*Interim Report*



# The Queensbridge Health Maintenance Service for the Elderly, 1961–1965

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THE QUEENSBRIDGE Health Maintenance Service for the Elderly, now in its fourth year, is an attempt to solve the manifold problems that accompany a rapidly growing community of older citizens. This program incorporates some unique and precedent-setting features, which could have application and usefulness in health and medical programs designed not only for elderly groups but for other groups of persons of varying composition and character.

A joint undertaking of official and nonofficial agencies, under the leadership of the New York City Department of Health, the program was established in 1961 in Queensbridge Houses, one of the oldest and largest federally aided public housing projects. Its purposes are: (*a*) to help the older persons live independently and as active members of their community, (*b*) to identify the health and medical needs of an elderly population, (*c*) to develop an acceptable system of meeting their needs as quickly and as comprehensively as possible through the coordinated efforts of cooperating agencies, and (*d*) to integrate the system where possible into the programs of voluntary and official agencies.

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The historical development and other background information which contributed to the eventual establishment of the Queensbridge Health Maintenance Service for the Elderly were presented in a previous report (*1*). This interim report describes patients, staff, and services as of March 31, 1965. A future report will present the results of an extensive evaluation of the program.

## Queensbridge Clinic

The Queensbridge clinic operates as a branch of the Elmhurst City Hospital outpatient department. It is still housed in the same rent-free space provided in 1961 and converted for clinic use by the New York City Housing Authority. When more activities were added to the program and more space was required, the clinic layout was altered by the housing authority to permit a freer flow of traffic, to minimize confusion during hours of peak usage, and to provide greater privacy in examining rooms.

The health maintenance service is offered free of charge to all residents of the Queensbridge Houses who are over 60 years of age. The staff provides complete initial and periodic (annually at present) health appraisals, many diagnostic procedures, laboratory examinations, and ambulatory therapy. In addition to the basic program are such services as emergency care; public health nursing activities; social work; nutrition, mental health, podiatric, and optometric services; home help; and friendly visiting in the home, hospital, and long-term institution.

Patients are registered for service by a community worker who has an office adjacent to the clinic. The worker is assigned by the Jacob Riis Neighborhood Settlement House, a voluntary agency which operates a Golden Age center at the housing project. Registration includes a history of previous hospitalization and other medical care. With the patients' consent, abstracts of their histories are obtained. Many of the Queensbridge residents over age 60 have received treatment at Elmhurst City Hospital, most of them fairly recently, and their records are obtained from the hospital before they visit the Queensbridge clinic. After their clinic sessions, these records are returned to the hospital. The clinic retains its own medical records. A system of referral and consultation forms has been developed for communication between the hospital and Queensbridge clinic.

Shortly after registration, the patients are given appointments for chest X-rays at the nearby Astoria District Health Center (for which transportation is provided). Department of health technicians perform urine analyses, hemoglobins and white blood cell counts, electrocardiograms, and cholesterol determinations at the Queensbridge clinic.

Each of the clinic patients is assigned a physician who becomes responsible for the subsequent medical management and followup of the patient and spouse, and in effect becomes their family physician. On the patient's initial

*New York City Department of Health*

**Golden Age Center at Queensbridge Houses, one facet of the Queensbridge Health Maintenance Project**

visit, a public health assistant checks height, weight, and visual acuity. The physician takes the medical history and performs a complete physical examination. Routine proctoscopic examination was started in December 1962; this is done by a proctologist who also performs sigmoidoscopic examinations when indicated. Tonometric testing became routine in August 1962, by which time all the physicians had been trained in the use of the Schiotz tonometer.

After completing the initial examination, the physician indicates when he wants the patient to return. He also indicates whether any of the following procedures are needed: additional tests; consultation workup at the hospital outpatient department; admission to inpatient service at Elmhurst; visit to the podiatrist or optometrist, or both; visit to the nutritionist; social worker consultation; or psychiatric consultation and treatment.

*Staff.* When the clinic opened, its staff consisted of two public health nurses (one full-time and one part-time), a public health assistant, a clerk, a laboratory technician 2 days a week, a nutritionist ½ day a week, and four part-time internists, who shared six weekly physician sessions at each of three clinic sessions per week. By March 1965 additional staff included a full-time registered nurse, a public health assistant, a clerk, a typist, a social work consultant, three laboratory technicians, a messenger-chauffeur, four internists, a proctologist, a psychiatrist, a physician-in-charge, a podiatrist, and an optometrist.

