held in the Northeast area earlier in the season.

During the course of the reporting period, the interest generated by this participation in the program by University of Colorado Medical Center physicians, grew into a new spirit of involvement which began to bear fruit after the close of the reporting period.

D. Increased Care:

Prior to the 1966 season, there was no provision in the Colorado Program for clinicians fees or fee-for-service. Since 1966, there has been a steady increase in the number of patient visits. During this time, including the reporting period, these visits have been largely the result of referrals by program nurses to local private physicians on a fee-for-service basis. To a lesser degree, services were also rendered in clinic or 'evening-office hours' settings. The more inovative systems to which reference is made in the introduction to this report had not been implemented during the period for which this report is written.

Some comparative data relating to patient visits is presented to illustrate progress thus far:

Year	Total Patient Visits
1965	653
1966	1,115
1967	1.252
1968	3,871
1969	4,302
1970	5,463

While a complete breakdown of diagnoses and conditions is found in the Nursing Services Section of this report, the visits referenced to in the above table were connected with the following I.C.D. categories.

Condition	Total Patient Visits
Diseases of the respiratory system	1,180
Diseases of the nervous system and sense organs	789
Infective and parasitic diseases	764
Accidents, poisonings, and violence	427
Diseases of the digestive system	419
Diseases of the skin and subcutaneous tissue	359
Diseases of the genitourinary system	335
Endocrine, nutritional and metabolic diseases	259
Diseases of the circulatory system	233
Symptoms and ill-defined conditions	232
Diseases of the musculoskelatal system and connective tissue	136
Complications of pregnancy, childhood and the puerperium	86
Mental disorders	81
Diseases of blood and blood-forming organs	76
Congenital anomalies	46
Neoplasms	41
Certain causes of perinatal morbidity and mortality	2

Additionally, 8,462 individuals were seen by physicians or program nurses in regard to special conditions and for examinations without sickness. For a detailed breakdown as to these conditions and examinations, see the state-wide statistical summary in the Nursing Section of this report.

While the cost for services have increased throughout the years owing to the general increase in care for medical services, on the basis of data revised forward to the first of June 1971, $42,977 was spent in connection with the 5,463 visits at an average cost of $7.867 per visit. Of the total amount, $24,346 was Health, Education and Welfare Migrant Grant funds and $18,631 State Funds, or 43.35 percent. This amount, however, represented unanticipated over-expenditures which were necessary to extend medical care to all those in need, and will not be available during the present season due to the current State fiscal situation.

The quality of care provided was generally the same as that received by the non-migrant members of the various area communities. Some physicians cooperating with the Program voiced the complaint that inadequate screening of patients resulted in many being referred to them when medical intervention was not necessary. Better training of nurses with respect to the treatment of minor conditions was undertaken during the latter part of the reporting period. It is also believed that child growth and development education of the parents would eliminate much of the fear and panic arising out of what only appear to be signs and symptoms of illness. More in-depth training of Family Health Workers might also be of value in assisting new parents in differentiating between conditions which do or do not require professional attention.

E. More Family Health and Categorical Clinics:

In the previous reporting period, eight clinic locations were established. During this reporting period, 17 locations were used for various periods of time. Specific reference to these is made in each of the area reports in the Nursing Services section of this report. The clinics operated from county health department facilities, hospital out-patient departments, local physician's offices, and in the cases of some categorical clinics, a mobile health unit, migrant summer school locations, and borrowed private facilities such as church meeting halls.

In nearly all cases, the best service was rendered in those settings which made access to laboratory and other diagnostic facilities possible. In general, paid or volunteer clinicians were reluctant to conduct general medical clinics in substandard facilities even though these facilities might have served the patient's convenience with respect to distance and other considerations such as familiar or 'confortable' surroundings.

In general, considerable progress has been made since the 1955-1966 era when only two locations, Palisade and Fort Lupton, offered clinic services, and finally, only Fort Lupton after the closing of the old Palisade labor camp.

During the latter part of the reporting period, a great deal of progress was made with respect to the idea of establishing year-round facilities. The primary area under consideration, after consultation with the State Consumer Policy Board, was the North Central Area. After tentative selection of La Salle (Weld County) an East Greeley location was finally selected with the area consumer board's approval.

Other locations slated to receive permanent clinic operations were Lamar, (Arkansas Valley); Center, (San Luis Valley); and Delta, (Western Slope).

F. In-Patient Hospital Care:

During the reporting period an appropriation of $50,000 was requested from the State General Assembly to fund an in-patient hospital care component. This amount would have been in addition to the same approximate amount spent by Colorado General Hospital in Denver for migrant patients. The request was submitted to enable other hospitals to extend care to migrant patients in the various program areas. Unfortunately, the legislature did not approve this request and Colorado General Hospital remained almost the sole resource for in-patient care of program clients.

With some notable exceptions, access to hospital care beyond a 100-mile radius of Denver remains most difficult for indigent patients. Two of these exceptions were found in Delta and Montrose Counties (Western Slope Area). Care seems to be available without the harassment with respect to payment that is too often found in many short-term hospitals in other areas of the State.

One of the most outstanding problems encountered during the reporting period was the absence of sufficient funds to meet the needs of all migrant patients requiring medical care. In mid-August, program funds for medical and dental care had been exhausted. In order to care for program patients through the balance of the season, a substantial deficit had to be incurred. This deficit reflects a basic lack of sufficient funding within the framework of the grant award under which the program operated. Compounding this, the inclusion by the Congress of the seasonal agricultural worker within the scope of the Migrant Health Act and an inferential mandate to care for the rural poor have placed considerable strain upon program funding and manpower resources which remained relatively static.

Planning, during the reporting period, included greater efforts to secure other resources, seek consolidation of other migrant service program health care funds as well as strengthening the role of the nurse and para-professional in rendering care to program patients. Alternative methods of medical care delivery were also explored and a number of these methods selected for implementation during the 1971 season. These methods are discussed in the Introduction of this report.

A supportive component of the medical care activity was the prescription item provision of the plan. Under this plan, Program patients received prescription items as required by the physician. A manifold NCR form was used for the authorization, the prescription and the pharmacist's statement.

In this area too, considerable over-expenditure was necessary, corresponding to the deficit in medical care funds. In order to reduce the cost-per-patient, new systems of providing medication were examined during the reporting period. One of these was the possibility of ordering drugs and medications from the General Services Administration. The system used during the reporting period as well as in previous years was based upon local retail pharmacies. This system has been used in order that the physician would have maximum freedom in prescribing and to make it as convenient as possible for the patient to obtain the prescribed item along with adequate instructions for its use.

MIGRANT NURSING PROGRAM NARRATIVE REPORT

The nursing staff of the Migrant Health Program will tell you that they are involved in the most dynamic, frustrating, rewarding program in the Colorado Department of Health. Each staff member, nurse and out-reach worker, must be a migrant advocate to be effective.

Being a migrant advocate requires:

- vision, initiative, courage, compassion and love.
- alienation of the traditional, narrow, fearful, prejudice.
- long hours of work, a continuous struggle for funds.
- interpreting program to people and people to program.
- satisfaction in assisting the materially deprived.
- satisfaction in gaining a better way of life for others.
- learning new meanings of love and understanding through a process of awareness, concern, involvement and inner-commitment.

The migrant nurse serves as director of the Migrant Health Program in her area. She is given considerable latitude in setting local goals and planning services for migrant workers. Because of this responsibility she is the key person in the Migrant Health Program. She is interested in early case-finding for obvious reasons. With this objective, her efforts are directed to locating migrants with health problems and assisting them to obtain care. This entails notifying growers, crew bosses, and migrant families of her name and address, names and addresses of physicians in the area, hospital addresses and telephone numbers. Family Health Workers and volunteers from the various agencies serving migrants in the summer season are oriented to the need of migrants in regards to health care and resources available to them.

Following case-finding, the obtaining of medical care is of primary importance. Family medical clinics are held in all but one area for the convenience of ill migrants.

In addition to regularly scheduled medical clinics, care is available in the emergency rooms of the hospitals and in physician's offices for emergency conditions that cannot await the clinic date.

The third objective of the nursing program is assuring the migrant patient of follow-up visits to ascertain that he understands the orders or recommendations of the physician and is able to carry out such recommendations. The nurse makes sure he has his medication, understands his diet and is able to obtain the required foods. She assists in any way needed to help the migrant regain his health and remain healthy.

A fourth objective of the nursing program is to provide personal and family centered health counseling and teaching. The nurse makes every opportunity for health teaching important to the migrant patient. Formal classes are seldom held but group work is attempted in showing films and holding discussions on subjects timely to the group or chosen by the group. Group activities may concern cancer, family planning, sex education, nutrition, etc.

A fifth objective of the nursing program is to consult, plan, and coordinate with other state and local agencies in meeting health needs of migrant workers in Colorado. The nurse works with representatives of the Colorado Migrant Council, Colorado Rural Legal Services, Migrant Ministry, V.I.S.T.A. volunteers, volunteer nurses and physicians, out-reach workers, and local health agencies. She is recognized by all as the primary resource for planning health programs for migrants. She assumes this leadership role and in turn makes appropriate referrals to the other agencies for services from them.

The nursing staff of the Colorado Migrant Health Program included eight project nurses, one of whom was employed permanently as coordinator for the northern area which encompasses nine counties and the heaviest impact area of the state. In addition, five Migrant Council nurses were assigned to the project nurses and the programs of the two agencies were coordinated and combined. Two school nurses were contracted to the Migrant Health Program also. Three nuns volunteered for nursing assignments this season in areas where they were needed.

In addition to the professional staff, family health workers made an appearance for the first time when Migrant Action Program students from the University of Colorado were assigned to work with migrant health personnel. The services of the program nurses were greatly expanded with this valuable adjunct of knowledgeable workers.

The Colorado Migrant Council's Health Coordinator worked closely with the Migrant Council nurses, project nurses, and other health workers in the migrant program. A week's orientation program designed for nurses working in the summer's migrant health program was open to all interested personnel. There were approximately 50 nurses attending the week's session.

Services to Migrants:

Nursing services were provided to migrants and families by project nurses, Colorado Migrant Council nurses, school nurses, and local public health nurses. Coordination of all these services was made possible by including all in the orientation program which was held the first week in June. The migrant project nurse was recognized as the focal person in each of the five major impact areas. The project nurses and Migrant Council nurses divided the areas into districts with each nurse responsible for all migrant health activities in her area. The school nurses referred health problems to the project nurse and the project nurse in turn gave consultation and assistance to the school nurses in conducting a meaningful

health program in the schools. The local public health nurses were available to follow-up families when the migrant nurse was unable to be in a specific locality. The nurses met frequently and informally in each area throughout the season. All were satisfied with the working arrangement and felt that services covered all problems.

A manual was assembled and made available to all nurses working with migrants. Standing orders for caring for minor conditions were included in the manual. Each nurse was responsible for obtaining local physicians' approval of the orders. This was no problem as the standing orders were simple, concise, and clear. Family health clinics were held in each area except one -- the Western Slope. In this region the local physicians cooperated in an ideal manner. Physicians said that they were so confident of the referrals made by migrant nurses that when they saw a migrant patient in their offices, they knew they were needing care and did not make the migrant wait. In one area nursing clinics were held very successfully. In another area PAP clinics were held. Immunization clinics were held in all areas.

Local referrals were made for medical care, nutrition consultation, and dental care. Referrals were made to other agencies for welfare assistance, employment, housing, and for various other kinds of assistance. Local referrals were usually well handled without delay. In some counties food stamps proved a difficult problem. Considerable effort by many migrant agencies was made to solve this problem.

Nurses supervised care in Day Care Centers, making daily visits in most cases. Home visiting in the evening or on weekends was an integral part of every nurse's program. Health teaching was a part of every service. Spanish literature as health aid teaching was made available as well as the use of Spanish-speaking films for the adults.

Referrals were made out-of-state, mainly to Texas. Many were answered but the answers showed that it was difficult to locate families in Texas since many were not at the address given the nurse as indicated on the referral.

It was difficult to maintain a continuing in-service education program once the season was in full swing. Consultation and help was available by telephone and personal visits by the nursing consultant. At the end of the season, a questionnaire was sent to all nurses to attempt to evaluate the season's program, its strengths and weaknesses. An evaluation meeting was held in September with all the nurses in attendance again. Recommendations for orientation, information dissemination, and program planning were made.

With all nurses coordinated in the health program and with family health workers for the first time, many more migrants were treated in clinics and physicians' offices. Nurses were active in tine testing screening programs for tuberculosis, immunization clinics for all age groups, as well as providing follow-up care for illnesses which were serious or had potential of becoming serious unless care was provided.

The large number of illegal aliens in the state was a factor that the nurses met. When the aliens presented themselves for care it was for an acute condition often long-standing and sometimes a danger to the total population. Tuberculosis was found, and in one case required a nine-month hospitalization period. Nurses referred all for care. The alien presented himself as an emergency outside the regular clinic hours. Such diagnoses as kidney failure, heart attack, typhoid fever, scarlet fever, and other serious problems required immediate care.

Nurses worked long hours, often 16 hours was spent in nursing program services in one day. This is a clear indication that more staff is needed. Since the program is seasonal and the funding is limited, most of the staff has to be employed for the season only. This means that the staff needs considerable orientation and introduction to the area geographically. Their efficiency is not fully developed until the program is well under way, and in areas where the season is only three or four months, the nurses felt they were working at a disadvantage.

Plans for the 1972 season include three full-time nurses for the migrant areas. This will expedite services and aid the orientation of new workers coming into the area. It is hoped to have many of the staff return for the temporary positions in 1972. Nurses without exception are thrilled by the nursing program. They become migrant advocates and enjoy the freedom of planning without too much structure; they are encouraged to become innovative and new ideas and ways of rendering service are tried.

The season was not without its heartaches, too. Not enough funds for dental prostheses for adults who needed them was hard to live with. No funds for hospitalization placed nurses in the position of always explaining to hospitals and physicians the reasons, and they encouraged administrators and physicians to let their State representatives know of their dilemma. When local red tape and inertia on the part of local welfare departments made food stamps an impossibility, the nurses suffered. The nurses were happy for the assistance from VISTA, Colorado Rural Legal Service, and Migrant Ministry in solving some of their problems. The best possible use of medical and dental funds was made by the program. Nurses had no complaints regarding these services in general. Some individual physicians declined to serve the migrants or if they did were so disagreeable the patients would not return. The nurses learned who was sympathetic with the migrants and these were the physicians to whom the migrants were referred. Some physicians devoted long evenings to holding clinics and helping the migrant patients who were ill. It was not uncommon for a physician to make a home call with a nurse to evaluate a patient's condition. Some physicians volunteered their services entirely.

Physicians often complained, however, that they were seeing migrant patients for minor conditions that could be handled without medical intervention. It was evident that nurses should do more screening and treating of minor conditions. With the emerging emphasis on the expanded role of nurses, together with physicians' acceptance of this role, it was planned to conduct a two-week workshop for migrant nurses giving them intensive training in the skills necessary for the new function. The program was planned with the Continuing Education Department of the University of Colorado School of Nursing. Also involved was the medical staff at University of Colorado Medical Center.

In April, 1971, the Salud y Justicia Program granted under the Colorado Migrant Council contracted with the State Migrant Health Program for four full-time nurses.

In February, 1971, the Migrant Health Program and the Colorado Department of Education, Title I, Migrant Education Program began planning for contract health nurses. By June, 1971, 17 of the migrant schools had contracted for nursing service. The total contract for school dental and medical care was made with the Migrant Health Program.

The State Migrant Health Program, together with school representatives planned a model school health program to be conducted by our contract nurses. A copy is attached. Also attached are copies of nursing reports from each of the five major migrant areas of Colorado.

STATEWIDE

DATE SUBMITTED

PART II - MEDICAL, DENTAL, AND HOSPITAL SERVICES

MIGRANTS RECEIVING MEDICAL SERVICES

TOTAL MIGRANTS RECEIVING MEDICAL SERVICES AT FAMILY HEALTH CLINICS, PHYSICIANS OFFICES, HOSPITAL EMERGENCY ROOMS, ETC.

AGE	NUMBER OF PATIENTS			NUMBER OF VISITS
	TOTAL	MALE	FEMALE	
TAL	3923	1689	2234	5828
DER 1 YEAR	270	158	112	475
4 YEARS	814	410	404	1186
14 YEARS	901	409	492	1307
44 YEARS	1516	537	979	2174
64 YEARS	398	169	229	630
AND OLDER	24	6	18	59

OF TOTAL MIGRANTS RECEIVING MEDICAL SERVICES, HOW MANY WERE:

(1) SERVED IN FAMILY HEALTH SERVICE CLINIC? 1739

(2) SERVED IN PHYSICIANS' OFFICE, ON FEE-FOR-SERVICE ARRANGEMENT (INCLUDE REFERRALS) 2140

MIGRANT PATIENTS HOSPITALIZED

(Regardless of arrangements for payment):

No. of Patients (exclude newborn) 134

No. of Hospital Days 701

2. MIGRANTS RECEIVING DENTAL SERVICES

ITEM	TOTAL	UNDER 15	15 AND OLDER
a. NO. MIGRANTS EXAMINED-TOTAL			
(1) NO. DECAYED, MISSING, FILLED TEETH			
(2) AVERAGE DMF PER PERSON			
b. INDIVIDUALS REQUIRING SERVICES - TOTAL			
(1) CASES COMPLETED			
(2) CASES PARTIALLY COMPLETED			
(3) CASES NOT STARTED			
c. SERVICES PROVIDED - TOTAL			
(1) PREVENTIVE			
(2) CORRECTIVE-TOTAL			
(a) Extraction			
(b) Other			
d. PATIENT VISITS - TOTAL			

IMMUNIZATIONS PROVIDED

TYPE	COMPLETED IMMUNIZATIONS, BY AGE					IN-COMPLETE SERIES	BOOSTERS, REVACCINATIONS
	TOTAL	UNDER 1 YEAR	1 - 4	5 - 14	15 AND OLDER		
TAL-- ALL TYPES	1968	281	972	427	288	1165	496
MALLPOX	8	--	4	4	--	--	--
IPHTHERIA	426	63	196	74	93	285	113
ERTUSSIS	415	63	196	67	89	246	51
ETANUS	472	63	196	119	94	283	115
OLIO	349	59	196	91	3	225	153
YPHOID	2	--	--	--	2	--	--
EASLES	132	14	51	61	6		
THER (Specify)							
Rubella	125	15	98	11	1		
D.T.						112	40
D.P.T.	39	4	35				

ARKS

CLINICS, HOSPITAL OUTPATIENT DEPARTMENTS, AND PHYSICIANS' OFFICES.

