Queensbridge Health Maintenance Service for the Elderly

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IN NEW YORK CITY the population over 65 expanded from 5.6 percent of the total population in 1940 to 10.4 percent in 1960, or from about 420,000 to more than 810,000. The rapid growth of this population group has paralleled other significant changes such as retirement at an increasingly earlier age, the growing popularity of smaller apartments, disappearance of three-generation families, continued increase in life expectancy, inflation, and the disproportionate rise in medical care costs.

These phenomena have produced many major problems among our older citizens. The magnitude and urgency of these problems, particularly in a large city such as New York, are multiplied by indigency, inertia, ignorance, failing eyesight and hearing, language barriers, long waiting lists at community agencies, whose services frequently offer insuperable complexities for elderly users, and often long, complicated, and inordinately expensive travel from home to agency.

There is an obvious need for a program which will not only meet these urgent and complex needs of the elderly but will do so at a cost far below the expenditures now incurred in perpetuating the present archaic patchwork system. Such a program should not only be designed to improve the social, recreational, environmental, and physical and mental health lot of older citizens, but it also must be acceptable to elderly clients. It must, wherever possible, draw upon the resources of agencies already serving the community for the basic services it will offer (*1*, *2*).

A program of this type should consider elderly citizens in various settings, including those living in public housing. The problems of older residents of public housing are in most respects just as serious, if not more so, than those of older citizens living elsewhere. Actually, there are some advantages to testing a program in a public housing setting because residents tend to move about less and, in a sense, are a captive group. Designing and controlling the research aspects of such a program are simpler.

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The Vladeck Houses Experience

In June 1955 the New York City Housing Authority placed before the Mayor's Advisory Committee for the Aged its concern about older persons with physical, emotional, social, financial, and other needs residing in public housing projects. The Vladeck Houses study and demonstration was born as a result (*3*). In retrospect it was a modest forerunner for the Queensbridge program.

The New York City Department of Health and Gouverneur Hospital, a city-operated institution near Vladeck Houses project, joined in developing under the direction of the local

district health officer a health and medical program for the older residents at the project. This program was active for only 8 months during 1957 and reached only 99 of the 600 over age 65 at Vladeck. However some of its findings and conclusions are of interest (*4,5*).

The health officer and medical staff of the Vladeck program pointed out in their final report that the health problems among Vladeck's senior citizens were mainly those of longstanding chronic illnesses productive of incapacitation of varying degrees. The program had been responsible in a number of instances for retarding the progress of a chronic disabling condition. The authors of the report found that the discriminating and coordinated use of outpatient departments, hospitalization, home services, counseling and referral, and public health nursing were useful tools.

The health officer also declared that poor health was only one aspect of the problem in these older folk, that health services must be part of a more inclusive effort to fill recreational, financial, housekeeping, nursing, and casework needs. The health service itself must be oriented toward long-term care and guidance. Finally, the report stated that while all of these services were available in the community, they were not easily available to older people. The great need was for a scheme to unite and synchronize these services.

The Elderly in Public Housing

In 1962 there were some 15,000 people over age 65 in public housing projects in New York City. As of November 1961, they lived in 1,030 apartments specially designed for elderly occupants and in many of 20,042 conventionally designed two- and three-room units. In November 1961 the New York City Housing Authority had 18 low-cost housing projects under construction and 26 more were planned, a total of 44. These will add 5,990 apartments specially designed for older people and 5,295 two- and three-room conventional units, most of which conceivably would also be occupied by the aged. The 15,000 aged now living in public housing will probably double in number when these apartments become available.

Early in 1961 the housing authority proposed that the New York City Department of Health take the leadership in developing a comprehensive health, medical, and social program at Queensbridge Houses, a federally aided project in Queens where 13,000 people reside. Of these, a recent count had shown more than 1,400 were past their 60th birthday, and more than 700, past their 70th (table 1).