*Physicians.* All the "family physicians" at Queensbridge, except the proctologist and the psychiatrist, are board-certified or board-eligible internists who are members of Elmhurst's medical staff. One of these physicians, director of the hospital's outpatient department and a member of its medical board, has not only promoted acceptance of the Queensbridge program by the hospital staff but has also insured the hospital's complete cooperation with the program. Another internist, admitting physician at Elmhurst City Hospital, has also provided considerable help in furthering the program at Queensbridge.

Most of the physicians experienced their first exposure to public health philosophy and techniques by working at the Queensbridge clinic. For many it was a unique and exhilarating experience to serve as family physicians, and their increasingly enthusiastic acceptance of the program was ultimately spread to the hospital. During the first 2 years of the program, the project director, almost singlehandedly, had to attract Elmhurst City Hospital internists to serve at Queensbridge. During the third year, however, there was a perceptible change—when additional physicians were needed at Queensbridge the hospital encouraged its internists to serve.

*Public health nurse.* The public health nurse dispenses drugs prescribed by the physician, explains services available, further assesses the patient's needs, interprets and reinforces the physician's recommendations, arranges for referrals or tests specified by the physician, and informs the patient that she is available for consultation.

In addition to her counseling function, the nurse has a key role in medical care followup. She has almost three times as many contacts as the physician has with the patient. Patients may visit the nurse between physician visits for consultation, for injections, for refills of drug prescriptions, or for periodic weighing or blood pressure readings. These contacts allow the nurse to detect changes in the patient's condition and to determine whether the patient is following the prescribed regimen. Motivating patients to accept referral to Elmhurst City Hospital is an important aspect of the nurse's role in followup. It entails systematic review of the clinic charts.

*Mental health services.* Early in the program mental health services were minimal, consisting of a biweekly visit by a psychiatric social worker assigned from the Jewish Community Service of Queens. We estimated that about 15 to 20 percent of the registrants suffered from chronic brain syndrome, and it became increasingly apparent that a more comprehensive mental health program was needed. Consequently, late in 1963 the service of a psychiatrist was obtained for 2½ days a week.

The psychiatrist serves as a consultant concerning problem patients in joint conferences with clinic physicians, public health nurse, and social worker. He also confers with the director of the Jacob Riis Day Center as to recreational

needs and activities of individual patients. The psychiatrist evaluates the patient in terms of his medical, psychological, social, economic, and religious status in relation to the specific problem for which he was referred. When indicated, the psychiatrist recommends followup therapy or drugs, and makes referrals to religious or social agencies or to psychiatric institutions (not mandatory). Additionally, he makes periodic followup visits to institutionalized clinic patients and patients under psychiatric care in other facilities, confers with clinic physicians on patients' progress, and reviews the records of those whose mental condition indicates a need for medication or other services. As of mid-1965, the psychiatrist has been holding weekly group sessions for selected patients.

From December 1963 through March 1965, the psychiatrist saw 82 patients for a total of 260 visits. These figures do not include the Queensbridge patients he visited at the inpatient psychiatric facility at Elmhurst City Hospital and the State mental institution for long-term care.

*Podiatry.* Included in the program in January 1962, podiatry has become one of its most popular services. Originally, one session a week was held; by May 1965 there were three sessions per week. Visits are scheduled 3 months in advance.

As of March 31, 1965, 293 patients had made 1,887 visits to the podiatrist. Because of the advanced age of the average patient and the restrictions imposed by time limitations and available facilities, treatment is tailored to the individual patient and his immediate needs. Priority is given to patients with diabetes or peripheral vascular disease. Nearly 25 percent of the visits are made by diabetic patients. These patients are seen regularly and frequently, and they account for almost 450 of the visits to the podiatrist. In addition to therapy, diabetic patients are given detailed and painstaking instruction in proper care of their feet.

The most frequently treated foot conditions are skin hyperplasias, calluses, corns, toenail dystrophies, ulcerations, and fungal infections. Relatively few of the patients seen by the podiatrist require inpatient care.

Patients requiring foot care are referred by the clinic physicians; self-referrals are not accepted. One of the three weekly sessions is devoted to rehabilitative therapy, which consists of fabrication of foot appliances, minor corrective procedures, and other rehabilitative podiatric modalities. The eventual goal of the podiatric service is to provide both routine periodic examination for all clinic patients and appropriate therapy when indicated.

*Optometry.* An optometrist was added to the clinic staff in May 1962, and his service is sought almost as frequently as that of the podiatrist. The prime objective in providing optometric service centered about provision of refraction service, eyeglasses, and other related services. Visual ability has special significance for the elderly because their activities are frequently limited to sewing, knitting, cooking, reading, or watching television.