ICD CLASS	MII CODE	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
VII.		TOTAL ALL CONDITIONS	5463	3551	1917
	01-	INFECTIVE AND PARASITIC DISEASES: TOTAL	764	511	253
	010	TUBERCULOSIS	31	20	11
	011	SYPHILIS	40	18	22
	012	GONORRHEA AND OTHER VENEREAL DISEASES	22	8	14
	013	INTESTINAL PARASITES	23	18	5
		DIARRHEAL DISEASE (infectious or unknown origins):	9	6	3
	014	Children under 1 year of age	46	26	20
	015	All other	63	38	25
	016	"CHILDHOOD DISEASES" – mumps, measles, chickenpox	71	61	10
	017	FUNGUS INFECTIONS OF SKIN (Dermatophytoses)	22	14	8
	019	OTHER INFECTIVE DISEASES (Give examples):			
		Pos. Typhoid Strep. Throat	151	121	30
		Thrust	10	5	5
		Hepatitis	19	15	4
		Encephalitis	3	1	2
		Other	254	160	94
	02-	NEOPLASMS: TOTAL	41	16	25
	020	MALIGNANT NEOPLASMS (give examples):			
		Leukemia	4	1	3
		Ca. in Situ.	4	1	3
		Lymphaticca	4	2	2
		Adenoid Cystisum	6	1	5
		Chest Tumas	6	3	3
	025	BENIGN NEOPLASMS Breast Node	7	4	3
	029	NEOPLASMS of uncertain nature	3	3	
		Chronic Tupus Discord	7	1	6
I.	03-	ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES: TOTAL	259	120	139
	030	DISEASES OF THYROID GLAND	6	4	2
	031	DIABETES MELLITUS	166	52	114
	032	DISEASES of Other Endocrine Glands	3	2	1
	033	NUTRITIONAL DEFICIENCY	34	31	3
	034	OBESITY	37	23	14
	039	OTHER CONDITIONS	13	8	5
V.	04-	DISEASES OF BLOOD AND BLOOD FORMING ORGANS: TOTAL	76	54	22
	040	IRON DEFICIENCY ANEMIA	72	50	22
	049	OTHER CONDITIONS	4	4	
.	05-	MENTAL DISORDERS: TOTAL	81	49	32
	050	PSYCHOSES	4	3	1
	051	NEUROSES and Personality Disorders	58	30	28
	052	ALCOHOLISM			
	053	MENTAL RETARDATION	7	6	1
	059	OTHER CONDITIONS	12	10	2
I.	06-	DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS: TOTAL	789	551	238
	060	PERIPHERAL NEURITIS			
	061	EPILEPSY	28	19	9
	062	CONJUNCTIVITIS and other Eye Infections	143	85	58
	063	REFRACTIVE ERRORS of Vision	206	195	11
	064	OTITIS MEDIA	305	176	129
	069	OTHER CONDITIONS	107	76	31

ICD CLASS	MH CODE	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
I.	07-	DISEASES OF THE CIRCULATORY SYSTEM: TOTAL	233	122	111
	070	RHEUMATIC FEVER	6	4	2
	071	ARTERIOSCLEROTIC and Degenerative Heart Disease	13	8	5
	072	CEREBROVASCULAR DISEASE (Stroke)			
	073	OTHER DISEASES of the Heart	59	20	39
	074	HYPERTENSION	100	54	46
	075	VARICOSE VEINS	30	13	17
	079	OTHER CONDITIONS	25	23	2
III.	08-	DISEASES OF THE RESPIRATORY SYSTEM: TOTAL	1180	826	354
	080	ACUTE NASOPHARYNGITIS (Common Cold)	331	261	70
	081	ACUTE PHARYNGITIS	178	137	41
	082	TONSILLITIS	251	194	57
	083	BRONCHITIS	143	80	63
	084	TRACHEITIS/LARYNGITIS	1	1	
	085	INFLUENZA	28	26	2
	086	PNEUMONIA	93	42	51
	087	ASTHMA, HAY FEVER	57	29	28
	088	CHRONIC LUNG DISEASE (Emphysema)	9	3	6
	089	OTHER CONDITIONS	89	53	36
IX.	09-	DISEASES OF THE DIGESTIVE SYSTEM: TOTAL	419	284	135
	090	CARIES and Other Dental Problems	84	66	18
	091	PEPTIC ULCER	65	31	35
	092	APPENDICITIS	20	8	12
	093	HERNIA	6	5	1
	094	CHOLECYSTIC DISEASE	70	35	35
	099	OTHER CONDITIONS	174	139	35
X.	10-	DISEASES OF THE GENITOURINARY SYSTEM: TOTAL	335	193	142
	100	URINARY TRACT INFECTION (Pyelonephritis, Cystitis)	177	87	90
	101	DISEASES OF PROSTATE GLAND (excluding Carcinoma)	8	6	2
	102	OTHER DISEASES of Male Genital Organs	13	9	4
	103	DISORDERS of Menstruation	67	43	24
	104	MENOPAUSAL SYMPTOMS	12	8	4
	105	OTHER DISEASES of Female Genital Organs	45	31	14
	109	OTHER CONDITIONS	13	9	4
XI.	11-	COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM: TOTAL	86	42	44
	110	INFECTIONS of Genitourinary Tract during Pregnancy	4	1	3
	111	TOXEMIAS of Pregnancy	17	8	9
	112	SPONTANEOUS ABORTION	22	9	13
	113	REFERRED FOR DELIVERY	22	13	9
	114	COMPLICATIONS of the Puerperium	9	6	3
	119	OTHER CONDITIONS	12	5	7
XII.	12-	DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE: TOTAL	359	238	121
	120	SOFT TISSUE ABSCESS OR CELLULITIS	82	48	34
	121	IMPETIGO OR OTHER PYODERMA	79	63	16
	122	SEBORRHEIC DERMATITIS	18	12	6
	123	ECZEMA, CONTACT DERMATITIS, OR NEURODERMATITIS	83	48	35
	124	ACNE	4	3	1
	129	OTHER CONDITIONS	93	64	29

PART II - 5. (Continued)

ICD CLASS	MH CODE	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISIT
XIII.	13-	DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE: TOTAL	136	85	51
	130	RHEUMATOID ARTHRITIS	16	7	9
	131	OSTEOARTHRITIS	32	19	13
	132	ARTHRITIS, Unspecified	29	16	13
	139	OTHER CONDITIONS	59	43	16
XIV.	14-	CONGENITAL ANOMALIES: TOTAL	46	34	12
	140	CONGENITAL ANOMALIES of Circulatory System	11	10	1
	149	OTHER CONDITIONS	35	24	11
XV.	15-	CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY: TOTAL	2	2	
	150	BIRTH INJURY	1	1	
	151	IMMATURITY	1	1	
	159	OTHER CONDITIONS			
XVI.	16-	SYMPTOMS AND ILL-DEFINED CONDITIONS: TOTAL	232	163	69
	160	SYMPTOMS OF SENILITY			
	161	BACKACHE	66	43	23
	162	OTHER SYMPTOMS REFERRABLE TO LIMBS AND JOINTS	29	26	3
	163	HEADACHE	58	40	18
	169	OTHER CONDITIONS	79	54	24
XVII.	17-	ACCIDENTS, POISONINGS, AND VIOLENCE: TOTAL	427	269	158
	170	LACERATIONS, ABRASIONS, and Other Soft Tissue Injuries	119	92	27
	171	BURNS	23	14	9
	172	FRACTURES	102	44	58
	173	SPRAINS, STRAINS, DISLOCATIONS	108	60	48
	174	POISON INGESTION	7	6	1
	179	OTHER CONDITIONS due to Accidents, Poisoning, or Violence	68	53	15

			NUMBER OF INDIVIDUALS
6.	2--	SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS: TOTAL	8462
	200	FAMILY PLANNING SERVICES	193
	201	WELL CHILD CARE	89
	202	PRENATAL CARE	260
	203	POSTPARTUM CARE	57
	204	TUBERCULOSIS: Follow-up of inactive case	19
	205	MEDICAL AND SURGICAL AFTERCARE	13
	206	GENERAL PHYSICAL EXAMINATION	1710
	207	PAPANICOLAOU SMEARS	82
	208	TUBERCULIN TESTING	1292
	209	SEROLOGY SCREENING	70
	210	VISION SCREENING	2239
	211	AUDITORY SCREENING	2306
	212	SCREENING CHEST X-RAYS	38
	213	GENERAL HEALTH COUNSELLING	43
	219	OTHER SERVICES:	
		(Specify) Pediculosis	
		Speech	
		Colic	
		Masvunbution	51
		etc.	

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PART III - NURSING SERVICE

TYPE OF SERVICE	NUMBER
NURSING CLINICS:	
a. NUMBER OF CLINICS	35
b. NUMBER OF INDIVIDUALS SERVED - TOTAL	462
FIELD NURSING:	
a. VISITS TO HOUSEHOLDS	1882
b. TOTAL HOUSEHOLDS SERVED	831
c. TOTAL INDIVIDUALS SERVED IN HOUSEHOLDS	2604
d. VISITS TO SCHOOLS, DAY CARE CENTERS	769
e. TOTAL INDIVIDUALS SERVED IN SCHOOLS AND DAY CARE CENTERS	4202
CONTINUITY OF CARE:	
a. REFERRALS MADE FOR MEDICAL CARE: TOTAL	3035
(1) Within Area	1895
(Total Completed)	1812
(2) Out of Area	90
(Total Completed)	2121
b. REFERRALS MADE FOR DENTAL CARE: TOTAL	50
(Total Completed)	36
c. REFERRALS RECEIVED FOR MEDICAL OR DENTAL CARE FROM OUT OF AREA: TOTAL	3
(Total Completed)	3
d. FOLLOW-UP SERVICES FOR MIGRANTS, not originally referred by project, WHO WERE TREATED IN PHYSICIANS OFFICES (Fee-for-Service)	50
e. MIGRANTS PROVIDED PRE-DISCHARGE PLANNING AND POST-HOSPITAL SERVICES	75
f. MIGRANTS ASKED TO PRESENT HEALTH RECORD Form PMS-3652 or Similar Form) IN FIELD OR CLINIC: TOTAL	all
(1) Number presenting health record.	20%
(2) Number given health record	80%
OTHER ACTIVITIES (Specify):	
Conferences-planning and evaluations.	
Parent Groups	
Open House at School	
Migrant Coalition-state and local	
Coordinating with local health services, schools, ministry, etc.	

REMARKS

New computor septum inaguarated for nursing section! Not appropriate for migrant nursing-tabulation by hand and incomplete.

NORTHEAST AREA NARRATIVE REPORT
April 15 - August 15, 1970

During the month of April, the Migrant Nurse did most of the planning for the season. This year, the Colorado Migrant Council extended the Head Start Program at Ovid, Holyoke, Wray, and Yuma. The Migrant Nurse had the responsibility of the nursing program in Ovid and Holyoke. The staff in both areas cooperated very well.

At Holyoke the nurse organized a local migrant council, made up of some of the key people in the community. This was a fine start and more could have been done to coordinate all the programs if the council had been organized earlier in the season. Also, it probably would have been a better feeling in the community if some of the staff in the Head Start Program was from the community. Perhaps this can be worked out with the Migrant Council for the coming season.

At the beginning of June, the Migrant Nurse was relieved of duties in Yuma County. She spent much of her time in the Head Start Program in Ovid and Holyoke. It would benefit the program if all needed supplies were obtained before the beginning of school.

An excellent family planning clinic was held at the Educational Building of the Ovid Methodist Church. The clinics were conducted each Friday evening for five weeks. The clinic treated only young couples at an average attendance of 20 patients per week. Dr. Ruth Bennett, a retired medical doctor, helped out with the teaching; she was well suited for this type of program.

The first meeting discussions were on prenatal care and care of the new born baby. The last two meetings were strictly on different methods of family planning. Films were shown at these meetings followed by group discussions. The meetings were very informal and refreshments were served. These meetings presented the opportunity to give information on the services available to migrants. This also gave closer contact with the nurse and the migrants. The nurse felt that this was the highlight of the season.

A pap smear clinic was held at the Ovid Methodist Church the morning of June 20. Doctor Harding from Colorado General Hospital was the examining physician. This was a successful clinic with 20 persons examined. Another pap smear clinic was held the afternoon of June 20 in Holyoke in Doctor Chestnut's office. Only six patients were seen, however. This may be an indication that another pap smear clinic should be held in Ovid.

The Migrant Nurse assisted at two Sunday clinics in Sterling. This will be reported in the report from the Northeast Health Department in Sterling.

Many interesting cases were found, however, it would be impossible to write about all of them. A case in point is the case of pulminary tuberculosis found by Dr. John Lundgren of Julesburg and referred to the Migrant Nurse for follow-up. The patient was hospitalized and her two children were put on I.N.H. Another case is a young man with uretha obstruction, bilateran who was hospitalized in Julesburg then transferred to Colorado General Hospital for surgery. He returned to Julesburg with two tubes inserted to both pelvics and the urine collected into two bags, one on each thigh. Additional surgery was needed in four to six months. The doctors felt it was necessary to have surgery at Colorado General Hospital in Denver which created still another problem since the patient had entered the country illegally. The Social Worker at Colorado General Hospital took the case to the Immigration Department in Denver and succeeded, after two months, to get a visa for the patient. The six-month visa can be renewed later. Without the assistance of the Catholic priest and other interested people who were able to get the patient on Aid for Needy Disabled, he would not have survived.

One man who was found to have some type of liver ailement was sent back to Texas because the physician had difficulty diagnosing the case due to the lack of cooperation from the patient.

Pediculosis was a big problem this year in the school as well as in the homes. Twenty patients were taken to Colorado General Hospital for check-ups. Several patients were diagnosed as mentally retarded, epeleptic, hearing loss, and one entire family with scabies. All are being referred for follow-up in Texas.

Several college students were sent to this area for different migrant programs and they served as interpreters, contact persons, and assisted in clinics and transported patients to Colorado General Hospital. It was an inspiration for the Migrant Nurse as well as the migrants to have these idealistic and enthusiastic young people working here and it was beneficial to them to be exposed to the needs of the poverty-stricken people.

It would be dishonest to say it had been a pleasant summer. There have been several tragic situations where a few people tried to make everything hard and almost impossible for working. However, in spite of their efforts, so much was accomplished that it was worthwhile being a part of the Migrant Health Program.

NORTHEAST AREA

DATE SUBMITTED

PART II - MEDICAL, DENTAL, AND HOSPITAL SERVICES

1. MIGRANTS RECEIVING MEDICAL SERVICES

a. TOTAL MIGRANTS RECEIVING MEDICAL SERVICES AT FAMILY HEALTH CLINICS, PHYSICIANS OFFICES, HOSPITAL EMERGENCY ROOMS, ETC.

AGE	NUMBER OF PATIENTS			NUMBER OF VISITS
	TOTAL	MALE	FEMALE	
TOTAL	688	278	410	827
UNDER 1 YEAR	48	24	24	69
1 - 4 YEARS	107	49	58	134
5 - 14 YEARS	159	69	90	183
15 - 44 YEARS	309	121	188	363
45 - 64 YEARS	64	15	49	93
65 AND OLDER	1		1	1

b. OF TOTAL MIGRANTS RECEIVING MEDICAL SERVICES, HOW MANY WERE:

(1) SERVED IN FAMILY HEALTH SERVICE CLINIC? 140

(2) SERVED IN PHYSICIANS' OFFICE, ON FEE-FOR-SERVICE ARRANGEMENT (INCLUDE REFERRALS) 494

3. MIGRANT PATIENTS HOSPITALIZED

(Regardless of arrangements for payment):

No. of Patients (exclude newborn) 18

No. of Hospital Days 144

2. MIGRANTS RECEIVING DENTAL SERVICES

ITEM	TOTAL	UNDER 15	15 AND OLDER
a. NO. MIGRANTS EXAMINED-TOTAL			
(1) NO. DECAYED, MISSING, FILLED TEETH			
(2) AVERAGE DMF PER PERSON			
b. INDIVIDUALS REQUIRING SERVICES-TOTAL			
(1) CASES COMPLETED			
(2) CASES PARTIALLY COMPLETED			
(3) CASES NOT STARTED			
c. SERVICES PROVIDED - TOTAL			
(1) PREVENTIVE			
(2) CORRECTIVE-TOTAL			
(a) Extraction			
(b) Other			
d. PATIENT VISITS - TOTAL			

4. IMMUNIZATIONS PROVIDED

TYPE	COMPLETED IMMUNIZATIONS, BY AGE					INCOMPLETE SERIES	BOOSTERS, REVACCINATIONS
	TOTAL	UNDER 1 YEAR	1 - 4	5 - 14	15 AND OLDER		
TOTAL-- ALL TYPES	665	32	122	247	264	197	167
SMALLPOX							
DIPHTHERIA 159	159	8	23	40	88	58	22
PERTUSSIS 135	173	8	23	54	88	58	13
TETANUS 159	197	8	23	78	88	58	22
POLIO 104	106	8	23	75		23	110
TYPHOID							
MEASLES							
OTHER (Specify) Rubella 30	30		30				

REMARKS

CLINICS, HOSPITAL OUTPATIENT DEPARTMENTS, AND PHYSICIANS' OFFICES.