Table 1. Age distribution of those over age 60 residing at Queensbridge Houses, October 1961

Age (years)	Number	Percent
60–64	254	18
65–69	377	27
70–74	391	28
74–79	246	17
80–84	112	8
85 and over	30	2
Total	1,410	100
Spouse under 60	85	----

The following is the distribution of the over-60 population by family size. Nearly two-thirds of the group were one-person families.

Number of persons	*Number of families*
1	623
2	419
3	31
4	7
5	7
6	2
7	1
8	1
Total	1,091

Table 2 shows family income levels. The 1961 incomes were considerably lower than the 1956 incomes of individuals between ages 60 and 74 in New York City (*6*).

Queensbridge housing project is located in an industrial area, isolated from any other residential area. The nearest medical facility, Elmhurst City Hospital, is about 4 miles from the project, a short drive, but more than 1 hour away by public bus transportation. This was a major reason why Queensbridge's predominantly indigent residents, the aged in particular, were not receiving sufficient health and medical services. In addition, this older age group, like their peers in projects in other parts of the city, suffered from fragmented, poorly

coordinated health and social care. Fragmentation, lack of coordination, and gaps in service result when health, medical, and social agencies over the years develop their own priorities, types of clientele, techniques, special interests, and inflexible if not restrictive policies.

The department of health agreed to the housing authority's proposal, because at Queensbridge was a chance to show how the services of a group of agencies could be mobilized, coordinated, and, if need be, altered to meet the needs of older people. The department had been planning somewhat similar programs in two housing projects which were still on the drawing boards. But at Queensbridge was a chance to get started at least 2 years before either of the other two would become realities.

Because such a program must represent the combined planning, cooperation, and services of a number of city agencies, the approval of the New York City Interdepartmental Health Council was next sought and obtained. The council is the official body coordinating the services of the health, hospitals, and welfare departments and the community mental health board in New York City. The council consists of the commissioners of these official agencies.

The department of health, in cooperation with the departments of hospitals and welfare, the community mental health board, the city housing authority, and a group of voluntary agencies established on November 3, 1961, a health maintenance program for the elderly at Queensbridge Houses. The voluntary agencies were the Visiting Nurse Service of New York, Jewish Community Service of Queens, and the Jacob Riis Neighborhood Settlement House. The settlement house maintained a Golden Age Club with 350 members, all residents of the project.

Table 2. Income of families with members over age 60, Queensbridge Houses, October 1961

Family income	Number	Percent
Under $1,000	226	20.7
$1,000–$1,999	550	50.4
$2,000–$2,499	150	13.7
$2,500–$2,999	56	5.1
$3,000–$3,999	74	6.8
$4,000–$4,999	25	2.3
Over $5,000	10	1.0
Total	1,091	100.0

Prior to opening the Queensbridge Health Maintenance Service for the Elderly, the New York City Commissioner of Hospitals designated the Queensbridge clinic as a branch clinic of the outpatient department of Elmhurst City Hospital. The clinic's relationship to the outpatient department of Elmhurst has many advantages.

The clinic at Queensbridge contains about 1,200 square feet of floor space, originally designed for other purposes, and altered at a cost to the New York City Housing Authority of $6,800. The authority charges no rent and also supplies maintenance services. Major items of furniture and equipment were supplied by the departments of health and hospitals.

The Queensbridge clinic is open from 9 a.m. to 5 p.m. Mondays through Fridays, holidays excepted. The basic clinic staff consists of one full-time and one part-time public health nurse, one full-time and one part-time social worker, one full-time and one part-time laboratory technician, two public health assistants, a clerk, a part-time nutritionist, and a psychiatric social worker 1 day every other week.

There are three morning clinics and two afternoon clinics weekly, each staffed by two or three physicians. A podiatrist and an optometrist each attend one-half day per week. These clinic sessions are intended exclusively for the over-60 population in the housing project. This is understood and accepted by the project population. There have been no instances, except in rare emergencies, where those below 60 have requested care.

