TESTIMONY BEFORE THE

U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON FINANCIAL SERVICES
SUBCOMMITTEE ON HOUSING AND COMMUNITY OPPORTUNITY
Hon. Maxine Waters, Chairwoman

HEARING ON

LEGISLATIVE PROPOSALS TO INCREASE WORK AND HEALTH CARE OPPORTUNITTIES FOR PUBLIC AND SUBSIDIZED HOUSING RESIDENTS

PRESENTED BY
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Good morning, my name is Suleika Cabrera Drinane. I am the Founding President and Chief Executive Officer of the Institute for the Puerto Rican/Hispanic Elderly, which is a not for profit minority-based, multicultural, and multilingual citywide human services network of programs and services that serves Latino, African American, Asian and other ethnic minority seniors, and their families.

I am proud to appear before this Subcommittee today on behalf of the Institute, as well as its Hispanic Senior Action Council, in **full support** of **Congresswoman Nydia Velázquez' legislative proposals** under consideration by this Committee.

The Together We Care Act, as well as **the Earnings and Living Opportunities Act,** is each an example of Congresswoman Velázquez' longstanding support and tremendous concern for our poor and low income seniors, and families, in this city, state, and nation.

I want to thank the Sub-Committee for this opportunity to declare our full support for these two worthy proposals, and to speak on several issues that are very much at the core of the Institute's mission, ***and are my passion***—**First,** the elimination of health disparities for our Latino, African American and minority community,

Second, securing **fair-share and access** to real job training and employment opportunities, and, **Third,** protecting our older adults to ensure that they get their **full benefits and entitlements** as well as the critical supports and services necessary to **age in place** within their community and **with dignity** rather than suffer displacement, isolation or institutionalization.

The Institute has come a long way over the last 30 years. Today we serve over **100,000 seniors** annually through our city-wide network of programs, 11 senior centers—the majority of which are located in **public housing**; senior and other housing developments; a fully licensed Homecare Agency, and State licensed Mental Health Clinic. **The Institute's 5000-member Hispanic Senior Action Council** has become a strong advocacy arm, and we are proud of our accomplishments. However, our gains for Latino and other minority seniors over the years are today seriously compromised by the economic crisis and the worsening levels of poverty, health disparities, unemployment, and homelessness, which plague our communities and that have not been successfully and systemically addressed.

In the late 90's, the **Clinton Administration's National Disparities Initiative, released the "Healthy People 2010 Report" as a** strategic plan to eradicate these disparities as well as increase the numbers and the status of **minority health professionals** in the Health System across the country.

A subsequent report issued in 2002 by the **Institute of Medicine**, ***Unequal Treatment***, beyond documenting the [quote] "deep and pervasive disparities in health and health care for racial and ethnic minority populations in the United States" [closed quote], also noted how **little** had been done to date to meet this challenge. It noted that the Clinton

Administration's ***National Disparities Initiative*** had given the problem an **"appropriate moral urgency"** and had provided a national platform to demonstrate the stark and disproportionately greater burden of disease, disability, and death experienced by racial and ethnic minorities. **It was nationally documented that:**

- Hispanics were twice as likely to suffer diabetes as whites,
- THAT, 26 percent of mainland Puerto Rican Americans between ages 45 and 74 have diabetes.
- THAT, the number of uninsured Hispanics nearly doubled from 1990 to 2002—from 6.9 to 12.8 million.
- THAT, African-American women are four times as likely to die in labor and delivery as their white counterparts.
- THAT, African-Americans males over 65 years are twice as likely to have prostate cancer.
- THAT, dramatic disparities in adult immunizations, which speaks to lack of access and education indicate that while Forty-seven percent (47%) of whites receive the pneumococcus vaccine, thirty-four percent (34%) of Hispanics, and thirty percent (30%) of African-Americans, over the age of 65 years are vaccinated.

The Institute's experience in New York City evidences an **even more serious dilemma** with significant concentrations of poor and low income minority seniors and families within Public Housing and other subsidized developments that lack adequate services and supports for job training and employment, let alone healthy aging and aging in place.

New York City has the largest concentration of Public Housing in this nation. For Example, two communities among the many that we work in, *East Harlem (El Barrio) and the Lower East Side (Loisaida),* have some of the largest concentrations of Public Housing in this City. Our most recent analysis of New York City Housing Authority (NYCHA) data shows that in many of the large developments within these two sample communities, Heads

of Households that are 62 years of age and above already account for well over 40 percent of all Households. Some developments present figures as high as 63 percent!

There is no doubt that the number of seniors has increased over the last decade, and will continue to do so **exponentially** in Public Housing. Already, there is a serious issue of isolation, depression, lack of adequate nutrition, and generally unhealthy aging in these developments.