D AS	MH CO'S	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
		TOTAL ALL CONDITIONS	708	526	182
	01-	INFECTIVE AND PARASITIC DISEASES: TOTAL	156	113	43
	010	TUBERCULOSIS	17	14	3
	011	SYPHILIS	32	11	21
	012	GONORRHEA AND OTHER VENEREAL DISEASES	7	1	6
	013	INTESTINAL PARASITES	2	2	
		DIARRHEAL DISEASE (infectious or unknown origins):			
	014	Children under 1 year of age			
	015	All other	2	1	1
	016	"CHILDHOOD DISEASES" – mumps, measles, chickenpox	15	10	5
	017	FUNGUS INFECTIONS OF SKIN (Dermatophytoses)			
	019	OTHER INFECTIVE DISEASES (Give examples):			
		Pos. Strep.	77	77	
		Liver Inx.	5	1	4
		Thrush	4	2	2
		Blepharitis	1	1	
	02-	NEOPLASMS: TOTAL	3	3	
	020	MALIGNANT NEOPLASMS (give examples):			
	025	BENIGN NEOPLASMS	3	3	
	029	NEOPLASMS of uncertain nature			
	03-	ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES: TOTAL	24	20	4
	030	DISEASES OF THYROID GLAND	12	9	3
	031	DIABETES MELLITUS			
	032	DISEASES of Other Endocrine Glands	5	5	
	033	NUTRITIONAL DEFICIENCY	7	6	1
	034	OBESITY			
	039	OTHER CONDITIONS			
	04-	DISEASES OF BLOOD AND BLOOD FORMING ORGANS: TOTAL	23	22	1
	040	IRON DEFICIENCY ANEMIA	21	20	1
	049	OTHER CONDITIONS	2	2	
	05-	MENTAL DISORDERS: TOTAL	10	8	2
	050	PSYCHOSES	2	2	
	051	NEUROSES and Personality Disorders	4	3	1
	052	ALCOHOLISM			
	053	MENTAL RETARDATION	4	3	1
	059	OTHER CONDITIONS			
	06-	DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS: TOTAL	49	41	8
	060	PERIPHERAL NEURITIS	6	4	2
	061	EPILEPSY	8	6	2
	062	CONJUNCTIVITIS and other Eye Infections	16	14	2
	063	REFRACTIVE ERRORS of Vision	15	15	
	064	OTITIS MEDIA	4	2	2
	069	OTHER CONDITIONS			

GRANT NUMBER

ICD CLASS	MII CODE	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
VII.	07-	DISEASES OF THE CIRCULATORY SYSTEM: TOTAL	37	28	9
	070	RHEUMATIC FEVER	4	2	2
	071	ARTERIOSCLEROTIC and Degenerative Heart Disease	10	5	5
	072	CEREBROVASCULAR DISEASE (Stroke)			
	073	OTHER DISEASES of the Heart	4	4	
	074	HYPERTENSION	11	10	1
	075	VARICOSE VEINS	5	4	1
	079	OTHER CONDITIONS	3	3	
VIII.	08-	DISEASES OF THE RESPIRATORY SYSTEM: TOTAL	129	103	26
	080	ACUTE NASOPHARYNGITIS (Common Cold)	18	18	
	081	ACUTE PHARYNGITIS	26	26	
	082	TONSILLITIS	14	8	6
	083	BRONCHITIS	11	9	2
	084	TRACHEITIS/LARYNGITIS			
	085	INFLUENZA	13	13	
	086	PNEUMONIA	21	9	2
	087	ASTHMA, HAY FEVER	4	4	
	088	CHRONIC LUNG DISEASE (Emphysema)	1	1	
	089	OTHER CONDITIONS	21	15	6
IX.	09-	DISEASES OF THE DIGESTIVE SYSTEM: TOTAL	77	56	21
	090	CARIES and Other Dental Problems	9	9	
	091	PEPTIC ULCER	12	8	4
	092	APPENDICITIS	1	1	
	093	HERNIA			
	094	CHOLECYSTIC DISEASE	13	8	5
	099	OTHER CONDITIONS	42	30	12
X.	10-	DISEASES OF THE GENITOURINARY SYSTEM: TOTAL	29	16	13
	100	URINARY TRACT INFECTION (Pyelonephritis, Cystitis)	19	9	10
	101	DISEASES OF PROSTATE GLAND (excluding Carcinoma)			
	102	OTHER DISEASES of Male Genital Organs			
	103	DISORDERS of Menstruation	4	3	1
	104	MENOPAUSAL SYMPTOMS			
	105	OTHER DISEASES of Female Genital Organs	5	3	2
	109	OTHER CONDITIONS	1	1	
XI.	11-	COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM: TOTAL	33	18	15
	110	INFECTIONS of Genitourinary Tract during Pregnancy	4	1	3
	111	TOXEMIAS of Pregnancy	1	1	
	112	SPONTANEOUS ABORTION	6	4	2
	113	REFERRED FOR DELIVERY	10	6	4
	114	COMPLICATIONS of the Puerperium	6	4	2
	119	OTHER CONDITIONS	6	2	4
XII.	12-	DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE: TOTAL	41	25	16
	120	SOFT TISSUE ABSCESS OR CELLULITIS	5	4	1
	121	IMPETIGO OR OTHER PYODERMA	1	1	
	122	SEBORRHEIC DERMATITIS	1	1	
	123	ECZEMA, CONTACT DERMATITIS, OR NEURODERMATITIS	7	5	2
	124	ACNE			
	129	OTHER CONDITIONS	27	14	13

RT II - 5. (Continued)

ICD CLASS	HII CODE	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
I.	13-	DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE: TOTAL	12	8	4
	130	RHEUMATOID ARTHRITIS	4	1	3
	131	OSTEOARTHRITIS	4	3	1
	132	ARTHRITIS, Unspecified	2	2	
	139	OTHER CONDITIONS	2	2	
V.	14-	CONGENITAL ANOMALIES: TOTAL	7	5	2
	140	CONGENITAL ANOMALIES of Circulatory System	7	5	2
	149	OTHER CONDITIONS			
/.	15-	CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY: TOTAL			
	150	BIRTH INJURY			
	151	IMMATURITY			
	159	OTHER CONDITIONS			
/I.	16-	SYMPTOMS AND ILL-DEFINED CONDITIONS: TOTAL	34	29	5
	160	SYMPTOMS OF SENILITY	12	10	2
	161	BACKACHE	11	11	
	162	OTHER SYMPTOMS REFERRABLE TO LIMBS AND JOINTS	7	4	3
	163	HEADACHE	4	4	
	169	OTHER CONDITIONS			
VII.	17-	ACCIDENTS, POISONINGS, AND VIOLENCE: TOTAL	49	36	13
	170	LACERATIONS, ABRASIONS, and Other Soft Tissue Injuries	21	19	2
	171	BURNS			
	172	FRACTURES	12	7	5
	173	SPRAINS, STRAINS, DISLOCATIONS	12	6	6
	174	POISON INGESTION			
	179	OTHER CONDITIONS due to Accidents, Poisoning, or Violence	4	4	

			NUMBER OF INDIVIDUALS
6.	2--	SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS: TOTAL	962
	200	FAMILY PLANNING SERVICES	26
	201	WELL CHILD CARE	14
	202	PRENATAL CARE	39
	203	POSTPARTUM CARE	12
	204	TUBERCULOSIS: Follow-up of inactive case	7
	205	MEDICAL AND SURGICAL AFTERCARE	
	206	GENERAL PHYSICAL EXAMINATION	90
	207	PAPANICOLAOU SMEARS	16
	208	TUBERCULIN TESTING	360
	209	SEROLOGY SCREENING	59
	210	VISION SCREENING	108
	211	AUDITORY SCREENING	144
	212	SCREENING CHEST X-RAYS	9
	213	GENERAL HEALTH COUNSELLING	43
	219	OTHER SERVICES: (Specify) Pediculosis	35

PART III - NURSING SERVICE

TYPE OF SERVICE	NUMBER
1. NURSING CLINICS:	
a. NUMBER OF CLINICS	
b. NUMBER OF INDIVIDUALS SERVED - TOTAL	
2. FIELD NURSING:	
a. VISITS TO HOUSEHOLDS	499
b. TOTAL HOUSEHOLDS SERVED	251
c. TOTAL INDIVIDUALS SERVED IN HOUSEHOLDS	680
d. VISITS TO SCHOOLS, DAY CARE CENTERS	132
e. TOTAL INDIVIDUALS SERVED IN SCHOOLS AND DAY CARE CENTERS	205
3. CONTINUITY OF CARE:	
a. REFERRALS MADE FOR MEDICAL CARE. TOTAL	513
(1) Within Area 405	
(Total Completed 391)	
(2) Out of Area 37	
(Total Completed)	
b. REFERRALS MADE FOR DENTAL CARE: TOTAL	
(Total Completed)	
c. REFERRALS RECEIVED FOR MEDICAL OR DENTAL CARE FROM OUT OF AREA: TOTAL	
(Total Completed)	
d. FOLLOW-UP SERVICES FOR MIGRANTS, not originally referred by project, WHO WERE TREATED IN PHYSICIANS OFFICES (Fee-for-Service)	
e. MIGRANTS PROVIDED PRE-DISCHARGE PLANNING AND POST-HOSPITAL SERVICES	
f. MIGRANTS ASKED TO PRESENT HEALTH RECORD (Form PMS-3652 or Similar Form) IN FIELD OR CLINIC: TOTAL Majority	
(1) Number presenting health record.	
(2) Number given health record.	
4. OTHER ACTIVITIES (Specify):	
Thrift Shop	
Parents Groups	
Open House at School	
Volunteer Outreach and Clinic Workers	

REMARKS

ARKANSAS VALLEY NARRATIVE REPORT - 1970

The Migrant Nurse for the Arkansas Valley began the summer with these objectives in mind:

1. To determine the health needs of the people in order of urgency so that she would know which area of health to concentrate on first.

2. To let the migrants know through out-reach work what medical services the Migrant Health Program would offer.

3. To encourage the migrants to use the health resources and encourage it in such a way that no ones pride would be hurt and no ones self-esteem lowered.

4. To make more widely known the concept of preventive care.

5. To make known the importance of early diagnosis, treatment and follow-up care of an illness.

6. To obtain assistance from members of the community in helping with the migrant program.

Since the Colorado Migrant Council nurse and State Migrant Health Program nurse had basically the same objectives, the Migrant Council nurse worked on one end of the Arkansas Valley and the Migrant Health Program nurse worked the other. This worked out quite well as they could each spend more time with the migrants and less time on the road.

The Nurse felt that more migrants received medical care this year than last as clinic attendance was larger and she made out more referrals. Some of the reasons for this may be:

1. Working more closely with other agencies so that they were aware of what was available if someone came to them for help.

2. Many migrants return to the same places year after year and the word soon spread as to where they could get help and where they could not.

3. This year seemed to be poorer than other years for the migrants and the Nurse believed that some of those who usually took care of their own medical bills could not afford to this year out of their less than meager earnings.

The two physicians in Lamar who saw patients at the weekly clinic did not seem too happy with the way the program was handled, but on the other hand,

they did not have any practical solutions as to how to handle medical care for the migrants. One thing she felt would make the physicians happier was to stop patients from 'doctor hopping' which is seeing two or three different doctors in the same town and maybe for the same illness. Another thing upsetting to the physicians which the Nurse tried to discourage was patients, especially children, brought to clinic for 'not eating well' or not sleeping enough', or 'a runny nose since yeaterday'. Children of different ages do not eat more or less and its quite normal for them to sleep less than they used to and it is very seldom that a child with a runny nose needs to see a physician. She felt that more teaching should be given mothers on child growth and development. However, no matter how minor the health problem seems, we do offer the clinics and we do not deny anyone their own opinion or their right to see a physician.

The Arkansas Valley Migrant Nurse felt that the quality of medical care given to the migrants this season was an improvement over last season. The clinics were held in the offices of Doctor Locke and Doctor Greeb. This worked out much better than makeshift vacant rooms at the hospital. Suggestions the nurse would like to make which would improve the program are:

1. Prompt payment. There have been many comments against the Migrant Program because of extreme slowness in payment and threats of not having anything to do with the Program in the future because of being unsure of payments. This suggestion should be taken seriously because without physicians and pharmacists there could be no migrant program.

2. More nurses. We must often spread so thin that at times we feel that maybe we are not of real value in any place.

3. Home health aides in each area. Aides are especially needed in more rural areas where distances are greater. The health aide can be invaluable transporting patients. The Nurse will then have more time to work at a skilled and professional level, although at times it will be necessary for her to become a taxi also.

The health of the migrant will be better when the care he receives is not sporadic as it is now. Health care will be better when the migrant program is expanded and changed to include all farmworkers and all rural poor. Health care will be better when people are no longer denied the right to an education, so that they can then read. Generally, the Migrant Nurse looks at the health program as good, but she believes it can be much better.

ARKANSAS VALLEY

DATE SUBMITTED

PART II - MEDICAL, DENTAL, AND HOSPITAL SERVICES

1. MIGRANTS RECEIVING MEDICAL SERVICES

a. TOTAL MIGRANTS RECEIVING MEDICAL SERVICES AT FAMILY HEALTH CLINICS, PHYSICIANS OFFICES, HOSPITAL EMERGENCY ROOMS, ETC.

AGE	NUMBER OF PATIENTS			NUMBER OF VISITS
	TOTAL	MALE	FEMALE	
TOTAL	1069	475	594	1252
UNDER 1 YEAR	67	46	24	85
1 - 4 YEARS	303	163	140	343
5 - 14 YEARS	246	128	118	267
15 - 44 YEARS	329	96	233	407
45 - 64 YEARS	117	41	76	137
65 AND OLDER	7	1	6	10

b. OF TOTAL MIGRANTS RECEIVING MEDICAL SERVICES, HOW MANY WERE:

(1) SERVED IN FAMILY HEALTH SERVICE CLINIC? 532

(2) SERVED IN PHYSICIANS' OFFICE, ON FEE-FOR-SERVICE ARRANGEMENT (INCLUDE REFERRALS) 537

c. MIGRANT PATIENTS HOSPITALIZED (Regardless of arrangements for payment):

No. of Patients (exclude newborn) 25

No. of Hospital Days 105

2. MIGRANTS RECEIVING DENTAL SERVICES

ITEM	TOTAL	UNDER 15	15 AND OLDER
a. NO. MIGRANTS EXAMINED-TOTAL			
(1) NO. DECAYED, MISSING, FILLED TEETH			
(2) AVERAGE DMF PER PERSON			
b. INDIVIDUALS REQUIRING SERVICES-TOTAL			
(1) CASES COMPLETED			
(2) CASES PARTIALLY COMPLETED			
(3) CASES NOT STARTED			
c. SERVICES PROVIDED - TOTAL			
(1) PREVENTIVE			
(2) CORRECTIVE-TOTAL			
(a) Extraction			
(b) Other			
d. PATIENT VISITS - TOTAL			

4. IMMUNIZATIONS PROVIDED

TYPE	COMPLETED IMMUNIZATIONS, BY AGE					INCOMPLETE SERIES	BOOSTERS, REVACCINATIO
	TOTAL	UNDER 1 YEAR	1 - 4	5 - 14	15 AND OLDER		
TOTAL-- ALL TYPES	457	163	223	66	5	76	132
SMALLPOX	1			1			
DIPHTHERIA	96	37	40	17	2	19	33
PERTUSSIS	82	37	40	5		19	33
TETANUS	99	37	40	19	3	19	33
POLIO	82	37	40	5		19	33
TYPHOID							
MEASLES	35		26	9			
OTHER (Specify) Rubella	62	15	37	10			

REMARKS

RT II (Continued) - 5. MEDICAL COMMITIONS TREATED BY PHYSICIANS IN FAMILY CLINICS, HOSPITAL OUTPATIENT DEPARTMENTS, AND PHYSICIANS' OFFICES.