The program at Queensbridge includes preventive health examinations, public health nursing services, certain simple and routine therapeutic services, podiatry, physiotherapy, counseling and referral services, vocational guidance services, friendly visiting, mental health services, and, with the cooperation of Elmhurst City Hospital, specialized diagnostic and outpatient and inpatient services, rehabilitation, and home care services.

On April 2, 1962, the program received a 3-year grant of $260,000 from the Public Health Service, under the provisions of the Community Health Services and Facilities Act of 1961.

The purpose of the grant is to provide funds for the integration into the program of an evaluation of its activities and accomplishments. The grant would also permit program expansion and enrichment in social work, podiatry, optometry, and laboratory services.

Clinic Operations

The department of health administers the health maintenance services. The district health officer of the Astoria District, within which Queensbridge Houses is situated, is the director of this project. An assistant director is responsible for day-to-day operations, development of evaluative procedures, and liaison with partner agencies and with other agencies whose programs are tangentially related.

Jacob Riis Neighborhood Settlement House has been responsible for publicizing the program within the housing project. Its workers arrange for all appointments of new patients who are drawn from residents who have reached their 60th birthdays. The workers also gather background social data, much of it from the files of the local housing project management. Considerable information is supplied by the department of welfare for those on its rolls.

The department of welfare has consolidated into the hands of three of its most experienced caseworkers all home relief cases of persons between 60 and 65 and all old age assistance and medical assistance for the aged cases. Prior to this consolidation the public assistance caseload at Queensbridge might have been scattered among 15 different caseworkers. Turnover of caseworkers was continuous. Without this consolidation, liaison and cooperation with the department of welfare would have been most difficult.

The settlement house schedules new patients at the rate of 15 a week. Appointments are seldom broken. Usually the patient who finds it necessary to break an appointment gives advance notice and requests another appointment. In 6 months about 400 persons have been admitted to the service. The backlog awaiting first visits has been maintained at 100. We believe that about 1,000 of the eligible population of about 1,400 will have voluntarily come into the program by the end of the first year.

During his initial visit to the clinic the patient undergoes certain routine laboratory tests: hemoglobin, complete blood count if hemoglobin is below 10 gm., urine and postprandial blood sugar analyses, and an electrocardiogram. At the second visit a few days later the patient sees one of three physicians, all board-certified or board-eligible internists on the visiting staff of Elmhurst City Hospital. The physician completes the history, reviews the laboratory findings, including a chest film taken in a special mass survey conducted at the housing project in October of 1961, and performs a complete physical examination, including tonometry, proctoscopy, and pelvic examination. He takes a Papanicolaou smear and does a finger cot examination for occult blood. If the physician desires other laboratory tests, specimens are obtained at the Queensbridge clinic and sent to Elmhurst City Hospital for processing.

After the physician's examination, the patient is seen by the public health nurse for interpretation of findings and recommendations and for advice, guidance, and referral to appropriate resources. The patient (and spouse) may also be referred to the social work consultant or the nutritionist if their services seem indicated to the physician or public health nurse. The social work consultant interviews those patients whose social problems need exploration in depth before a decision is made as to what type of therapy is indicated.

A patient requiring no referral or followup is informed that he will receive a notice to return for an annual examination. He is also told that if any medical or related problem arises in the interim, he should feel free to drop in for a conference with the public health nurse or social worker. In the short span since the facility has been opened, the number of impromptu nursing conferences by these and other patients has averaged 22 per day.

Of the first 400 processed, less than 10 percent were free of any condition requiring therapy or followup and were asked to come back in 1 year. About 30 percent are asked to return sooner for such services as podiatry, nursing or social counseling, or nutrition instruction. The other 60 percent are placed on some form of therapy. However, the first 400

patients are a self-selected sample and are probably not representative of the entire group of 1,400 elderly. It is unlikely that the percentage for the total group will be as high.