Soon after optometric service began, a significant amount of ocular pathology was noted. Some of this pathology, including that indicative of systemic disease, had been overlooked by the internists. Interestingly, eye pathology has been the most frequent reason for referral to the Elmhurst outpatient department.

The optometrist conducts two sessions per week. Patients are referred to him when they complain of vision difficulties or they have findings indicative of possible eye disease. The optometrist also performs routine examinations on patients who wear eyeglasses constantly and who have not been examined in some time. By March 1965, the optometrist had seen 352 patients for a total of 578 visits.

Provision of eyeglasses has not been costly for the program; some patients are financially able to purchase them, some receive eyeglasses through the medical aid to the aged program, and others receive them free of charge through provisions made by the Long Island chapter of the Lions Club.

*Chauffeur-messenger service.* The Queensbridge clinic, located 4½ miles from Elmhurst City Hospital, originally depended on a welter of delivery services for drugs, supplies, laundry, forms, and other items, for exchange of records between hospital and clinic, and for delivery of specimens to the hospital. Slip-ups in delivery services were not uncommon.

Early in the program, patients referred to the outpatient department at Elmhurst almost

**Table 1. Status of registrants for Queensbridge health maintenance service, as of March 31, 1965**

| Status | Registrants | |
|---|---|---|
| | Number | Percent |
| Receiving service | 614 | 63 |
| Pending service | 6 | |
| Under Elmhurst City Hospital medical supervision [1] | 55 | 7 |
| Under welfare department supervision | 2 | |
| In long-term institutions | 28 | 3 |
| Dropped out during registration period | 93 | 9 |
| Moved from housing project | 64 | 8 |
| Dead | 109 | 10 |
| Total | 971 | 100 |

[1] 26 inpatients and 29 patients under home care.

invariably kept their appointments. However, as an increasingly representative group of elderly Queensbridge residents registered for service, in contrast to the self-selection characteristics of the first registrants, the percentage of patients failing to keep appointments climbed to 30 percent. It was felt that this figure could be lowered considerably if transportation were provided to Elmhurst.

The two problems of delivery service and patient transportation were solved in December 1963, when the health department assigned a vehicle and a full-time chauffeur-messenger was hired. Several round trips are made daily between the clinic and hospital, and occasionally between clinic and health center. The viability and quality of the Queensbridge program has been aided immeasurably by this transportation service, and it has become one of the program's most important assets.

*Registrants.* By March 31, 1965, 971 residents had registered and 614 were receiving medical supervision (table 1). Among the 93 persons who dropped out after registering were many whose reasons for seeking care were contrary to clinic policy: some wanted to get medication without seeing a physician, some were patients of private physicians and were only interested in having certain laboratory tests performed, and others wanted to compare the program's services with those of their private physicians. Of the 614 patients under Queensbridge supervision at this time, 213 had had at least two annual examinations in addition to their initial examinations.

A comparison was made of the age distribution of the population aged 60 years and over living in the housing project with that of the population who registered for medical supervision during the first 17 months of the program (table 2). The results revealed that the percentages of clinic registrants in the 65–69, 70–74, and over 80 age groups were almost identical to the percentages of residents in the same age groups. However, differences were noted for the 60–64 and 75–79 age groups. Apparently the program was least popular among persons aged 60–64 years and most popular for those aged 75–79 years. The trailing off in pop-

**Table 2. Distribution of residents aged 60 years and over compared with distribution of clinic registrants during first 17 months of Queensbridge health maintenance service, by age groups**

| Age group (years) | Residents | | Clinic registrants | | Percent registrants in each age group |
|---|---|---|---|---|---|
| | Number | Percent of total | Number | Percent of total | |
| 60–64 | 254 | 18 | 81 | 13 | 32 |
| 65–69 | 377 | 27 | 167 | 26 | 44 |
| 70–74 | 391 | 28 | 181 | 29 | 46 |
| 75–79 | 246 | 17 | 139 | 22 | 57 |
| 80 and over | 142 | 10 | 70 | 10 | 49 |
| Total | 1,410 | 100 | 638 | 100 | |

ularity in the over 80 age group (last column table 2) is probably accounted for by the higher percentage of homebound in this group.

Fifty-six of the 623 persons living alone and 44 percent of 787 persons living with someone else registered during the first 17 months. In October 1963, the mean ages were 71 years for the total population, 72 years for men, and 70.5 years for women.

### Emergency Service

In February 1964 emergency services were made available in the home or by telephone during hours when the clinic was closed. Patients were notified of the service by mail and during contacts with clinic staff. An identification card mailed to each patient included instructions and telephone numbers to be called by nonwelfare and welfare patients.