ICD CLASS	MH CODE	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISIT
VII.	-	TOTAL ALL CONDITIONS	1147	929	218
	01-	INFECTIVE AND PARASITIC DISEASES: TOTAL	90	67	23
	010	TUBERCULOSIS	2	2	
	011	SYPHILIS	2	2	
	012	GONORRHEA AND OTHER VENEREAL DISEASES			
	013	INTESTINAL PARASITES	4	4	
		DIARRHEAL DISEASE (infectious or unknown origins):	9	6	3
	014	Children under 1 year of age	6	4	2
	015	All other	28	17	11
	016	"CHILDHOOD DISEASES" - mumps, measles, chickenpox	13	12	1
	017	FUNGUS INFECTIONS OF SKIN (Dermatophytoses)	6	6	
	019	OTHER INFECTIVE DISEASES (Give examples):			
		Meningitis	1	1	
		Strep Throat	13	9	4
		Encephalitis	3	1	2
			3	3	
	02-	NEOPLASMS: TOTAL			
	020	MALIGNANT NEOPLASMS (give examples):			
	025	BENIGN NEOPLASMS			
	029	NEOPLASMS of uncertain nature			
	03-	ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES: TOTAL	53	39	14
	030	DISEASES OF THYROID GLAND	2	1	1
	031	DIABETES MELLITUS	14	8	6
	032	DISEASES of Other Endocrine Glands	1	1	
	033	NUTRITIONAL DEFICIENCY	26	24	2
	034	OBESITY	10	5	5
	039	OTHER CONDITIONS			
	04-	DISEASES OF BLOOD AND BLOOD FORMING ORGANS: TOTAL	19	15	4
	040	IRON DEFICIENCY ANEMIA	17	13	4
	049	OTHER CONDITIONS	2	2	
	05-	MENTAL DISORDERS: TOTAL	12	8	4
	050	PSYCHOSES			
	051	NEUROSES and Personality Disorders	4	2	2
	052	ALCOHOLISM			
	053	MENTAL RETARDATION	1	1	
	059	OTHER CONDITIONS	7	5	2
	06-	DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS: TOTAL	164	143	21
	060	PERIPHERAL NEURITIS			
	061	EPILEPSY	3	3	
	062	CONJUNCTIVITIS and other Eye Infections	34	27	7
	063	REFRACTIVE ERRORS of Vision	38	33	5
	064	OTITIS MEDIA	61	54	7
	069	OTHER CONDITIONS	28	26	2

CD ASS	MH CODE	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
	07-	DISEASES OF THE CIRCULATORY SYSTEM: TOTAL	35	25	10
	070	RHEUMATIC FEVER	1	1	
	071	ARTERIOSCLEROTIC and Degenerative Heart Disease			
	072	CEREBROVASCULAR DISEASE (Stroke)	5	4	1
	073	OTHER DISEASES of the Heart			
	074	HYPERTENSION	22	13	9
	075	VARICOSE VEINS			
	079	OTHER CONDITIONS	7	7	
II.	08-	DISEASES OF THE RESPIRATORY SYSTEM: TOTAL	332	268	64
	080	ACUTE NASOPHARYNGITIS (Common Cold)	110	99	11
	081	ACUTE PHARYNGITIS	25	21	4
	082	TONSILLITIS	88	78	10
	083	BRONCHITIS	35	25	10
	084	TRACHEITIS & LARYNGITIS			
	085	INFLUENZA	10	9	1
	086	PNEUMONIA	28	9	19
	087	ASTHMA, HAY FEVER	8	8	
	088	CHRONIC LUNG DISEASE (Emphysema)	2	1	1
	089	OTHER CONDITIONS	26	18	8
	09-	DISEASES OF THE DIGESTIVE SYSTEM: TOTAL	115	101	14
	090	CARIES and Other Dental Problems	28	22	6
	091	PEPTIC ULCER	5	5	
	092	APPENDICITIS			
	093	HERNIA	1	1	
	094	CHOLECYSTIC DISEASE	12	7	5
	099	OTHER CONDITIONS	69	66	3
	10-	DISEASES OF THE GENITOURINARY SYSTEM: TOTAL	80	59	21
	100	URINARY TRACT INFECTION (Pyelonephritis, Cystitis)	40	27	13
	101	DISEASES OF PROSTATE GLAND (excluding Carcinoma)	3	2	1
	102	OTHER DISEASES of Male Genital Organs	4	2	2
	103	DISORDERS of Menstruation	10	9	1
	104	MENOPAUSAL SYMPTOMS	6	6	
	105	OTHER DISEASES of Female Genital Organs	7	7	
	109	OTHER CONDITIONS	10	6	4
XI.	11-	COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM: TOTAL	12	7	5
	110	INFECTIONS of Genitourinary Tract during Pregnancy			
	111	TOXEMIAS of Pregnancy	5	2	3
	112	SPONTANEOUS ABORTION	3	1	2
	113	REFERRED FOR DELIVERY	2	2	
	114	COMPLICATIONS of the Puerperium	1	1	
	119	OTHER CONDITIONS	1	1	
XII.	12-	DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE: TOTAL	68	64	4
	120	SOFT TISSUE ABSCESS OR CELLULITIS	4	4	
	121	IMPETIGO OR OTHER PYODERMA	22	21	1
	122	SEBORRHEIC DERMATITIS	6	6	
	123	ECZEMA, CONTACT DERMATITIS, OR NEURODERMATITIS	9	8	1
	124	ACNE			
	129	OTHER CONDITIONS	27	25	2

GRANT NUMBER

PART II - 5. (Continued)

ICD CLASS	HH CODE	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
XIII.	13-	DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE: TOTAL	45	33	12
	130	RHEUMATOID ARTHRITIS	2	2	
	131	OSTEOARTHRITIS	14	7	7
	132	ARTHRITIS, Unspecified	29	24	5
	139	OTHER CONDITIONS			
XIV.	14-	CONGENITAL ANOMALIES. TOTAL	7	4	3
	140	CONGENITAL ANOMALIES of Circulatory System	1	1	
	149	OTHER CONDITIONS	6	3	3
XV.	15-	CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY: TOTAL	1	1	
	150	BIRTH INJURY			
	151	IMMATURITY	1	1	
	159	OTHER CONDITIONS			
XVI.	16-	SYMPTOMS AND ILL-DEFINED CONDITIONS: TOTAL	51	42	9
	160	SYMPTOMS OF SENILITY			
	161	BACKACHE	14	11	3
	162	OTHER SYMPTOMS REFERRABLE TO LIMBS AND JOINTS	1	1	
	163	HEADACHE	19	15	4
	169	OTHER CONDITIONS	17	15	2
XVII.	17-	ACCIDENTS, POISONINGS, AND VIOLENCE: TOTAL	54	47	7
	170	LACERATIONS, ABRASIONS, and Other Soft Tissue Injuries	8	8	
	171	BURNS	2	2	
	172	FRACTURES	9	7	2
	173	SPRAINS, STRAINS, DISLOCATIONS	8	8	
	174	POISON INGESTION			
	179	OTHER CONDITIONS Due to Accidents, Poisoning, or Violence	27	22	5

			NUMBER OF INDIVIDUALS
6.	2--	SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS: TOTAL	628
	200	FAMILY PLANNING SERVICES	27
	201	WELL CHILD CARE	
	202	PRENATAL CARE	86
	203	POSTPARTUM CARE	17
	204	TUBERCULOSIS: Follow-up of inactive case	5
	205	MEDICAL AND SURGICAL AFTERCARE	5
	206	GENERAL PHYSICAL EXAMINATION	274
	207	PAPANICOLAOU SMEARS	17
	208	TUBERCULIN TESTING	104
	209	SEROLOGY SCREENING	4
	210	VISION SCREENING	24
	211	AUDITORY SCREENING	53
	212	SCREENING CHEST X-RAYS	12
	213	GENERAL HEALTH COUNSELLING	
	219	OTHER SERVICES: (Specify)	

PART III NURSING SERVICE

TYPE OF SERVICE	NUMBER
NURSING CLINICS:	
a. NUMBER OF CLINICS	14
b. NUMBER OF INDIVIDUALS SERVED - TOTAL	187
FIELD NURSING:	
a. VISITS TO HOUSEHOLDS	400
b. TOTAL HOUSEHOLDS SERVED	126
c. TOTAL INDIVIDUALS SERVED IN HOUSEHOLDS	374
d. VISITS TO SCHOOLS, DAY CARE CENTERS	166
e. TOTAL INDIVIDUALS SERVED IN SCHOOLS AND DAY CARE CENTERS	236
CONTINUITY OF CARE:	
a. REFERRALS MADE FOR MEDICAL CARE: TOTAL	345
(1) Within Area	313
(Total Completed)	
(2) Out of Area	
(Total Completed)	
b. REFERRALS MADE FOR DENTAL CARE: TOTAL	5
(Total Completed)	4
c. REFERRALS RECEIVED FOR MEDICAL OR DENTAL CARE FROM OUT OF AREA:	3
TOTAL	3
(Total Completed)	
d. FOLLOW-UP SERVICES FOR MIGRANTS, not originally referred by project, WHO WERE TREATED IN PHYSICIANS OFFICES (Fee-For-Service)	
e. MIGRANTS PROVIDED PRE-DISCHARGE PLANNING AND POST-HOSPITAL SERVICES	10
f. MIGRANTS ASKED TO PRESENT HEALTH RECORD (Form PMS-3652 or Similar Form) IN FIELD OR CLINIC: TOTAL	
(1) Number presenting health record.	
(2) Number given health record	
OTHER ACTIVITIES (Specify):	
Conference and meetings to plan programs, to evaluate programs, to facilitate communication.	

REMARKS

Two migrant nurses worked in the Arkansas Valley. One a project nurse who worked for six months one a nurse employed by Colorado Migrant Council who worked three months. The two nurses divided the Valley and each performed all services in her area.

NORTH CENTRAL AREA NARRATIVE REPORT

The North Central Colorado Migrant Health Program includes Larimer, Adams, Weld, and Boulder Counties. A description of the activities in North Central will be discussed by area rather than county because the health program was carried out by area according to the flow of the migrant worker.

Clinics were held in Fort Collins on Tuesday evenings, the period of time the school was in operation. These clinics were the most comprehensive clinics held. Optometrist and Ophthalmologist volunteered to do visual screening at each and every clinic. All people who were found to have some visual difficulty were referred for follow-up care.

The Larimer County Department of Welfare sent a representative to each clinic to give information on food stamp eligibility and other appropriate information. During clinic hours, clothing was available for purchasing for a minimal amount of money.

The clinics were staffed by two physicians. (All physicians were paid the standard $15 per hour.) The physicians in the clinic were the same each week with the exception of one week when the Director of the Colorado State University Student Health Center volunteered her time to serve. The Larimer County Health Department nurses staffed these clinics along with Migrant Health Program nurses. The superior at Larimer County Health Department assisted in setting up the clinic and gave guidance to the migrant nurse working out of the Larimer County Health Department. (A routing system was worked out for the clinic.) Two Family Health Workers assigned to the Migrant Health Program assisted in the clinic and were given appropriate jobs to do. Larimer County Health Department assigned at least three regular public health nurses to work in each clinic as well as a practical nurse. Volunteers were recruited and used whenever appropriate.

The Family Health Clinic in Fort Collins benefitted the school in that it gave the teacher and principal an opportunity to meet the parents of the children and see the child in his family unit. The school operated a teenage evening program on the same evening and migrants who wished to come to the clinic were premitted to ride the buses which were sent out for the teenage school. Maternity patients and patients wishing information or materials for planned parenthood were taken care of during the clinic rather than referring them to the regular Larimer County Health Department clinics.

GREELEY:

Clinics in Greeley initially operated two nights a week during June. In early July it was determined that the attendance was low at the clinics, and consolidated to one-night clinics, with the understanding as the attendance increased, another evening clinic would be added.

The clinic was staffed by one physician, one intern, a Weld County Public Health Nurse and a Migrant Health Program Nurse. In addition, the migrant secretary, one or two family health workers, and a neighborhood youth corp student attended and assisted in the clinics. The clinics in Greeley continued through the month of September.

One problem associated with the Greeley clinic is the problem of sending the migrant patient for x-ray or laboratory work. The x-ray and laboratory department billed the Program in one lump sum indicating the names of patients served. They gave a 20 percent discount on the bill, however. (Due to the confusion of the new referral we found duplication in charges in that a patient would be sent over with a referral, the referral would be sent in for payment and in addition, a charge for the patient would appear in the monthly bill received by the migrant clinic.)

FORT LUPTON:

Clinics were held in the Weld County Health Department office in Fort Lupton one night a week. The clinics were staffed by one Weld County Public Health Nurse, and one or two migrant health nurses, as well as the migrant secretary and a family health worker.

Maternity or planned parenthood patients were not seen in the migrant clinics in Fort Lupton and Greeley. This procedure made it difficult for a migrant woman to receive pre-natal care or any planned parenthood information or materials. We experienced a great number of failures in the maternity clinics in that it was difficult for the migrant woman to ask her husband to leave the field or for her to leave the field to go to a clinic.

The Migrant Nurse recommends that during 1971, the initial clinic visit be done in the regular migrant clinic as well as the follow-up. There are too many migrant women who come for care and are told to come back in two weeks. Clinic policy should be indicated by need, not by physician preference. If additional medical staff is needed to accomplish this, the money would be well spent.

BRIGHTON:

The Migrant Clinic in Brighton at the outpost in Adams County initially operated one evening a week. Another evening was added earlier in July as the number of migrants in the area increased. The Brighton Health Department staffed each of the clinics with Adams County Public Health Nurses. A nurse was hired by the Adams County Health Department especially to help in the clinics and the migrant nurse assisted in these clinics. (The family health workers were a little lax in attending this clinic.) The local migrant ministry student assisted in clinics and was of great assistance.

The Family Practice Group in Denver agreed to staff the clinic in Brighton one night a week. The second night, when it was added, the clinic was staffed by a physician whose services were contracted.

The clinic in Brighton offered a great opportunity for migrants in that they could receive whatever health care was needed. The Brighton Out-Post has Children and Youth and Maternal and Infant Clinics. Migrant patients who found it necessary to come during the day could receive care and it was not always necessary to determine the eligibility status if he was a migrant or non-migrant.

The University of Colorado Medical School decided to start Sunday clinics. The attendance at the first two clinics was very low, possibly due to the existance of clinics in both Brighton, two nights a week, and Fort Lupton, one night a week. After some discussion, it was decided to move the Sunday clinic to Keenesburg.

KEENESBURG:

The Medical School at the University of Colorado sent at least two physicians to each clinic and it was requested they send a nurse for each physician. The migrants were notified about the clinic by notes sent home through the migrant schools, family health workers, migrant health nurses and Catholic Sisters going throughout the Prospect Valley and Keenesburg area. After this was done, the attendance jumped to over 60 patients on one Sunday.

Approximately 25 to 30 patients were not seen at the clinic. The reason for this was time and space. Each of these 25 people discussed their health problem with a migrant nurse and it was determined that they could attend clinics the next night in Fort Lupton or return to the Sunday clinic in Keenesburg the next week.

The Title I Mobile Van was used at one of the Keenesburg clinics and the interest shown by the migrant population was fantistic. The operator of the van was busy screening patients from 2 p.m. until 8 p.m. All referrals were then followed up by the migrant nurse. The State Dental Hygienist for the Program attended the clinics as well as some of the other clinics and made appropriate referrals for dental care for migrant people as funds were available.

FREDERICK:

The Migrant Health Program nurse covered the Frederick area attempting to set up a family health clinic in Frederick. The physician who agreed to staff this clinic and who had reasonable amount of money to contribute toward equipment for the clinic hesitated to complete the contract. The nurse was then forced to conduct nursing clinics and make appropriate referrals for either eye, dental or health care.

One of the major problems experienced with all of the migrant clinics was the fact that we had different physicians almost every week seeing migrant patients. The migrant, in some cases, did a great deal of clinic hopping. We documented the fact that one young woman in her first trimester in pregnancy saw six different physicians in clinics and in private offices. Her chief complaint was nausea and vomiting. She received six different medications for this complaint. It is hoped for the 1971 season, that one nurse be used for all clinics and train one or two family health workers to assist her in doing all clinics. We dope this will enable us to give some continuity to the clinics instead of each operating as an independent installation.

Another problem is the migrants not keeping appointments for follow-up of special health problems identified at clinics. The central housing concept will assist in helping to resolve this problem if the migrant is asked to come to the unit to pick up the appointment and the referral forms. In this way, the migrant will indicate his intent to keep the appointment, take some responsibility for himself and eliminate some of the negative attitudes by physicians generated when appointments are not kept.

A continual nursing clinic can be established in this unit to screen health problems and determine proper measures for dealing with this problem. i.e., can the problem wait until clinic, where is the clinic, or, is immediate care needed.

The forms used by the health departments vary. This problem proved to be difficult for the migrant nurses and family health workers. A uniform record and acceptance of the record by all health care delivery agencies, including hospitals would be most useful.

It is recommended that the family health clinics deal not only with diseases, but put emphasis on health, quality of health and health education. This would lead to nutritional teaching and consumer buying as well as information on normal growth and development. The recognition that the environment one lives in effects his health indicates the need for social and legal services. An understanding and respect of the culture of the individual must be present to assist him in the utilization of the resources available to him.

SCHOOL IN NORTH CENTRAL COLORADO:

In Fort Collins the migrant school is located in the same building as the Colorado Migrant Council Day-Care Center. One nurse was contracted for 25 hours a week by the school with the Larimer County Health Department; the health department paid the other 12 1/2 hours of salary. The school ran nine weeks. The relationship with the school and the Migrant Health Program is excellent. They were very helpful in providing space and all the materials that go along with having a clinic located in a school.

LONGMONT:

The school in Longmont hired a nurse who cooperated in every way with the migrant nurse and the family health worker. A Colorado Migrant Council Day-Care Center was located in the school building in Longmont and the migrant health nurse responsible for that area served that day-care center.

FORT LUPTON:

The Fort Lupton school had no nurse hired by them to serve the migrant children in the regular school. Discussions were held with the school and they were encouraged to have a nurse the 1971 summer session. The reason given by the school for not having a nurse was that they could not find enough for her to do. The migrant nurse offered assistance in identifying objectives and goals for the school nurse. The Colorado Migrant Council Day-Care Center was located in the Fort Lupton school and the migrant health nurse serving the area served as the nurse resource for that Center.

BRIGHTON:

The Brighton school system contracted with the Brighton Out-Post for a nurse for the school. The nurse was hired by the Department of Health for 40 hours a week. This was apparently the first nurse ever hired for the migrant school in Brighton. This was a difficult situation in that the principal insisted that the nurse stay in that school all 40 hours and not leave the building. The Day-Care Center located in the Brighton school operated by the Colorado Migrant Council was served by a nurse whose time was purchased by the Colorado Migrant Council from the Brighton Health Department.

GILCREST:

Gilcrest migrant school hired the regular school nurse for 15 hours a week. The migrant nurse in the area cooperated in every way possible with the regular school nurse.

AULT:

The Ault Migrant School hired the school nurse. The Day-Care Center operated by the Colorado Migrant Council was served by the migrant health nurse in that area.

GREELEY:

East Memorial School hired the school nurse. The Day-Care Center operated by the Colorado Migrant Council was served by the migrant health nurse in the area.

WINDSOR:

Windsor school did not have a school nurse. The migrant health nurse who served the Day-Care Center operated by the Colorado Migrant Council in Windsor gave minimal service to the school. The coordinator in the North Central area discussed the positive and negative aspects of having a nurse available to the school and encouraged school officials to consider hiring one for next year. One of the major holes that must be plugged for the 1971 school session is the understanding of all nurses who participated in the migrant school program as to the resource available and how to use these resources. Another problem area exists in the relationship between the migrant school and the Migrant Health Program is the difference in the definition of a migrant. The child in the migrant school is considered a migrant for five years which differs with the definition from the State Migrant Health Program. Unless each school nurse understands this difference, the funds for migrant health may be used in inappropriate ways when other funds may be available as medicare, and welfare.

DRUGS:

The new prescription blanks used this year in the Migrant Health Program have some real strength. It was no longer necessary for the local migrant nurse to keep track of the bills from the pharmacies. All dealings in terms of paying for migrant prescriptions were handled directly with the State. The prescriptions were used by physicians for whatever was necessary for the patients health. On rare occasions, the prescription was used to obtain foods specifically for a diabetic patient when no money was available and there was no other source of food for the patient. (One problem with the prescription referral is that unless the physicians write on the referral what drug he has prescribed for the patient, the migrant nurse has no idea what drugs the migrant might have in his possession. This problem can be worked out with a little thought.)