By the same token, the rate of unemployment and the lack of adequate job training and access to good jobs for residents in Public Housing is a major crisis.

There is no doubt that the legislative proposals on the table today, go a long way to form the basis of a great model that can have a significant impact and lay the ground work for replication in many more deserving Public Housing developments.

If I may say, the only disappointment I encountered in my reading each proposal is that I believe that the appropriation for each is too low given the potential and promise of the intervention, in the face of the substantial problem it intends to tackle.

Nonetheless, we believe that given the support and resources, community based organizations, such as the Institute and others like community health centers are best suited and can be instrumental in providing the training and services to public housing residents and the elderly as described in these proposals. We know how to make this work at the community level and with the active participation and support of local residents.

Time does not permit a full reading of our testimony. Therefore, as suggested by the Sub-Committee, we have attached as part of this testimony, more specific answers to the issues and questions your invitation posed to us, and that we address as organizations and

practitioners that are on the frontline working every day with the elderly and their families in Public Housing.

We commend Congresswoman Velazquez for conceptualizing and proposing what we believe can be a significant model worthy of broader replication, for tackling two fundamental but complementary dilemmas in Public Housing—elderly residents who need homecare, and fellow residents who need good jobs, with benefits in a growing employment sector. The Institute stands ready to assist in any way to ensure that both proposals are affirmed.

Thank you.

INSTITUTE FOR THE PUERTO RICAN/HISPANIC ELDERLY

Attachment

Specific Issues/Questions:

1. We believe that community based organizations, such as the Institute and others like community health centers can be instrumental in providing training and services to public housing residents and the elderly. For example, the Institute can do so both on-site within our senior centers (many of which are already in public housing) or off-site at the individual housing sites in the community, when warranted. Training and provision of services is usually provided through partnerships with local hospitals that usually go into the communities to perform regular screenings to include blood pressure and glucose monitoring. Bone density, vision, hearing, and podiatry screenings are also offered.

2. Besides senior centers, the Institute has various housing developments and outreach/ satellite offices strategically located citywide as well as private home care agency that

accepts referrals for and places home health aides and home attendants in the client's homes.

Within the community, staff is appropriately trained to assess, make referrals, and facilitate a client's application for home health care. At times, clients are in need of but are resistant to care. IPR/HE staff is knowledgeable and provide counseling to clients to explain the process and all options available to the client including health care.

Staff facilitates medical appointments scheduling and obtaining transportation. They provide follow-up with the client to ensure the physician has completed referral forms and will mail or hand-deliver the application to CASA for processing. If necessary, social work staff will strengthen the application by providing an additional advocacy summary explaining the clients need for homecare. Often, this additional summary is very persuasive and influences the final favorable decision granting homecare services to the client. The staff follows up with the client and counsels them on the process, next step, to accessing care carefully explaining all the client should anticipate. When referred to the city, it can take up to 30-45 days for the client to be seen and their papers to be processed.

3. The Institute follows the client throughout the process, evaluates the client's satisfaction upon placement of the home attendant, and will follow up with regular recertification. The Institute can be more hands - on whereas local community clinics will instruct clients on what to do and expect the client or caregivers to follow through on their own, which presents various issues such as,

- Clients may be isolated and not able to access care due to not getting to the doctor because of lack of transportation/ lack of money/ language barriers.
- They may not be aware these services are available or how to access them.

- Clients are resistant to accepting care because they feel their independence will be taken away.
- The application process is too long and confusing.
- The referral form (M11Q) is valid only for 30 days only before it expires. If it expires, the client must go back to the physician to get another referral form completed.
- In subsidized housing, the rooms may be too small. CASA will not allow 24 hour care in an SRO (Single Room Occupancy).
- On occasion, clients are discouraged due to costs i.e. over-income and must pay for a spend-down. Most do not know about spend downs. Also, if they qualify, a spend-down may be a hardship for them. Even worse is pooled income trust which is very confusing.
- Clients do not know their eligibility or their rights.
- Clients are discouraged by family members who may be taking advantage of them.

4 &5. In theory, it is somewhat innovative. Optimally, the workforce will be increased to accommodate the increased numbers of older adults. Revenue for NYCHA will be increased. Currently, the New York City Department for the Aging (DFTA) takes older unemployed Public Assistance recipients and trains them to become home health aides. A partnership with a program like DFTA with an already established training program should be explored as they have certified trainings and standards in place (which the legislation has not identified). DFTA can increase the number of participants that reside in Public Housing as they are training and direct the certified home health care workers to NYCHA developments. Funds can be directed to re-employing Service Coordinators who are the first line responders to coordinate care.