Telephone calls from nonwelfare patients are handled by an answering service. After the operator inquires as to the nature of the emergency, she relays the message to the physician. The physician either visits or telephones the patient, depending on the kind of emergency.

Public assistance patients call a special department of welfare number, and their messages are relayed to one of the volunteer private physicians who works at the clinic. Occasionally, a local Health Insurance Plan group also provides emergency service. However, the use of physicians on the clinic staff is preferred, because they are familiar with the policies and procedures of the Queensbridge clinic and the Elmhurst hospital. Information concerning each call, whether handled by telephone or home visit, is entered on the patient's clinic record.

By the end of December 1964, the physicians had made 107 home visits and 23 telephone consultations. As a result of the emergency calls, 11 patients had been hospitalized. The cost of the services, including telephone answering, averaged $137.75 per month.

### Participation of Other Agencies

*Welfare department.* When the Queensbridge program started, an appreciable number of the housing project residents over 60 years of age were under the chronic care program of the welfare department, and subsequently the two programs were merged. The welfare department assigned a physician, a member of the medical staff of Elmhurst General Hospital, to a daily session at the Queensbridge clinic. This physician sees all the welfare patients, whether or not they are under the chronic care program. Two chronic care patients who are not able to attend the clinic are visited at home by the physician. However, the welfare department's medical records for the two patients have been transferred to the clinic, which has assumed responsibility for their supervision and ancillary services.

*Home aides.* The home aide service, introduced in May 1962, was conceived as part of the total health maintenance prescription for certain patients or households. With the cooperation of the city housing authority and the Jacob Riis Neighborhood Service, home aides were recruited among the younger residents of the Queensbridge Housing Project. The social work consultant screens applicants, and hires, trains, and supervises the aides. The service started with one aide; after the first year it was expanded to its present complement of five.

Home aides work 8 hours a day, 5 days a week, and they are paid $1.50 per hour. The five aides serve 38 households consisting of 44 persons. Most households are given a half day of service per week; a few a half day twice a week. Since the program started, more than 200 persons have received service for varying lengths of time. The service is not offered patients on the hospital's home care program or on public assistance, because somewhat similar service is available to them through the hospital or department of welfare.

A home aide is assigned only on written order of the patient's physician or the psychiatrist. Each aide is briefed by the public health nurse as to the particular needs and problems of the patient or household. If a patient is being seen by the clinic psychiatrist, the aide is also briefed by the psychiatrist. The aides submit brief weekly reports on each patient or household, and they also report immediately any abnormal change in patient behavior or in the home situation.

*Home visitor.* A commmunity worker, one of Jacob Riis Neighborhood Settlement's many

contributions to the program, not only processes initial registration of patients, but also serves as a home visitor, primarily to shut-ins. We are fortunate to have a knowledgeable, compassionate, and extremely skillful worker. The following excerpt from one of her reports reveals her insight as well as a few of the tasks she performs.

> Help is given as needed by the home visitor. Welfare problems are discussed and cleared, and referrals made to various agencies. Repeat visits are made when necessary. Where medical attention is immediately needed, the home visitor contacts the health maintenance clinic; arranges for wheel chair service if possible; and if the patient is bedridden, contacts the public health nurse who sends the doctor to the home of the patient. He in turn arranges for medical care or hospitalization.
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> Nearly all of these individuals arbitrarily refuse to go to institutions—feeling that by doing so they are being shunted off, that living stops, and that they are just waiting. They like being 'at home.' It gives them a feeling of independence. Their greatest need is to feel needed. Perhaps some day there will be a program that will completely meet the requirements of the homebound and end the present unpleasant picture of these shut-ins.
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> Many elderly people exist on incomes that are too low. They do not understand public assistance and that they are probably eligible for it. This is a delicate matter to interpret as they are fiercely proud.

*Sheltered workshop.* Bird S. Coler Memorial Hospital and Home, a municipal institution affiliated with New York Medical College, provides long-term care and special services for the chronically ill. It is located within a short bus ride from the housing project. The institution operates a sheltered workshop for both older people and the chronically disabled. Its program includes use of power machines, sewing, cutting, gluing, and assembling.

Late in 1962 arrangements were made to allow Queensbridge patients of both sexes to work in the sheltered workshop. Since then, depending on the availability of work, up to 24 Queensbridge patients have been employed there. As of March 1965, 20 patients were working and earning from $8 to $22 per month. Each patient works a minimum of 2 hours a day, 4 to 5 days a week.

The workshop constitutes an important item in the Queensbridge program. Its goals are to maintain and restore self-esteem and dispel feelings of uselessness, to prevent boredom and loneliness, to provide a more structured pattern to life, and to supply added income.