Referrals

The simplest type of medical referral is to the followup clinic session held weekly in the Queensbridge facility. Because the facility is a branch clinic of the hospital's outpatient department, these followup sessions can provide simple forms of therapy prescribed by the Queensbridge medical staff, the Elmhurst City Hospital inpatient service, or by a specialty clinic of the hospital. Arthritis, rheumatism, hypertension, many cardiac, pulmonary, and gastrointestinal conditions, diabetes, and anemias are treated at Queensbridge. A large assortment of drugs and other medications are dispensed at Queensbridge through a small pharmacy the hospital has established there.

Many patients are referred to a podiatrist who has a weekly session at the Queensbridge clinic. We have found that foot care often results in dramatic benefits. Some individuals have been returned from longstanding and at times nearly absolute immobility to the relative freedom that new-found foot ease brings. This has meant rejuvenated ability to take care of shopping needs, to attend church services, to keep medical appointments, to visit relatives, and to pursue other long-neglected activities (*7*).

A smaller group of patients are referred by the social work consultant for guidance, counseling, and evaluation by a psychiatric social worker from Jewish Community Service of Queens who visits the Queensbridge clinic every 2 weeks. Plans are being developed to include the services of a psychologist and possibly a psychiatrist from Jewish Community Service. The possibility of starting a group counseling program is being explored.

Our clinic physicians on occasion prescribe simple forms of physical therapy to be provided in the patient's own home or at the Queensbridge clinic by nurse therapists from the Visiting Nurse Service of New York. More complex or elaborate rehabilitative procedures are carried out by the department of physical medicine and rehabilitation at Elmhurst City Hospital. In May 1962 the services of an optometrist were added to the program. It is too soon to judge the usefulness of this service. In the near future the advisability of introducing some limited dental service into our program will be considered.

At times the social work consultant will recommend that a patient can best be served by a return to gainful employment, either in his previous employment or in a new job. These persons are sent to the Federation Employment and Guidance Service, supported by the Federation of Jewish Philanthropies of New York, which conducts vocational rehabilitation and job placement for vocationally handicapped persons over age 55.

Frequently the public health nurse or social work consultant uncovers problems and situations which can only be resolved via conferences and joint planning by two or more of the partner agencies. During conferences held on behalf of individual patients or families or during larger staff conferences held monthly and attended by one or more representatives of each partner agency, problems are explored, programs reviewed, and gaps in service or service duplications uncovered. On-the-spot corrective decisions are made. This often means taking liberties with agency policies.

Outpatient Department

Referral of about 20 patients per month to the various specialty clinics at Elmhurst is easily accomplished. The complexities of outpatient services have been minimized for these patients. Consequently, and quite remarkably, there has been almost a 100 percent record of appointments being kept at the outpatient department.

When a health maintenance clinic physician desires to refer a patient to Elmhurst, a clerk at Queensbridge makes the appointment at the specialty clinic or service to which the patient is being referred and obtains a clinic number for that patient, completing this procedure before the patient leaves the Queensbridge clinic. A photocopy of the health maintenance clinic record is sent to the Elmhurst specialty clinic prior to the patient's appointment. Such a pa-

tient is neither subjected to a means test nor to the necessity of going through a screening clinic at the hospital. The patient may subsequently receive therapy at the specialty clinic or at Queensbridge, depending upon the relative complexity of the therapy prescribed. The patient's outpatient department record shuttles between the hospital and the health maintenance clinic and is always at the health maintenance clinic whenever that patient has an appointment with the physician.

Home Care

Elderly residents from Queensbridge Houses may be admitted to the Home Care Service of Elmhurst City Hospital via one of three routes: directly from the health maintenance clinic, from a specialty clinic at Elmhurst outpatient department, or from the hospital's inpatient service. During the first 6 months of the health maintenance clinic's existence, 16 patients were admitted to home care, 10 directly from the Queensbridge clinic, and the remainder from the outpatient or inpatient service of Elmhurst City Hospital. Six patients who lived alone were among those admitted to home care.