One excellent suggestion came from one of the family health workers. He recommended that we distribute to each pharmacy the directions for taking drugs in Spanish and ask the druggist to type the prescription directions in Spanish and English. This was done and was a great help to the migrant. Another addition to the prescription would be a request for the labeling of the drug by all pharmacists. The pharmacists in Weld County went a step further with our initial vocabulary list of dosages and times in Spanish by asking a local Spanish teacher to write up the various parts of the body where drugs or prescriptions might need to be applied or ingested.

MIGRANT NURSES:

The migrant nurses in North Central Colorado this year were great. They worked very long, very hard, and they got very involved with their patients and they were truly patient advocates. The problems experienced with several of the nurses, I think, can be taken care of in a reasonably simple fashion:

1. To attempt to hire nurses who have public health preparation,

2. Hire a nurse who understands the Mexican-American culture or who is willing to learn these things.

3. Hire a nurse who respects the migrant as an individual.

A written agreement must be drawn up with any group the Migrant Health Program is coordinating or contracting with. An example of this is: The serving of the Colorado Migrant Council Day-Care Center by the migrant nurse in that area in exchange for the services of the Colorado Migrant Council nurse

During 1971, the State Migrant Health Program funded three nurses for four months, and one nurse coordinator for six months in North Central Colorado. The quality of nursing was greatly enhanced when the nurse had previous public health training or work experience. One Migrant Health Program nurse for the area was able to speak Spanish, the other nurses felt a great need to have an opportunity to learn the language. Family Health Workers helped fill this gap but a short period of total immersion in the language and culture would improve the total care picture.

One nurse was hired for three months by the Colorado Migrant Council in North Central Colorado.

FAMILY HEALTH WORKERS:

The Migrant Health Program funded one family health worker in 1970. This person was used as a resource for one of the migrant health nurses. In addition, the family health worker was assigned to maternity clinics. She was given instruction on how to make out maternity histories. She was expected to have these histories done before the migrant came into the maternity clinic to offer transportation or to be of any assistance she could to the migrant woman in the clinic and to follow-up failed clinic appointments on maternity patients.

Four family health workers were obtained from the M.A.P. Program at the University of Colorado. The overall outcome was very good. There were some failures and some spectacular successes with the family health workers. The family health workers can act as a real go-between for the non-Spanish speaking nurse and the family as an interpreter for both family and nurse. The family health worker acted as out-reach people trying to determine the needs of the migrants as the migrant saw them and go from there. A careful screening of the prospective family health workers as well as a longer more complete training program for family health workers will assure a better percentage of success on the part of the family health worker.

CENTRAL HOUSING:

One of the great problems experienced by all the migrant health nurses last year was an adequate place to work and a place to communicate with each other. No health department has room for all the migrant health nurses. The migrant health nurse must have a place where she can communicate with each family to avoid duplication of services to the family. The medical legal teams who were to act as a resource in legal matters for the migrant health nurse were often difficult to locate as were the Colorado Rural Legal Service people at times.

If all services are available under one roof, the migrant will have only one place to locate help. In this center, hopefully, he could get information on food stamps, legal problems, health problems, supplemental food, and employment or housing. The other direction of communication is between the people who are serving the migrant so that they know and understand what each other has to offer the migrant.

Hospitalization was a major problem again this year. The struggle was not to get the migrant into the hospital but to get him out. Early in May, one of the counties in North Central Colorado had $100,000 in its general assistance fund. It was understood by the Migrant Health Program from one of the officials in the Department of Welfare that medically indigent migrants would have assistance with hospitalization. However, as of July 1, those funds were completely cut off. The experience of hospitalization for a middle class American is rather frightening, but when the migrant patient finds it necessary to seek hospitalization he usually is faced with no money for the $50 down payment that is frequently required to enter the hospital. He frequently can not read all the things he must sign, such as papers saying he is financially responsible for the bill, permission slips giving physicians or other hospital personnel power to do examination, treatment, etc. The migrant does not understand his basic

rights. One young man was stabbed at a dance; he was hospitalized at one of the local hospitals and had a colostomy. His hospital bill was $1,900. Great Western Insurance Company paid $1,000 of the bill. When the young man's mother wanted to get him released from the hospital, she had $100 and was told she must have $200 to get him released. She then borrowed from whomever she could to raise the $200. It was the young man's understanding that he would not be readmitted to the hospital to have the colostomy closed until the additional $700 was paid and until he had something toward the additional surgical procedure.

FOOD STAMPS:

Food stamps in Weld County were quite a problem in that at one point to obtain emergency food stamps one had to make an appointment. The appointment was 8 to 14 days after the initial contact. Because of the restrictiveness in the administration of the program it was very difficult on the migrants, especially if he happened to be diabetic without any resources.

A migrant nurse and the migrant coordinator attended a meeting about the food stamp crisis organized by the director of the Community Action Program. From this meeting a committee of influencial people from the county went to the county commissioners and some adjustments were made.

The migrant nurse coordinator attended an evening meeting with a county commissioner, a physician, county health department personnel, a migrant council representative and other interested people. The problems of two migrant families were presented by the migrant coordinator but these problems were discounted by the commissioner. Fortunately, a family health worker and a migrant nurse arrived at the meeting with one of the families. After careful questioning by the commissioner he instructed the family to come to the welfare department at 8 a.m. the next morning. He said he would authorize emergency food as the woman was diabetic and he would locate employment for the family even if he had to hire them himself. When the family arrived the next day, they were unable to convenience the welfare worker of the commissioner's instructions until 10 a.m. The commissioner was quite disturbed by the worker's actions. The commissioner was unable to locate employment for the family and discovered he needed no more help on his own land. The family found work with the assistance of the family health worker. The migrant health nurses authorized supplemental food for migrants who were eligible for this program. The food obtained under this program helped many migrants but by fall, the food available was very limited.

HOUSING:

The migrant nurse and the family health worker experienced a real dilema this year in migrant housing. When they found a house that did not meet the basic need of clean or safe water and sanitary facilities, they faced a

difficult decision. If this housing was turned in to the sanitarian, the results were usually the explusion of the migrant family from the house. This was difficult to do. Sometimes the family would live in the park. An example was the experience with the Kickapoo Indian family. The housing condition identified by one of the Catholic sisters was very bad. The sanitarians were notified and the housing evaluated and the grower notified of the findings. The three families of Indians who were living outside were told they had until sundown to leave. One of the children of the Indian families was in Colorado General Hospital with a diagnosis of Kwashiocor. When this child was discharged from the hospital, a referral was received requesting the migrant nurse to visit the child at least every other day. Since the nurse had been at the home she was identified by the family as one of those who was responsible for making them move, consequently, the family was quite hesitant to allow the nurse to know where they were living. It took the migrant nurse almost three weeks to establish enough rapport again for the family to allow her to come to their home. In the meantime, they did bring the child into the migrant clinics so that he could be checked.

OTHER RESOURCES:

Foundation for Urban and Neighborhood Development:

Several families were referred to the F.U.N.D. settling-out project in Fort Lupton. The determination of information needed by F.U.N.D. to consider migrants for settling-out was difficult. Since that time a small form has been developed to be used to refer families for settling-out. The number accepted was small. The family had to have housing and the family was studied for several weeks before being accepted by the Program.

INTERN PROGRAM:

As money was used up for the Migrant Health Program, the intern program at Weld County Hospital was used for migrant families who were trying to settle-out. Each intern is assigned one afternoon a week to a physician's office. In this office he carries a case load of families. Eight migrant families were referred for care through the intern program.

HANDICAPPED CHILDREN"S PROGRAM:

A number of migrant children got care under the Handicapped Children's Program at the State Health Department. Children were referred for hearing problems and a number of surgical procedures were done on those children. In October, one of the mothers of one of the children cared for under the Program brought 50 pounds of onions and 50 pounds of carrots to the Weld County Health Department. She said this was to try to begin to thank the nurses for helping her child.

WELFARE:

As it became apparent that other families were trying to settle-out, they were referred to the Department of Employment to try to find jobs and then to the Welfare Department for financial assistance as well as medical assistance. A communication gap exists here also. An example of this is a family in which the mother is diabetic and all members of the family have been certified unable to work. This family was referred to welfare. They received their first welfare check on November 7. They assumed they would receive another check on December 7; however, on further investigation it was learned that they would not get another welfare check until December 20. Consequently, they were out of food, out of money, and in danger of having two children removed from the grant because they were not in school. In a discussion with the welfare worker on this case, it was pointed out to him that the two children who were not attending school were 18 and 19 years of age, unable to work and had the equivalent of fourth grade education. It was recommended to the welfare worker that he had some responsibility in pursueing some sort of retraining for these two children and he was given some resource to investigate for such training.

COLORADO MIGRANT COUNCIL:

The Colorado Migrant Council has some money for man-power training. One girl who had skill as a typist was referred to the Colorado Migrant Council in Denver. Colorado Migrant Council visited with the girl and was able to locate a position for her in Greeley.

OUT-OF-STATE REFERRALS:

Conditions requiring follow-up of the migrants who left the area were sent to the State Health Department in the appropriate state. These were usually Texas but one referral went to Kentucky and one to Utah. To date no response to any referrals has been received. Two letters were received from migrants requesting health information and one request from a private physician in Texas. The referral was made out in triplicate. Two copies were mailed to the appropriate state and one was left for the file.

Several referrals were received from Texas. One was received several weeks after the family had left the area. Other referrals were followed up but frequently the address given as the destination in Colorado did not exist.

The Migrant Public Health Nurse for Adams and portions of Weld and Boulder Counties worked primarily in Brighton, Fort Lupton, Keenesburg, Prospect Valley and Commerce City. During the peak portion of the summer the heaviest work was done in Fort Lupton and Keenesburg whereas during the slack periods she was able to work in more depth around the Brighton, Henderson, and Commerce City areas. Sunday clinics were held in Keenesburg toward the latter portion of the peak season in that area. Brighton held two clinics every week to accommodate the large influx of people during this same period.

CLINICS:

In the early summer the Brighton clinics were very adequately staffed with a supervisory nurse from Tri-County District Health Department, a regular clinic nurse, at least one interpreter, a doctor from one of the Denver medical societies (these physicians donated all their pay to their society), two volunteers from the Migrant Ministry, a volunteer who also worked at the Day-Care Center during the day. By having this number of people to work, the nurse was able to devise a working system for filling out initial records, pre-interviewing, examination, and post-interviewing. In all this delegation of duties, the nurse tried to emphasize the need for making the people feel that they were the most important part of the clinic and that we were interested in them as total persons, now just cases or numbers to be herded through clinic procedures. The nurse urged all workers to just "talk" to the people to obtain the information needed for records. Many times in the initial interviews we would learn that the families were unaware of their ability to obtain food stamps, of being able to get supplemental food. We explained that we would do everything we could to help them obtain the food they needed.

We were fortunate to have a student working in our clinic. The student had worked with people at the Department of Welfare for a number of summers and had won their confidence to such a degree that when he authorized the issuance of food stamps, very few questions were asked. The Migrant Nurse relied on the student heavily because of his knowledge of food stamps and she was confident he would follow through with the families. The Nurse focused on the health aspects and the student dealt primarily in food stamps.

As another facet in treating the clinic patients as "people", the clinic would use an interpreter not only for people who spoke only Spanish but also for those who spoke some English. The Nurse found that many times her understanding of the problems was greatly enhanced when she could have an interpreter verify, more specifically, the symptoms of the patient in Spanish. As much as was possible, the interpreter was used in the examining rooms to help the doctor in his examination as well as being able to re-explain any instructions the doctor had given the patient. In this way the patients felt more confortable in telling the doctor more of their problems and were often given a better explanation of why they were feeling bad.

The post interview was also seen as an essential part of good overall care. In many cases, the Nurse found that the doctor had diagnosed something completely different from what the patient originally described. If the nurse could not see a correlation of symptoms, she would ask the patient to wait and go back to the doctor to see if he had overlooked some of her

nursing notes or to see if he could give any explanation of what the symptoms were due to. The patients in a majority of cases did not feel comfortable im questioning the doctors, even with an interpreter with them. The nurse felt that this way, again, was telling the patient that we did not care about them as "people". This procedure was another good source of educating the patient in certain disease processes.

Aside from the evening clinics, many migrants were told to bring their children into the child clinics during the day and the pregnant mothers were told to come to the maternity clinics in either Brighton or Fort Lupton. During the peak period of the summer, the nurse was seeing 10 to 14 pregnant women. It was very beneficial for her understanding of their progress to attend the maternity clinics in Brighton and help with the pre-interviewing of the maternity patients. In this way she could clear up much of the confusion the regular clinic personnel had regarding the transients seen in clinic.

HOME VISITING:

In the beginning of the summer, home visiting was sporadic due to no clinics and because the nurse was unfamiliar with the areas where migrants resided. The nurse spent a great deal of time case-finding. Some of the case-finding was unnecessary because the nurse did not have the cooperation of the family health workers. She did, however, receive assistance from the Migrant Ministry student and the contact worker from the Tri-County Health Department.

The nurse was dissatisfied with the family health workers assigned to her area because they often created more problems. The family health workers were never easily reached and there was very little communication between them. The family health workers did not use the skills they were trained for such as filling out forms for food stamps, transporting patients to clinics, helping families to understand all the agencies and facilities which would help them, and interpreting for the families.

On a few occasions when the nurse did home visits with the family health workers, she was pleased by the way they talked with the men in the families (gaining insight into the total family dilemma). This enables the nurse to center more on the women and children and their health needs. The nurse found later that the family health workers were not centering their conversation on the overall health of the family. They were often talking only about the poor pay the agricultural workers were receiving and what ways they could fight back at the growers. This is important to families and it was good that the health worker could offer suggestions on how to acquire or demand better conditions, but when these goals begin to dominate the funding meant for the acutely ill people wanting immediate help, we were not utilizing our time and money as was planned. The Family Health Worker was not able to understand the difference the nurse was trying to make. A long-term goal would be to instill more pride and aspirations into the migrant workers but the short-term goal was helping those who needed immediate health care. The latter was of prime importance and the former could be incorporated in suitable ways as we work further with the families.

Family Health Workers are valuable in that they do have insight into the problems of the people and the people trust their judgment more than the caucasions working in the program. However, in order for them to be of help to the nurses, they need close screening instruction and field experience so that they completely understand their role in the program. By having a reliable health worker, the nurse could cut down many of the home visits, work in more depth with teaching, and provide more follow-up care.

The Migrant Nurse for Adams County enjoyed home visiting. By visiting at different times of the day and evening she was able to see a broader perspective of the tremendous amount of frustrations, wants, and hard work these people must live with every day. As one works with the various physicians and agencies for the migrants, he has more success in persuading agencies to give immediate care, if he can speak from knowing how the families live and how their routines of the day are performed. Whenever a family brought a sick child into the office, the nurse would not hesitate to call a doctor if the child was showing symptoms of any severity. She felt that when the family is concerned enough about a child to stop work and transport him many miles to a nurse, the family needs some kind of reassurance that they will receive care without delay. This need of immediate care was conveyed to the various doctors and agencies and there was little conflict.

DAY-CARE CENTER:

Another activity was the work in the Day-Care Center in which the nurse spent at least two to three days a week for one to two hours a day. In this respect she felt a reliable family health worker would have allowed her more time to work in the schools. The nurse was very fortunate in having a very alert Licensed Practical Nurse who was assigned to the nursery in the Fort Lupton school. The regular school program had no school nurse and, therefore, the duties of the migrant nurse overlapped with the older children. The nurse did very minimal work in the regular school because she wanted the school to feel the need for a full-time nurse and provide one for the next summer.

The Day-Care Center became another source for case-finding and also became a communication link with the people. The nurse was able to send notification of clinics in Weld County and the Day-Care Center teachers functioned as family health workers by meeting families and riding home with the children on the bus. A great deal of insight into many of the health problems was obtained from these workers. As an additional link with the families, the nurse sent a letter, written in both English and Spanish, with every child who received a physical. The letter explained when physicials were given, where they were given, the name of the physician who examined the child, and the results of the examination. The letter also included a checklist stating that the child was found to be healthy or that minor re-checks should be followed up by the parents in the near future in the evening clinics. A list of all migrant clinics, including time and location was also included. The nurse was pleased at the number

of parents who brought the letter to clinic and asked for the care specified.

Apart from the physicians, a tuberculosis screening and regular vision and hearing screenings were done. Immunizations (DPT and polio) were given only to the infants and, of those, only the ones that the parents gave explicit information regarding past immunization history. Immunization information was so poorly obtained in the Fort Lupton school that the nurse asked the parents to bring their health cards for the children when they attended the evening clinics so that better records could be made. The nurse was somewhat afraid of over-immunizing children without having the parents consent for the necessary immunizations.

NORTH CENTRAL AREA

DATE SUBMITTED

PART II - MEDICAL, DENTAL, AND HOSPITAL SERVICES

IGRANTS RECEIVING MEDICAL SERVICES

TOTAL MIGRANTS RECEIVING MEDICAL SERVICES AT FAMILY HEALTH CLINICS, PHYSICIANS OFFICES, HOSPITAL EMERGENCY ROOMS, ETC.

AGE	NUMBER OF PATIENTS			NUMBER OF VISITS
	TOTAL	MALE	FEMALE	
TAL	1777	739	1038	3069
DER 1 YEAR	123	71	52	265
4 YEARS	320	161	159	577
14 YEARS	414	166	248	722
44 YEARS	715	244	471	1147
64 YEARS	191	94	97	312
AND OLDER	14	3	11	46

OF TOTAL MIGRANTS RECEIVING MEDICAL SERVICES, HOW MANY WERE:

(1) SERVED IN FAMILY HEALTH SERVICE CLINIC? 943

(2) SERVED IN PHYSICIANS' OFFICE, ON FEE-FOR-SERVICE ARRANGEMENT (INCLUDE REFERRALS) 844

MIGRANT PATIENTS HOSPITALIZED (Regardless of arrangements for payment):

No. of Patients (exclude newborn) 69 Ap.