For the hospital and its affiliated medical school there were other objectives. The patients constituted a "research laboratory" for the study of work-centered problems of older citizens. It also offered a way to test the ability of a sheltered workshop to meet, through use of a common program, the often differing needs of hospital patients and community residents.

### Evaluation

The results of an extensive evaluation of the Queensbridge health maintenance service, underway since the receipt of a Public Health Service grant in April 1962, will be presented in a future report.

The medical phase of the evaluation will attempt to determine (*a*) the degree to which the program met individual health and medical needs, (*b*) the extent to which the program has been effective in providing prompt, early diagnoses, and in motivating patients to use approved therapeutic regimens, and (*c*) the incidence and nature of morbidity, disability, and mortality in the Queensbridge population over 60 years of age.

Through the use of questionnaires, the evaluation will also attempt to provide data about the degree to which the program enables the older person to live independently as an active member of the community, the degree to which the program has been acceptable to the elderly, and the program's impact on their health attitudes.

### Elsewhere in New York City

Within months of the opening of the Queensbridge health maintenance service, the City Housing Authority, applying its own yardstick to assess the program's early accomplishments, found that many of its problems concerning elderly residents of Queensbridge were solved. About the same time, the City Housing Authority needed to crystallize plans for a group of housing projects that were almost in the blueprint stage. Each project would not only contain 200–400 apartments designed for older persons, but also many other 3-room apartments for possible rental to the elderly. The

authority pressed the health department as to whether any of the projects should have health maintenance clinics which the department would operate. The health department did not have time to wait for the evaluation of the Queensbridge program. Therefore, based on acceptance of the program by participating agencies and the high percentage of response by patients, the department agreed to operate facilities in five of the housing projects.

The health department decided that where a project was in an isolated location, the program would be similar to that at Queensbridge, with a full array of preventive and therapeutic services. On the other hand, where the housing project was located near a general hospital, the service would be simpler. Although the clinic would be a unit of the hospital's outpatient department, it would not provide all the therapeutic services offered at Queensbridge.

Plans for additional health maintenance service for the elderly have not been limited to housing projects. The concept of this service within a hospital setting developed soon after the Queensbridge program started. Around that time the city of New York began planning construction of a number of hospitals, and each of these facilities, whether for acute or long-term care, would feature a fully integrated health center. Included in the ambulatory care program would be a health maintenance service for the elderly.

Each of six facilities now in the planning stage and a seventh under construction includes a health maintenance service for the elderly, to be patterned after Queensbridge. Day centers for the elderly will also be designed within a few of these hospitals. Where day centers already exist close to the site for the planned combined hospital-health center, they are not included in the blueprints.

Thus, the pattern for the future of health maintenance services for the elderly in New York City has been largely determined. Many of the unique and precedent-setting features of the Queensbridge program will be applicable in future housing-project services. Among these features are the special relationship of the health maintenance clinic to the various hospital services and resources, particularly the outpatient department; the administrative and technical direction by the department of health; the pattern of staffing; the family physician concept; the recordkeeping and communication systems; the assimilation of major elements of welfare medical programs; the various home and hospital visiting activities; and other program elements developed or pioneered at Queensbridge.

The need for certain of the features cited is obviated when the health maintenance service is to be located within the hospital setting. However, other features, although unusual in a hospital outpatient department setting, can nevertheless be useful and important: the family physician concept, the easy availability of the public health nurse when the patient's physician is not available, and the inclusion within the confines of the health maintenance clinic of such services as podiatry, optometry, proctology, nutrition, mental health, social work, routine laboratory and electrocardiogram procedures, and a pharmacy. These features are being planned for each of the seven facilities previously mentioned.

### Future Plans

Although considerable planning for the future has already occurred in advance of the Queensbridge evaluation results, it is anticipated that future programs will have the necessary flexibility and adaptability to make use of the results. It is also expected that the further development of such programs in New York City will probably be compatible with Medicare.

Undoubtedly the Queensbridge program will continue to be a major research tool for delving into the medical, health, social, and recreational problems of the elderly as well as the methods of organizing to meet these problems. It can also serve for studies and pilot activities aimed at demonstrating the value of new kinds of preventive or therapeutic programs. Research proposals in all the areas mentioned are being explored. Currently, a comprehensive mental health program and a stroke prevention program are under consideration.

#### REFERENCE

(1) Starin, I., Kuo, N., and McLaughlin, M.: Queensbridge health maintenance service for the elderly. Public Health Rep 77: 1041–1047, December 1962.