Liaison is close between the health maintenance clinic and the home care service. The home care service is administered by a department of health physician under a plan concurred in by the commissioners of health and hospitals. This has resulted in significant improvements and innovations in the quality and breadth of the home care service, some of which have benefited Queensbridge patients. For example, one innovation is to admit some patients directly from a clinic to home care, thus obviating preliminary and expensive inpatient care. Preliminary inpatient diagnostic workup and care prior to admission to home care had been required previously. Another innovation is the acceptance of the concept that certain patients living alone could be maintained on home care in preference to being sent to a nursing home. Previously the rule had been that no patient living alone could be maintained on home care.

A third benefit has been the occasional transfer of a patient from the department of welfare's chronic disease program to Elmhurst's Hospital's home care program when it is felt that the patient would thereby receive better care. By making such transfers we are incurring a greater expense for New York City. The city is entitled to medical aid for the aged reimbursement from the State for elderly patients on the department of welfare's chronic disease program. The New York State Metcalfe-McClosky Act, which implements the Federal Kerr-Mills bill, provides no such reimbursement to the city for elderly patients carried on home care programs which are hospital based.

Housekeeping Service

Housekeeping and homemaking services at Queensbridge are provided in several ways. For those on home care, housekeeping services are provided by the home care program. Patients receiving old age assistance can get housekeeping services from the department of welfare. However, there are a large group of individuals not on old age assistance or in the home care program who, even while ambulatory, could benefit from housekeeping services. Funds are included in the Federal grant to provide this group of individuals with these services. We have been recruiting and training a group of local housewives to work as housekeepers on an hourly basis. The first of these has completed her training and is now providing service to six elderly persons. The recruiting, training, placement, and supervision of these workers are carried on by the city housing authority and Jacob Riis Neighborhood Settlement House, under the direction of the department of health's consultant in social work.

Evaluation

The health maintenance service has been planned not only as a continuing activity but also as a demonstration of what can be done to meet most of the health and medical needs of a group of aged persons. Before generalizing our experience to other groups of aged in the city or elsewhere, it is essential to determine if the program has succeeded in meeting its objectives.

Both the effectiveness of the program in meeting the needs of the individual and the impact upon the health status of the group can be considered in making an evaluation. Obviously, the two are interrelated.

An effort will be made to answer the following questions.

1. To what degree are the individual health needs of the aged met?

2. To what degree are elderly persons enabled to continue to live independently as active members of the community? This determination will depend on the use of a suitable control group in another housing project.

3. To what extent is the program effective in providing prompt and possibly early diagnosis and, subsequently, in getting the patient to utilize an approved therapeutic regime? This information will be gathered for certain conditions only, such as specific types of malignancy (breast, cervix, lung, and prostate) and heart conditions (decompensation, arrhythmias, and coronary disease).

4. Is the program acceptable to the elderly and what is the impact on their health attitudes?

5. What is the nature and incidence of morbidity and disability and, possibly, mortality in the study group?

While these indicate the lines along which the evaluation will be undertaken, there may well be other measurements suggested by experience with the program. These will be incorporated as they are identified.

If the evaluation is favorable we plan to continue this program as a permanent service and to start similar services in other locales in New York City.

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Temporal Bone Banks

The Deafness Research Foundation has been instrumental in establishing 22 temporal bone banks, or laboratories, throughout the country to obtain through bequests the temporal bones of persons with auditory disorders. The ear bones are being solicited exclusively for purposes of basic research. The program, begun 2 years ago, receives financial aid from the National Institutes of Health and is conducted in cooperation with the American Academy of Ophthalmology and Otolaryngology.

Microscopic study of the inner and middle ear structures is possible only after death, by removal of the temporal bones containing the structures. Investigation of the nature and causes of deafness has been seriously handicapped by the lack of temporal bone specimens from patients with well-documented auditory disorders.

Further information about the ear banks program and forms for making legal bequests are available from the Temporal Bone Banks Center, Box 146—Faculty Exchange, Chicago 37, Ill.