No. of Hospital Days 374 Ap.

2. MIGRANTS RECEIVING DENTAL SERVICES

ITEM	TOTAL	UNDER 15	15 AND OLDER
a. NO. MIGRANTS EXAMINED-TOTAL			
(1) NO. DECAYED, MISSING, FILLED TEETH			
(2) AVERAGE DMF PER PERSON			
b. INDIVIDUALS REQUIRING SERVICES-TOTAL			
(1) CASES COMPLETED			
(2) CASES PARTIALLY COMPLETED			
(3) CASES NOT STARTED			
c. SERVICES PROVIDED - TOTAL			
(1) PREVENTIVE			
(2) CORRECTIVE-TOTAL			
(a) Extraction			
(b) Other			
d. PATIENT VISITS - TOTAL			

MMUNIZATIONS PROVIDED

TYPE	COMPLETED IMMUNIZATIONS, BY AGE					IN-COMPLETE SERIES	BOOSTERS, REVACCINATIONS
	TOTAL	UNDER 1 YEAR	1 - 4	5 - 14	15 AND OLDER		
TAL-- ALL TYPES	300	70	105	106	19	639	91
MALLPOX	7			3			
IPHTHERIA	53	14	20	16	3	1[illegible]3	25
ERTUSSIS	42	14	20	7	1	139	5
ETANUS	58	14	20	21	3	161	27
OLIO	48	14	20	11	3	176	10
YPHOID	2				2		
EASLES	87	14	20	47	6		
THER (Specify) Rubella	3		1	1	1		

MARKS

Some care given in C & Y & M & I to migrant population-Difficult to sort out. May be immunizations given by independent school nurses which we have not been able to count. Physicians may have given immunization not recorded on referral sheet.

TOTAL ALL CONDITIONS	2915	1684	1231
INFECTIVE AND PARASITIC DISEASES: TOTAL	450	275	174
TUBERCULOSIS — Lupus (1)	9	3	6
SYPHILIS	13	5	9
GONORRHEA AND OTHER VENEREAL DISEASES	17	12	5
INTESTINAL PARASITES	29	16	13
DIARRHEAL DISEASE (infectious or unknown origins):			
Children under 1 year of age	28	15	13
All other	43	39	4
"CHILDHOOD DISEASES" -- mumps, measles, chickenpox	14	7	7
FUNGUS INFECTIONS OF SKIN (Dermatophytoses)			
OTHER INFECTIVE DISEASES (Give examples):	131	91	40
Viral Herpangina 2,1,1 — Gastroenteritis	20	13	7
Poss Thyphoid 16,8,8 — Impetigo	5	2	3
Monilial 3,2,1, — Hepititis	19	11	8
Tric 18, 13, 5 — Staph.	44	20	24
Thrush 4, 2, 2 — Strep.	34	12	22
Poss. Menningitis 1 — Poss. GC-Neg			
NEOPLASMS: TOTAL	4	1	3
MALIGNANT NEOPLASMS (give examples):	4	2	2
Ca in situ	6	1	5
Recurrent Lymphaticca (to Hosp.)	6	3	3
Epithelioma Adenoides Cysticum			
Chest Tumor			
BENIGN NEOPLASMS — Breast Node	7	4	3
NEOPLASMS of uncertain nature	7	1	6
Chronic Lupus Discord.			
ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES: TOTAL	164	55	109
DISEASES OF THYROID GLAND	4	3	1
DIABETES MELLITUS	124	30	94
DISEASES of Other Endocrine Glands	2	1	1
NUTRITIONAL DEFICIENCY	3	2	1
OBESITY	18	11	7
OTHER CONDITIONS — Cystic Fibrosis (refer to CGH)	6	5	1
Kwashiorkor (hosp)	3	2	1
Rickets	4	1	3
DISEASES OF BLOOD AND BLOOD FORMING ORGANS: TOTAL	18	9	9
IRON DEFICIENCY ANEMIA	18	9	9
OTHER CONDITIONS			
MENTAL DISORDERS: TOTAL	47	25	22
PSYCHOSES	42	20	22
NEUROSES and Personality Disorders — Anxiety-Depression			
ALCOHOLISM	2	2	
MENTAL RETARDATION	2	2	
OTHER CONDITIONS — Insomnia	1	1	
Hyperventalation			
DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS: TOTAL	497	322	175
PERIPHERAL NEURITIS	19	12	7
EPILEPSY	87	42	45
CONJUNCTIVITIS and other Eye Infections	144	142	22
REFRACTIVE ERRORS of Vision	196	88	108
OTITIS MEDIA	33	22	11
OTHER CONDITIONS — Hearing Loss	13	11	2
Ptyergium			
Stye 1, 1 — Cataractus	4	4	

PART II – 5. (Continued)

ICD CLASS	MH CODE	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
II.	07-	DISEASES OF THE CIRCULATORY SYSTEM: TOTAL	141	59	82
	070	RHEUMATIC FEVER			
	071	ARTERIOSCLEROTIC and Degenerative Heart Disease			
	072	CEREBROVASCULAR DISEASE (Stroke)			
	073	OTHER DISEASES of the Heart	43	10	33
	074	HYPERTENSION	60	28	32
	075	VARICOSE VEINS (1 Hemorroidectomy-Hosp)	25	9	16
	079	OTHER CONDITIONS	7	6	1
		Heart Murmur	4	4	
		Cong. Heart	2	2	
III.	08-	DISEASES OF THE RESPIRATORY SYSTEM: TOTAL	576	366	210
	080	ACUTE NASOPHARYNGITIS (Common Cold)	174	123	51
	081	ACUTE PHARYNGITIS	92	61	31
	082	TONSILLITIS	129	93	36
	083	BRONCHITIS	78	36	42
	084	TRACHEITIS/LARYNGITIS	1	1	
	085	INFLUENZA	3	3	
	086	PNEUMONIA 3 Hosp.	35	21	14
	087	ASTHMA, HAY FEVER	26	11	15
	088	CHRONIC LUNG DISEASE (Emphysema)			
	089	OTHER CONDITIONS	9	4	5
		Chemical & Allergic Bronchitis	29	13	16
IX.	09-	DISEASES OF THE DIGESTIVE SYSTEM: TOTAL	152	87	65
	090	CARIES and Other Dental Problems	25	23	2
	091	PEPTIC ULCER	33	13	20
	092	APPENDICITIS (1 Abcess with Ileostomy, Cecostomy)	15	5	10
	093	HERNIA	3	2	1
	094	CHOLECYSTIC DISEASE	41	19	22
	099	OTHER CONDITIONS Gastritis, rectal irritation	34	24	10
		Rectocle	1	1	
X.	10-	DISEASES OF THE GENITOURINARY SYSTEM: TOTAL	185	96	89
	100	URINARY TRACT INFECTION (Pyelonephritis, Cystitis)	105	43	62
	101	DISEASES OF PROSTATE GLAND (excluding Carcinoma)	2	2	
	102	OTHER DISEASES of Male Genital Organs	9	7	2
	103	DISORDERS of Menstruation	43	27	16
	104	MENOPAUSAL SYMPTOMS			
	105	OTHER DISEASES of Female Genital Organs	25	[illegible]	9
	109	OTHER CONDITIONS Cystocele	1	1	
XI.	11-	COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM: TOTAL	26	11	15
	110	INFECTIONS of Genitourinary Tract during Pregnancy			
	111	TOXEMIAS of Pregnancy	10	4	6
	112	SPONTANEOUS ABORTION	10	2	8
	113	REFERRED FOR DELIVERY	3+	3+	
	114	COMPLICATIONS of the Puerperium	2	1	1
	119	OTHER CONDITIONS Severe Dehydration	1	1	
XII.	12-	DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE: TOTAL	193	108	85
	120	SOFT TISSUE ABSCESS OR CELLULITIS	59	30	29
	121	IMPETIGO OR OTHER PYODERMA	34	26	8
	122	SEBORRHEIC DERMATITIS	11	5	6
	123	ECZEMA, CONTACT DERMATITIS, OR NEURODERMATITIS	55	27	28
	124	ACNE	4	3	1
	129	OTHER CONDITIONS	19	10	9
		insect bite	9	6	3
		Erythema Nodosum	2	1	1

PART II - 5. (Continued)

GRANT NUMBER

ICD CLASS	ICD CODE	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
XIII.	13-	DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE: TOTAL	60	30	30
	130	RHEUMATOID ARTHRITIS	9	3	6
	131	OSTEOARTHRITIS	12	7	5
	132	ARTHRITIS, Unspecified	23	12	11
	139	OTHER CONDITIONS Bursitis, Fibrositis	16	8	8
XIV.	14-	CONGENITAL ANOMALIES: TOTAL	30	24	6
	140	CONGENITAL ANOMALIES of Circulatory System	10	9	1
	149	OTHER CONDITIONS Bilat. Tibial Torsion	20	15	5
XV.	15-	CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY: TOTAL	1	1	
	150	BIRTH INJURY Celebral Palsy	1	1	
	151	IMMATURITY			
	159	OTHER CONDITIONS			
XVI.	16-	SYMPTOMS AND ILL-DEFINED CONDITIONS: TOTAL	108	71	37
	160	SYMPTOMS OF SENILITY			
	161	BACKACHE	29	17	12
	162	OTHER SYMPTOMS REFERRABLE TO LIMBS AND JOINTS	17	14	3
	163	HEADACHE	21	12	9
	169	OTHER CONDITIONS	39	27	12
		mass in abdomin	2	1	1
XVII.	17-	ACCIDENTS, POISONINGS, AND VIOLENCE: TOTAL	235	135	100
	170	LACERATIONS, ABRASIONS, and Other Soft Tissue Injuries	68	52	16
	171	BURNS	8	5	3
	172	FRACTURES	60	21	39
	173	SPRAINS, STRAINS, DISLOCATIONS	71	36	35
	174	POISON INGESTION			
	179	OTHER CONDITIONS due to Accidents, Poisoning, or Violence 1 Death	28	21	7

			NUMBER OF INDIVIDUALS
6	2--	SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS: TOTAL	5952
	200	FAMILY PLANNING SERVICES	126
	201	WELL CHILD CARE	28
	202	PRENATAL CARE	126
	203	POSTPARTUM CARE	25
	204	TUBERCULOSIS: Follow-up of inactive case	6
	205	MEDICAL AND SURGICAL AFTERCARE	6
	206	GENERAL PHYSICAL EXAMINATION	1100
	207	PAPANICOLAOU SMEARS	42
	208	TUBERCULIN TESTING	452
	209	SEROLOGY SCREENING	
	210	VISION SCREENING	2015
	211	AUDITORY SCREENING	2000
	212	SCREENING CHEST X-RAYS	10
	213	GENERAL HEALTH COUNSELLING	N/A
		OTHER SERVICES:	
		(Specify) Speech Difficulty	3
		Tubal Ligation	1
		Colic	2
		Masturbation	1
		Post. Op.	6
		Post. Op. brain Tumor (Texas)	3

TYPE OF SERVICE	NUMBER
NURSING CLINICS:	
a. NUMBER OF CLINICS	3
b. NUMBER OF INDIVIDUALS SERVED - TOTAL	45
FIELD NURSING:	
a. VISITS TO HOUSEHOLDS	743
b. TOTAL HOUSEHOLDS SERVED	253
c. TOTAL INDIVIDUALS SERVED IN HOUSEHOLDS	1091
d. VISITS TO SCHOOLS, DAY CARE CENTERS	236
e. TOTAL INDIVIDUALS SERVED IN SCHOOLS AND DAY CARE CENTERS	3581
CONTINUITY OF CARE:	
a. REFERRALS MADE FOR MEDICAL CARE: TOTAL	1989
(1) Within Area	1002
(Total Completed)	942
(2) Out of Area out of state	40
(Total Completed response)	15
b. REFERRALS MADE FOR DENTAL CARE: TOTAL	
(Total Completed)	
c. REFERRALS RECEIVED FOR MEDICAL OR DENTAL CARE FROM OUT OF AREA: TOTAL	
(Total Completed)	
d. FOLLOW-UP SERVICES FOR MIGRANTS, not originally referred by project, WHO WERE TREATED IN PHYSICIANS OFFICES (Fee-for-Service) Approx.	50
e. MIGRANTS PROVIDED PRE-DISCHARGE PLANNING AND POST-HOSPITAL SERVICES Approx.	60
f. MIGRANTS ASKED TO PRESENT HEALTH RECORD (Form PMS-3652 or Similar Form) IN FIELD OR CLINIC: TOTAL 1300	
(1) Number presenting health record. 75	
(2) Number given health record all served	

OTHER ACTIVITIES (Specify):

Nurses and Family Health Workers were involved with Welfare, CRLS, etc. There is no area on form to really describe total activities nurses involved in or patients served in settings other than field home or school visits. Nurses were located in location migrants come to for help as F.W.U. These could be considered nursing clinics but were not counted as such. Household visits by F.H.W. were not counted.

REMARKS

Clinic activities may be greater Re 6. 200's-difficult to tell wshich patients are migrant and which are not in regular clinic. Nursing visits are low in count due to computor and print out foul up.

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SAN LUIS VALLEY AREA NARRATIVE REPORT

INTRODUCTION:

The migrant season in the San Luis Valley began on May 1 with one week in Denver with the State Health Department and the Tri-County Health Department at Brighton for orientation.

However unprepared the Migrant Nurse felt in the beginning, she states that she was undaunted and stimulated to use the orientation experience for service to the migrant and as a learning experience for herself.

By the end of October, the nurse states that she had gained considerable emperical knowledge from day by day experiences with the migrants and others, who, despite conflicts, are trying to reconcile the differences between the migrant worker and the community where he works.

Some questions that remained after her experience are:

1. What services does the migrant need that are distinct from the needs of other poor in the local settled population?

2. What health services need to be made available and what is the better way of giving the service?

3. What health services will the migrant utilize if they are not within easy reach?

4. How can health services and habits, important to the majority of the "Anglo" population, be made important to the migrant? Or, is it necessary to insist that the migrant aspire to what the middle class Anglo thinks is important?

DESCRIPTION OF THE SEASON:

There were already migrants in the San Luis Valley when the Migrant Nurse arrived on May 11 and there were still a few migrants left in the area when the season was over October 31.

The actual number of migrants in the San Luis Valley was never known since growers were reluctant to give numbers and also because migrants were widely scattered. From unofficial but knowledgeable sources it was deducted that the numbers of migrants this season might be fewer because:

1. There was less recruitment because less housing was available.

2. There were more local residents working.

3. There was more mechanization in farming this season.

4. The lettuce strike movement may have deterred some.

The majority of the migrants encountered were Spanish-Americans from New Mexico, Arizona, Texas. There was a good sampling of illegal aliens, a few Negroes, Filipinos, and many Navajo Indians. There were crews of professional lettuce cutters from California. There were, also, interstate and "settled-out" migrants who needed health services.

The migrants lived in widely scattered areas on farms, in the poor sections of the towns, in second-rate hotels and motels, and there were some camps especially for single men. The migrant was extermely mobile and the turnover seemed high and fast. The housing in general was poor and less of it provided by the grower than in previous years.

The widely scattered homes and the mobility of the migrant population made case-finding difficult. The nurse depended on referrals from the migrants themselves for the most part. Other sources of contacts came from the head start and day-care centers, from growers, and from the Colorado Migrant Council. The State Health Department Sanitarians for the San Luis Valley were of tremendous assistance in locating the migrants.

WHAT WAS DONE:

The goals of the program and the duties of the migrant health nurse were reviewed and an attempt was made to work through these guidelines. The nurse followed through on all referrals, made evaluations, and planned needed care and made referrals for health and related services.

From the second week of June through August the work was shared by the Colorado Migrant Council nurses. The nurses divided the work by geographic areas rather than by job in the hope of giving better health supervision and for better utilization of time and mileage. The nurses did case-finding, made home visits, evaluated health programs and planned for care.

The few weeks of the "operation potato" program were hectic. There was much delay, confusion, and lack of organization in the operation of the program which in turn made the health care difficult. However, despite difficulties the nurses were able to do basic screening on many of the children and to bring many of the immunizations up to date. The nurses were able to handle the day-by-day health problems of the children and follow-up visits to the home. Few records were kept because time did not permit.

Local physicians, through their offices and the emergency rooms, provided most of the medical care for migrants. This system was in accordance with their idea of how the needs should be met. Health needs were screened by the nurse and referrals were made when necessary. No particular need was perceived for evening and Sunday clinics in the early part of the season.

At the request of local groups, a schedule of clinics was set up for the potato harvest. An evening clinic on Thursdays was to be held in Monte Vista at Doctor Orr's office with Doctor Orr available from 7 to 9 p.m. One evening clinic on Tuesday and an all-day clinic on Sunday were to be held each week on a rotating basis at the day-care centers. Each clinic was staffed by doctors from Sangre de Cristo Clinic and from Denver. Fifteen clinics were planned in all from September 27 through October 29. Since six clinics were held and only 59 patients were seen and the rotation was not done since the day-care centers did not open according to plans, the Catholic Church facilities in Del Norte were used instead.

Throughout the season both the nurses of the Colorado Migrant Council and the State Migrant Health Program felt quite competent in handling the health problems encountered and they found the physicians quite willing to take referrals and give advice. The most frequently encountered conditions were diarrhea, gastric upsets, upper respiratory infections, and impetigo. There was some prenatal care given but only two patients delivered (one by caesarean section.)

The nurses found it necessary to hospitalize some patients. There was no problem getting the patients in but there was some discussion on how the incurred bills were going to be paid. Several patients were referred to the U.S. Public Health Service for hospitalization on the reservations.

Throughout the season home visits were made as soon as the nurse became aware of needs or that a family had moved into the area. On the initial and subsequent visits attempts were made to evaluate and meet the health needs seen by the nurse or expressed by the migrant. The nurses were well accepted by the migrants. The plans did work out of [illegible] but there was little long-term planning possible, nor could any teaching but informal health teaching be done. This gave the nurse the feeling of doing "band-aid" type work. However, the immediate needs were met as well as some informal health teaching. Brief comments can be made on the following:

1. Work in the schools was very limited. Few migrant children were enrolled and their needs were met by the local school nurse. We did offer our services, however.

2. Dental work was limited to a rapid screening of the children at head start and then follow-up work on a small minority. Emergency work was referred to the local dentists with no more problem than getting patients to the offices.

3. Eye care: There were many requests for eye glasses. The children were referred who had obvious problems to an optometrist in Alamosa. Visual screening was done at the Head Start centers with about 50 percent success.

4. Adult education: One planned health program was given in Center through the cooperation of the WIN Program.

RECORDS:

Records and reports on the migrant families assisted and of the clinics and immunization services rendered were kept whenever possible. Those records kept do not reflect the true picture of the care given the migrants; nor do the dailies turned in each week to the State office. The records that were kept may be found in the file in the office at the Alamosa Health Office.

Those cases not closed by October 29 were turned over to the local public health nurses for further care if necessary.

EVALUATION OF SERVICES:

Medical Services:

- Care by private physicians: No patient was refused care when referred by the nurse or when the patient sought care on his own initiative. Some physicians seemed more approachable and available therefore we had no system of rotation but used those we knew would help. In general the local physicians were willing to give care when really necessary. The physicians expected the nurses to screen cases well. They did not want evening or Sunday clinics.

- Out-patient facilities: With 24-hour coverage at all the four hospitals through the emergency rooms, it was no problem to get assistance for patients referred. Some patients stated they got some "static" when they went in without referrals. The hospitals felt that some patients came in with minor ailments that could have been seen at another time.

- In established clinic: Sangre de Cristo Clinic provided good care and had the most time and services to offer.

- In the hospitals: Despite the criticisms of the program by hospital authorities and some of the personnel, the nurses were well received and as it became necessary for admission of a patient, they were not refused. Laboratory and x-ray work on out-patients was no problem. The Alamosa and Monte Vista hospitals were most helpful.

SPECIAL PROBLEMS:

1. The term "migrant" was not defined by all groups in the same way which created confusion when it was necessary to determine eligibility for Colorado Department of Public Health services.

2. The very word "migrant" was anathema to many people. Some of the reasons given were: "Migrants being babied, migrants are not the only ones needing help." Also, the growing Chicano movement and the lettuce strike had antagonized many,

3. There was a language problem with the Navajo Indians and an interpreter was difficult to find when needed.

RECOMMENDATIONS:

1. Pre-planning could and should establish communications, plans and enlistment of concrete help from hospital administrators, hospital business managers, pharmacists, churches, and all organizations. No one should be ignorant of the Migrant Health Program, whom it serves, and how the services are provided.

2. Knowledge of services available through the Migrant Health Program should be written in clear, precise, concise, English and Spanish and the information spread through posters, letters, flyers, radio media, talks in churches and clubs.

3. A list of growers should be obtained, if possible, for the nurse to include names of crew leaders, expected number of migrants to be used, approximate date of arrival, and where they will be housed.

4. A large map of the San Luis Valley should be available with farms and known housing areas marked.

5. The migrant health nurse should have business cards with her name, office address, and telephone numbers to be given to everyone.

6. The migrant health nurse could use a car-radio telephone if she is to cover the entire San Luis Valley and continue to be in touch with other persons and agencies.

7. Stenographic assistance is needed for record keeping and assistance with compiling and writing reports is essential.

Table I

Summary - - Estimated Employment and Origin of Seasonal Hired Agricultural Workers, Monthly, 1969 and 1970

Area San Luis Valley

Period Ending Date	Total Seasonal I		Total Domestic II		DOMESTIC Local III		DOMESTIC Intrastate IV		DOMESTIC Interstate V	
	1970	1969	1970	1969	1970	1969	1970	1969	1970	1969
5-15-70	415	387	415	387	295	280	43	42	77	65
6-15-70	615	670	645	670	310	300	60	70	275	300
7-15-70	1,221	1,187	1,221	1,187	525	450	110	110	586	627
8-15-70	1,200	1,330	1,200	1,330	380	452	210	203	610	675
9-15-70		756		756		335		110		311
10-15-70		950		950		250		100		600

PART II - MEDICAL, DENTAL, AND HOSPITAL SERVICES

DATE SUBMITTED

1. MIGRANTS RECEIVING MEDICAL SERVICES

a. TOTAL MIGRANTS RECEIVING MEDICAL SERVICES AT FAMILY HEALTH CLINICS, PHYSICIANS OFFICES, HOSPITAL EMERGENCY ROOMS, ETC.

AGE	NUMBER OF PATIENTS			NUMBER OF VISITS
	TOTAL	MALE	FEMALE	
TOTAL	237	109	128	419
UNDER 1 YEAR	18	13	5	27
1 - 4 YEARS	64	30	34	96
5 - 14 YEARS	54	31	23	89
15 - 44 YEARS	90	30	60	153
45 - 64 YEARS	11	5	6	54
65 AND OLDER				

b. OF TOTAL MIGRANTS RECEIVING MEDICAL SERVICES, HOW MANY WERE:

(1) SERVED IN FAMILY HEALTH SERVICE CLINIC? 124

(2) SERVED IN PHYSICIANS' OFFICE, ON FEE-FOR-SERVICE ARRANGEMENT (INCLUDE REFERRALS) 113

3. MIGRANT PATIENTS HOSPITALIZED

(Regardless of arrangements for payment):

No. of Patients *(exclude newborn)* 12

No. of Hospital Days 38+

2. MIGRANTS RECEIVING DENTAL SERVICES

ITEM	TOTAL	UNDER 15	15 AND OLDER
a. NO. MIGRANTS EXAMINED-TOTAL			
(1) NO. DECAYED, MISSING, FILLED TEETH			
(2) AVERAGE DMF PER PERSON			
b. INDIVIDUALS REQUIRING SERVICES - TOTAL			
(1) CASES COMPLETED			
(2) CASES PARTIALLY COMPLETED			
(3) CASES NOT STARTED			
c. SERVICES PROVIDED - TOTAL			
(1) PREVENTIVE			
(2) CORRECTIVE-TOTAL			
(a) Extraction			
(b) Other			
d. PATIENT VISITS - TOTAL			

4. IMMUNIZATIONS PROVIDED

TYPE	COMPLETED IMMUNIZATIONS, BY AGE					IN-COMPLETE SERIES	BOOSTERS, REVACCINATIONS
	TOTAL	UNDER 1 YEAR	1 - 4	5 - 14	15 AND OLDER		
TOTAL-- ALL TYPES	497	12	482	3		127	66
SMALLPOX							
DIPHTHERIA	118	4	113	1		45	33
PERTUSSIS	118	4	113	1		30	
TETANUS	118	4	113	1		45	33
POLIO	113		113			7	
TYPHOID							
MEASLES							
OTHER *(Specify)* Rubella	30		30				

REMARKS

CLINICS, HOSPITAL OUTPATIENT DEPARTMENTS, AND PHYSICIANS' OFFICES.

ICD CLASS	MH CODE	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
VII.		TOTAL ALL CONDITIONS	383	235	148
	01-	INFECTIVE AND PARASITIC DISEASES: TOTAL	52	42	10
	010	TUBERCULOSIS possible lymphatic	3	1	2
	011	SYPHILIS			
	012	GONORRHEA AND OTHER VENEREAL DISEASES III	6	6	
	013	INTESTINAL PARASITES			
		DIARRHEAL DISEASE (infectious or unknown origins):			
	014	Children under 1 year of age III	11	6	5
	015	All other III	5	5	
	016	"CHILDHOOD DISEASES" – mumps, measles, chickenpox			
	017	FUNGUS INFECTIONS OF SKIN (Dermatophytoses) I	2	1	1
	019	OTHER INFECTIVE DISEASES (Give examples):			
		Staph. Infec.	1	1	
		Thrush	2	1	1
		Strap Throat	10	9	1
		Hepatitis	12	12	
	02-	NEOPLASMS: TOTAL			
	020	MALIGNANT NEOPLASMS (give examples):			
	025	BENIGN NEOPLASMS			
	029	NEOPLASMS of uncertain nature			
	03-	ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES: TOTAL	17	5	12
	030	DISEASES OF THYROID GLAND			
	031	DIABETES MELLITUS	15	4	11
	032	DISEASES of Other Endocrine Glands			
	033	NUTRITIONAL DEFICIENCY			
	034	OBESITY	2	1	1
	039	OTHER CONDITIONS			
IV.	04-	DISEASES OF BLOOD AND BLOOD FORMING ORGANS: TOTAL	8	5	3
	040	IRON DEFICIENCY ANEMIA IIII	8	5	3
	049	OTHER CONDITIONS			
V.	05-	MENTAL DISORDERS: TOTAL	3	3	
	050	PSYCHOSES			
	051	NEUROSES and Personality Disorders	1	1	
	052	ALCOHOLISM			
	053	MENTAL RETARDATION			
	059	OTHER CONDITIONS Anxiety	2	2	
VI.	06-	DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS: TOTAL	39	23	16
	060	PERIPHERAL NEURITIS			
	061	EPILEPSY			
	062	CONJUNCTIVITIS and other Eye Infections	7	5	2
	063	REFRACTIVE ERRORS of Vision II	7	5	2
	064	OTITIS MEDIA IIIIII	10	8	2
	069	OTHER CONDITIONS III	15	5	10

ICD CLASS	MII CODE	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
VII.	07-	DISEASES OF THE CIRCULATORY SYSTEM: TOTAL	12	8	4
	070	RHEUMATIC FEVER	2	2	
	071	ARTERIOSCLEROTIC and Degenerative Heart Disease	2	2	
	072	CEREBROVASCULAR DISEASE (Stroke)	1	1	
	073	OTHER DISEASES of the Heart	5	2	3
	074	HYPERTENSION			
	075	VARICOSE VEINS			
	079	OTHER CONDITIONS	2	1	1
VIII.	08-	DISEASES OF THE RESPIRATORY SYSTEM: TOTAL	85	55	30
	080	ACUTE NASOPHARYNGITIS (Common Cold)	16	11	5
	081	ACUTE PHARYNGITIS	33	27	6
	082	TONSILLITIS	2	2	
	083	BRONCHITIS	7	4	3
	084	TRACHEITIS/LARYNGITIS			
	085	INFLUENZA	2	1	1
	086	PNEUMONIA	9	3	6
	087	ASTHMA, HAY FEVER	12	4	8
	088	CHRONIC LUNG DISEASE (Emphysema)			
	089	OTHER CONDITIONS Adenopathy	4	3	1
IX.	09-	DISEASES OF THE DIGESTIVE SYSTEM: TOTAL	23	15	8
	090	CARIES and Other Dental Problems	8	6	2
	091	PEPTIC ULCER	4	2	2
	092	APPENDICITIS	1	1	
	093	HERNIA	1	1	
	094	CHOLECYSTIC DISEASE	4	1	3
	099	OTHER CONDITIONS	5	4	1
X.	10-	DISEASES OF THE GENITOURINARY SYSTEM: TOTAL	30	16	14
	100	URINARY TRACT INFECTION (Pyelonephritis, Cystitis)	7	5	2
	101	DISEASES OF PROSTATE GLAND (excluding Carcinoma)	3	2	1
	102	OTHER DISEASES of Male Genital Organs			
	103	DISORDERS of Menstruation	10	4	6
	104	MENOPAUSAL SYMPTOMS	4	1	3
	105	OTHER DISEASES of Female Genital Organs	5	3	2
	109	OTHER CONDITIONS Acute uremia	1	1	
XI.	11-	COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM: TOTAL	10	5	5
	110	INFECTIONS of Genitourinary Tract during Pregnancy			
	111	TOXEMIAS of Pregnancy	1	1	
	112	SPONTANEOUS ABORTION	3	2	1
	113	REFERRED FOR DELIVERY	2	1	1
	114	COMPLICATIONS of the Puerperium			
	119	OTHER CONDITIONS	4	1	3
XII.	12-	DISE[illegible] SE[illegible] HE[illegible] [illegible]ND SUBCUTANEOUS TISSUE: TOTAL	22	15	7
	120	SO[illegible] E ABSCESS OR CELLULITIS	1	1	
	121	IMPETIGO OR OTHER PYODERMA	3	2	1
	122	SEBORRHEIC DERMATITIS			
	123	ECZEMA, CONTACT DERMATITIS, OR NEURODERMATITIS	6	4	2
	124	ACNE			
	129	OTHER CONDITIONS	4	4	

PART II - S. (Continued)

ICD CLASS	MEH CODE	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISIT
XIII.	13-	DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE: TOTAL	8	6	2
	130	RHEUMATOID ARTHRITIS			
	131	OSTEOARTHRITIS	2	2	
	132	ARTHRITIS, Unspecified			
	139	OTHER CONDITIONS	6	4	2
XIV.	14-	CONGENITAL ANOMALIES: TOTAL			
	140	CONGENITAL ANOMALIES of Circulatory System			
	149	OTHER CONDITIONS			
XV.	15-	CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY: TOTAL			
	150	BIRTH INJURY			
	151	IMMATURITY			
	159	OTHER CONDITIONS			
XVI.	16-	SYMPTOMS AND ILL-DEFINED CONDITIONS: TOTAL	[illegible]	15	15
	160	SYMPTOMS OF SENILITY			
	161	BACKACHE	11	5	6
	162	OTHER SYMPTOMS REFERRABLE TO LIMBS AND JOINTS			
	163	HEADACHE	5	5	
	169	OTHER CONDITIONS	14	5	9
XVII.	17-	ACCIDENTS, POISONINGS, AND VIOLENCE: TOTAL	45	24	21
	170	LACERATIONS, ABRASIONS, and Other Soft Tissue Injuries	8	4	4
	171	BURNS	10	5	5
	172	FRACTURES	12	6	6
	173	SPRAINS, STRAINS, DISLOCATIONS	6	3	3
	174	POISON INGESTION			
	179	OTHER CONDITIONS due to Accidents, Poisoning, or Violence	6	6	3

			NUMBER OF INDIVIDUALS
6.	2--	SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS: TOTAL	529
	200	FAMILY PLANNING SERVICES	4
	201	WELL CHILD CARE	47
	202	PRENATAL CARE	7
	203	POSTPARTUM CARE	33
	204	TUBERCULOSIS: Follow-up of inactive case	
	205	MEDICAL AND SURGICAL AFTERCARE	1
	206	GENERAL PHYSICAL EXAMINATION	167
	207	PAPANICOLAOU SMEARS	2
	208	TUBERCULIN TESTING	207
	209	SEROLOGY SCREENING	7
	210	VISION SCREENING	47
	211	AUDITORY SCREENING	47
	212	SCREENING CHEST X-RAYS	
	213	GENERAL HEALTH COUNSELLING	
	219	OTHER SERVICES: (Specify)	

PART III - NURSING SERVICES

TYPE OF SERVICE	NUMBER
1. NURSING CLINICS:	
a. NUMBER OF CLINICS	
b. NUMBER OF INDIVIDUALS SERVED - TOTAL	
2. FIELD NURSING:	
a. VISITS TO HOUSEHOLDS	
b. TOTAL HOUSEHOLDS SERVED	
c. TOTAL INDIVIDUALS SERVED IN HOUSEHOLDS	
d. VISITS TO SCHOOLS, DAY CARE CENTERS	
e. TOTAL INDIVIDUALS SERVED IN SCHOOLS AND DAY CARE CENTERS	
3. CONTINUITY OF CARE:	
a. REFERRALS MADE FOR MEDICAL CARE: TOTAL	
(1) Within Area	
(Total Completed)	
(2) Out of Area 15	
(Total Completed)	
b. REFERRALS MADE FOR DENTAL CARE: TOTAL	
(Total Completed)	
c. REFERRALS RECEIVED FOR MEDICAL OR DENTAL CARE FROM OUT OF AREA: TOTAL 2	
(Total Completed 1 1 (one not found))	
d. FOLLOW-UP SERVICES FOR MIGRANTS, not originally referred by project, WHO WERE TREATED IN PHYSICIANS' OFFICES (Fee-for-Service) 24	
e. MIGRANTS PROVIDED PRE-DISCHARGE PLANNING AND POST-HOSPITAL SERVICES 3	
f. MIGRANTS ASKED TO PRESENT HEALTH RECORD (Form PMS-3652 or Similar Form) IN FIELD OR CLINIC: TOTAL all	
(1) Number presenting health record. 10%	
(2) Number given health record 90%	
4. OTHER ACTIVITIES *(Specify)*:	
Head Start Day Care Win lectures (sermonal workers) Commullation to Dicko y Hicko Provide social services (clothes, food, social activities)	

REMARKS

WESTERN SLOPE AREA NARRATIVE REPORT

The following is the report by the Migrant Public Health Nurse for the Western Colorado area migrant program.

GENERAL DESCRIPTION:

Specific Objectives:

1. To meet the health needs of the migrant farm workers and their families to the highest possible degree.

2. To provide nursing services to the migrant workers. For example, preventive medicine such as screening, immunizations; health education; referring for professional medical and dental care; early case-finding; follow-up care; counselling and guidance.

The Staff Involved:

1. Professional

   - Two nurses work together. One employed by the Colorado Department of Health for a total of five months; one employed by the Colorado Migrant Council for three months.

2. Other:

   - Local county public health nurses in Delta. These nurses covered the area while the migrant nurses worked in other areas.

   - The secretary at the County Nurses' office in Delta was most helpful in taking telephone messages and advising migrants as to where to go for assistance when no one else was available.

   - The VISTA worker in Delta recruited people to provide transportation for the migrants.

Working Relationships:

1. Colorado Migrant Council:

   - There was continuous planning, cooperation, and coordination between the State Migrant Health Program nurse and the Colorado Migrant Council. The Migrant Council had contact workers who referred the migrants to the nurse for medical care. The day-care and head start centers were of primary importance in terms of the nurses and the Migrant Council working together.

2. Migrant Ministry:

- In the Delta area there was not much planning or working with the Migrant Ministry. The Migrant Ministry primarily served as a means of transportation. In Mesa County during the peach harvest there was a great deal of planning and working together between the nurse and the Migrant Ministry. A relocation center in Palisade was operated by the Migrant Ministry for the migrants. They allowed the nurse to use one of the rooms in the center for a clinic. The clinics were successful with over 200 migrants seen

3. Volunteers In Service to America

- The only VISTAS* who worked with the migrants were the two in Delta. They were very helpful in providing transportation for the children to doctor's offices. The volunteers cleaned up a room in the Holly Sugar Camp office for the purpose of nursing clinics. One volunteer was particularly helpful in relaying information about certain families that he knew previously.

4. Welfare:

- The Department of Welfare in both Mesa and Delta County were most cooperative. They provided food stamps for the migrants as quickly as possible. They also attempted to help meet some of the expenses for hospitalization. The Department of Welfare also made two applications for the Aid to Needy Disabled.

5. Local Health Department:

- There was very little cooperation or even a good working relationship with Mesa County Health Department. Certain staff members were hostile and not too willing to help out in any way. On the other hand, the county nurses in Delta were most helpful. They went out of their way to help the Migrant Health Program. The County Nurse in Montrose was also helpful in covering the area when either of the migrant nurses was not available.

6. Migrant Education:

- The program in Delta was excellent. Daily visits were made to the school. The teachers were cooperative in helping the nurse meet the health needs of the children. In Mesa County there was not as much cooperation and coordination with the school. This was primarily due to a lack of understanding of the roles of the nurse and a lack of communication between the nurse and the school.

7. Physicians and Dentists:

- The doctors in Delta should be commended for their fine work and effort in caring for the migrants. Patients were never turned down even though they were seeing over 100 patients per day in their office. The doctors in Montrose did not have too much contact with

the migrants except the physical examinations they gave the children. There was some problem with a physician in Palisade who did turn some migrants away and who did not like public health nurses. An Osteopath in Palisade took on most of the work and he was cooperative and interested in the migrants.

- The dental program in all areas was very good. The dental work was preplanned and most successful.

8. Hospitals:

- All hospitals in all areas did not refuse a migrant for hospitalization or emergency treatment.

SERVICES PROVIDED TO MIGRANTS:

General Description:

- There were no family health clinics.

- There were nursing clinics established in order to alleviate some of the home visits and to reach more of the migrant population. Nursing clinics were attempted at the camp in Delta but were unsuccessful because of the language problem between the nurse and the Navajos. The clinics were successful in Palisade at the Recreation Center.

- The Holly Sugar Camp in Delta was visited three times per week. Visits were made to the field whenever a home visit could not be made in the evening.

- Day-care and head start centers were visited every day. The main role of the nurse was to provide general supervision, health education, and refer the children for medical or dental care.

Health Education:

- Very little was done in this area due to the lack of time and the small staff. There were other duties of higher priority. There was an attempt to provide health education in the day-care centers and in the homes when follow-up care was warranted.

Referrals:

- Local referrals were successful in this area. There was a continual process of communication between the nurses and the local physicians.

referrals were made to the Bureau of Indian Affairs on the Navajo Reservation. The main reason for its failure was the lack of needed information about the patient to give to the Public Health Service. For example, there was not enough information about addresses on the reservation, census numbers, full name and names used both on and off the reservation, address to send the referral. About 50 percent of the out-of-state referrals were incomplete because the patient could not be located in his home-base area.

Other Resource Information:

- The consultation received outside the project was limited. The two migrant nurses made a trip to the Navajo Reservation which was most helpful, however, it was after the Navajos had left the area. This visit should have been done before the project began. Doctor Vanderwagon of the Indian Health Service provided a great deal of information about the delivery of health care on the reservation. Shiprock Hospital, Shiprock Public Health Service, and Chinle Clinic were visited. Helpful information was given on how to make the referrals more effective, information about the Navajo culture, and the services available to the Navajo on the reservation.

Statistical Information:

- 58 percent of the migrants receiving medical care were male.
  42 percent of the migrants receiving medical care were female.
  9 percent of the total receiving care were under one year of age.
  13 percent of the total receiving care were age one through four years.
  18 percent of the total receiving care were age five through 14 years.
  49 percent of the total receiving care were age 15 through 44 years.
  10 percent of the total receiving care were age 45 through 64 years.
  1.5 percent of the total receiving care were 65 years old and older.

- These figures are significant for this area. It was obvious that there were few families and children this season. There were a large number of males without families engaged in migrant agricultural work. This was particularly true in the Palisade area.

Diagnoses in Order of Frequency:

1 Diseases of the respiratory system
2 Diseases of the digestive system
3 Accidents, poisonings, and violence
4 Diseases of the nervous system and sense organs
5 Diseases of the skin and subcutaneous tissue
6 Infective and parasitic diseases
7 Diseases of the genitourinary system
  Diseases of the musculoskeletal system and connective tissue
8 Symptoms and ill-defined conditions
  Mental disorders
9 Diseases of the blood and blood-forming organs
  Diseases of the circulatory system
10 Complications of pregnancy, childbirth, and puerperium

11 Neoplasms
12 Congenital anamolies
13 Endocrine, nutritional, and metabolic diseases

Discussion and Recommendations:

- From an overall view, the nursing services rendered to the migrant workers were satisfactory. The area was large and the concentration of migrants was generally confined to one area at a time which was helpful.

- The coordination and communication between the two nurses was successful in planning and providing services to the migrant workers. Considering two nurses working together for 12 weeks and one alone for an additional eight weeks, a great deal was done in the tri-county area.

- More should have been done in the area of health education. Language was a problem, particularly with the Navajo. There was great need for Navajo health aides in the Delta-Montrose area. The nurse could not get accurate information about health problems and could not begin to work with health education.

- There was also a shortage of doctors in the Delta area which also posed problems. Sunday clinics would have been good had there been more doctors. Perhaps this can be arranged next year with the assistance of the Migrant Council.

DATE SUBMITTED

PART II - MEDICAL, DENTAL, AND HOSPITAL SERVICES

1. MIGRANTS RECEIVING MEDICAL SERVICES

a. TOTAL MIGRANTS RECEIVING MEDICAL SERVICES AT FAMILY HEALTH CLINICS, PHYSICIANS OFFICES, HOSPITAL EMERGENCY ROOMS, ETC.

AGE	NUMBER OF PATIENTS			NUMBER OF VISITS
	TOTAL	MALE	FEMALE	
TOTAL	152	88	64	261
UNDER 1 YEAR	14	4	10	29
1 - 4 YEARS	20	7	13	36
5 - 14 YEARS	28	15	13	46
15 - 44 YEARS	73	46	27	114
45 - 64 YEARS	15	14	1	34
65 AND OLDER	2	2	0	2

b. OF TOTAL MIGRANTS RECEIVING MEDICAL SERVICES, HOW MANY WERE:

(1) SERVED IN FAMILY HEALTH SERVICE CLINIC? 0

(2) SERVED IN PHYSICIANS' OFFICE, ON FEE-FOR-SERVICE ARRANGEMENT (INCLUDE REFERRALS) 152

3. MIGRANT PATIENTS HOSPITALIZED

(Regardless of arrangements for payment):

No. of Patients (exclude newborn) 10

No. of Hospital Days 40

2. MIGRANTS RECEIVING DENTAL SERVICES

ITEM	TOTAL	UNDER 15	15 AND OLDER
a. NO. MIGRANTS EXAMINED TOTAL	103	95	8
(1) NO. DECAYED, MISSING, FILLED TEETH			
(2) AVERAGE DMF PER PERSON			
b. INDIVIDUALS REQUIRING SERVICES - TOTAL	72	67	5
(1) CASES COMPLETED	45	40	5
(2) CASES PARTIALLY COMPLETED			
(3) CASES NOT STARTED	27	27	0
c. SERVICES PROVIDED - TOTAL			
(1) PREVENTIVE			
(2) CORRECTIVE - TOTAL		2	6
(a) Extraction			
(b) Other			
d. PATIENT VISITS - TOTAL	75	67	8

4. IMMUNIZATIONS PROVIDED

TYPE	COMPLETED IMMUNIZATIONS, BY AGE					IN-COMPLETE SERIES	BOOSTERS, REVACCINATION
	TOTAL	UNDER 1 YEAR	1 - 4	5 - 14	15 AND OLDER		
TOTAL -- ALL TYPES	49	4	40	5		126	40
SMALLPOX							
DIPHTHERIA							
PERTUSSIS						3	
TETANUS							
POLIO							
TYPHOID							
MEASLES	10		5	5			
OTHER (Specify)						112	40
D.T.						11	
D.P.T.	39	4	35				

REMARKS

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PART II (continued) — MEDICAL CONDITIONS TREATED IN FAMILY PLANNING CLINICS, HOSPITAL OUTPATIENT DEPARTMENTS, AND PHYSICIANS' OFFICES.

ICD CLASS	MIT CODE	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISIT
XVII.		TOTAL ALL CONDITIONS	310	177	133
	01-	INFECTIVE AND PARASITIC DISEASES: TOTAL	13	9	4
	010	TUBERCULOSIS			
	011	SYPHILIS	2	1	1
	012	GONORRHEA AND OTHER VENEREAL DISEASES			
	013	INTESTINAL PARASITES			
		DIARRHEAL DISEASE (infectious or unknown origins):			
	014	Children under 1 year of age			
	015	All other			
	016	"CHILDHOOD DISEASES" – mumps, measles, chickenpox			
	017	FUNGUS INFECTIONS OF SKIN (Dermatophytoses)			
	019	OTHER INFECTIVE DISEASES (*Give examples*):			
		Streptococcol Infection	7	6	1
		Pneumonoccol Infection	2	1	1
		Recurrent mild hepatitis	2	1	1
	02-	NEOPLASMS: TOTAL	4	1	3
	020	MALIGNANT NEOPLASMS (*give examples*):			
		Acute lymphatic leukemia	4	1	3
	025	BENIGN NEOPLASMS			
	029	NEOPLASMS of uncertain nature			
I.	03-	ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES: TOTAL	1	1	0
	030	DISEASES OF THYROID GLAND			
	031	DIABETES MELLITUS	1	1	0
	032	DISEASES of Other Endocrine Glands			
	033	NUTRITIONAL DEFICIENCY			
	034	OBESITY			
	039	OTHER CONDITIONS			
IV.	04-	DISEASES OF BLOOD AND BLOOD FORMING ORGANS: TOTAL	8	3	5
	040	IRON DEFICIENCY ANEMIA	8	3	5
	049	OTHER CONDITIONS			
V.	05-	MENTAL DISORDERS: TOTAL	9	5	4
	050	PSYCHOSES	2	1	1
	051	NEUROSES and Personality Disorders	7	4	3
	052	ALCOHOLISM			
	053	MENTAL RETARDATION			
	059	OTHER CONDITIONS			
VI.	06-	DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS: TOTAL	40	22	18
	060	PERIPHERAL NEURITIS			
	061	EPILEPSY			
	062	CONJUNCTIVITIS and other Eye Infections	7	5	2
	063	REFRACTIVE ERRORS of Vision	1	1	0
	064	OTITIS MEDIA	23	11	12
	069	OTHER CONDITIONS	9	5	4

PART II – 5. (Continued)

ICD CLASS	MH CODE	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVI
VII.	07-	DISEASES OF THE CIRCULATORY SYSTEM: TOTAL	8	2	6
	070	RHEUMATIC FEVER			
	071	ARTERIOSCLEROTIC and Degenerative Heart Disease			
	072	CEREBROVASCULAR DISEASE (Stroke)			
	073	OTHER DISEASES of the Heart Cor pulmonale	6	1	5
	074	HYPERTENSION	2	1	1
	075	VARICOSE VEINS			
	079	OTHER CONDITIONS			
VIII.	08-	DISEASES OF THE RESPIRATORY SYSTEM: TOTAL	58	34	24
	080	ACUTE NASOPHARYNGITIS (Common Cold)	13	10	3
	081	ACUTE PHARYNGITIS	2	2	0
	082	TONSILLITIS	18	13	5
	083	BRONCHITIS	12	6	6
	084	TRACHEITIS/LARYNGITIS			
	085	INFLUENZA			
	086	PNEUMONIA			
	087	ASTHMA, HAY FEVER	7	2	5
	088	CHRONIC LUNG DISEASE (Emphysema)	6	1	5
	089	OTHER CONDITIONS			
IX.	09-	DISEASES OF THE DIGESTIVE SYSTEM: TOTAL	52	25	27
	090	CARIES and Other Dental Problems	14	6	8
	091	PEPTIC ULCER	11	3	8
	092	APPENDICITIS	3	1	2
	093	HERNIA	1	1	0
	094	CHOLECYSTIC DISEASE			
	099	OTHER CONDITIONS	23	14	9
X.	10-	DISEASES OF THE GENITOURINARY SYSTEM: TOTAL	11	6	5
	100	URINARY TRACT INFECTION (Pyelonephritis, Cystitis)	6	3	3
	101	DISEASES OF PROSTATE GLAND (excluding Carcinoma)			
	102	OTHER DISEASES of Male Genital Organs			
	103	DISORDERS of Menstruation			
	104	MENOPAUSAL SYMPTOMS	2	1	1
	105	OTHER DISEASES of Female Genital Organs	3	2	1
	109	OTHER CONDITIONS			
XI.	11-	COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM: TOTAL	5	1	4
	110	INFECTIONS of Genitourinary Tract during Pregnancy			
	111	TOXEMIAS of Pregnancy			
	112	SPONTANEOUS ABORTION			
	113	REFERRED FOR DELIVERY	5	1	4
	114	COMPLICATIONS of the Puerperium			
	119	OTHER CONDITIONS			
XII.	12-	DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE: TOTAL	35	26	9
	120	SOFT TISSUE ABSCESS OR CELLULITIS	13	9	4
	121	IMPETIGO OR OTHER PYODERMA	11	9	2
	122	SEBORRHEIC DERMATITIS			
	123	ECZEMA, CONTACT DERMATITIS, OR NEURODERMATITIS	6	4	2
	124	ACNE			
	129	OTHER CONDITIONS allergies	5	4	1

GRANT NUMBER

RT II - 5. (Continued)

CD CLASS	MII CODE	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
I.	13-	DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE: TOTAL	11	8	3
	130	RHEUMATOID ARTHRITIS	1	1	0
	131	OSTEOARTHRITIS			
	132	ARTHRITIS, Unspecified	4	2	2
	139	OTHER CONDITIONS	6	5	1
V.	14-	CONGENITAL ANOMALIES: TOTAL	2	1	1
	140	CONGENITAL ANOMALIES of Circulatory System			
	149	OTHER CONDITIONS Turner's Syndrome	2	1	1
.	15-	CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY: TOTAL			
	150	BIRTH INJURY			
	151	IMMATURITY			
	159	OTHER CONDITIONS			
I.	16-	SYMPTOMS AND ILL-DEFINED CONDITIONS: TOTAL	9	6	3
	160	SYMPTOMS OF SENILITY			
	161	BACKACHE			
	162	OTHER SYMPTOMS REFERRABLE TO LIMBS AND JOINTS			
	163	HEADACHE	6	4	2
	169	OTHER CONDITIONS	3	2	1
II.	17-	ACCIDENTS, POISONINGS, AND VIOLENCE: TOTAL	44	27	17
	170	LACERATIONS, ABRASIONS, and Other Soft Tissue Injuries	14	9	5
	171	BURNS	3	2	1
	172	FRACTURES	9	3	6
	173	SPRAINS, STRAINS, DISLOCATIONS	11	7	4
	174	POISON INGESTION	7	6	1
	179	OTHER CONDITIONS due to Accidents, Poisoning, or Violence			

			NUMBER OF INDIVIDUALS
G.	2--	SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS: TOTAL	381
	200	FAMILY PLANNING SERVICES	10
	201	WELL CHILD CARE	
	202	PRENATAL CARE	2
	203	POSTPARTUM CARE	
	204	TUBERCULOSIS: Follow-up of inactive case	1
	205	MEDICAL AND SURGICAL AFTERCARE	1
	206	GENERAL PHYSICAL EXAMINATION	79
	207	PAPANICOLAOU SMEARS	5
	208	TUBERCULIN TESTING	169
	209	SEROLOGY SCREENING	
	210	VISION SCREENING	45
	211	AUDITORY SCREENING	62
	212	SCREENING CHEST X-RAYS	7
	213	GENERAL HEALTH COUNSELLING	
	219	OTHER SERVICES: (Specify)	

TYPE OF SERVICE	NUMBER
1. NURSING CLINICS:	
a. NUMBER OF CLINICS	18
b. NUMBER OF INDIVIDUALS SERVED - TOTAL	230
2. FIELD NURSING:	
a. VISITS TO HOUSEHOLDS	240
b. TOTAL HOUSEHOLDS SERVED	201
c. TOTAL INDIVIDUALS SERVED IN HOUSEHOLDS	292
d. VISITS TO SCHOOLS, DAY CARE CENTERS	235
e. TOTAL INDIVIDUALS SERVED IN SCHOOLS AND DAY CARE CENTERS	190
3. CONTINUITY OF CARE:	
a. REFERRALS MADE FOR MEDICAL CARE: TOTAL	188
(1) Within Area	175
(Total Completed)	165
(2) Out of Area	13
(Total Completed)	6
b. REFERRALS MADE FOR DENTAL CARE: TOTAL	45
(Total Completed)	32
c. REFERRALS RECEIVED FOR MEDICAL OR DENTAL CARE FROM OUT OF AREA: TOTAL	none
(Total Completed)	
d. FOLLOW-UP SERVICES FOR MIGRANTS, not originally referred by project, WHO WERE TREATED IN PHYSICIANS OFFICES (Fee-for-Service)	
e. MIGRANTS PROVIDED PRE-DISCHARGE PLANNING AND POST-HOSPITAL SERVICES	5
f. MIGRANTS ASKED TO PRESENT HEALTH RECORD (Form PMS-3652 or Similar Form) IN FIELD OR CLINIC: TOTAL	160
(1) Number presenting health record	40
(2) Number given health record	110
4. OTHER ACTIVITIES (Specify):	

REMARKS

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