Testimony for Committee on Financial Services
Subcommittee on Housing and Community Opportunity
By
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Attn: Work and Healthcare Opportunities Field Hearing
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Good Afternoon. My name is Larry McReynolds, Executive Director of the Lutheran Family Health Centers, a federally qualified health center network of 23 primary care sites in southwest Brooklyn which serves as the primary care provider for 89,500 people generating 550,000 billable visits annually. We are one of the largest and oldest federally qualified health centers in the nation. Our health center's mission, like all federally qualified community health centers, is to increase access to quality health care and to decrease health disparities. Persons living in public and subsidized housing are among our target population as these residents are most definitely underserved, underinsured, have little access to health care and usually experience health disparities because of lack to resources, knowledge of resources and/or generally have been disenfranchised for a lifetime.

- 40% of residents in public housing are children (842,000)
- 2.3 million children live in Section 8 housing
- 330,000 or 15% of residents in public housing are seniors and approximately 400,000 or 8% of residents of Section 8 housing are seniors
- 33% of public housing and 35% of Section 8 housing households include a member who is disabled.

The Environmental Landscape of Public Housing shows:

- High rates of unemployment
- Generations of poverty
- Consistent threats of violence
- Pest infestation and other environmental hazards
- Lack of transportation
- Little space for physical activity
- Few grocery stores and healthy food options available

In 1991 the Department of Health and Human Services, Health Services and Resources Administration (HRSA) established the Public Housing Primary Care Program recognizing that community health centers were uniquely positioned with skills to need the unique needs of those in public and subsidized housing and thus dedicated these additional federal funds. These programs, like all community health center programs, provide high-quality, comprehensive, case-managed and family-based preventive and primary health care services to residents. The federal government has made a small investment in the value of services that health centers can provide to public housing and subsidized housing residents through the Public Housing Primary Care program but has funded enough of these programs nationally or taken the next step to provide engagement services or support services to get/keep residents in care.

1) Community health centers can be instrumental in providing training and services to public housing and subsidized housing residents and to the elderly in the following ways:

- Directly providing or contract for training of home health aides—many health centers have a strong base of existing certified health aide, vocational, residency and other training programs upon which to build. Health centers hire from the community that they serve, have a larger percentage of minority employees, and concentrate on employees that want to offer services in their own community. At Lutheran we have a history of providing similar training programs through city council funding, job preparedness grants and stimulus grants.
- Health centers are primarily located in low income neighborhoods, have staff that understand the unique need of this population, posses the cultural competence to implement realistic health care plans, have infrastructure and history of providing health care and support services, and hold a long-standing of integrity for achieving great outcomes with minimal federal dollars. In short, health centers know the pharmacies, grocery stores, police, and other support services that residents need and use. Health centers are best positioned to help care for the medical issues which the resident and their family may have and to serve as a medical home.
- 2) Community health centers can provide be instrumental in providing services because:
    - Frequently centers have facilities somewhat proximate to the housing facility
    - Have experienced staff that speak, understand and are trained to meet the needs of the housing population.
    - Have a thorough knowledge of federal/state assistance programs that can assist the resident in maximizing their ability to “age in place” and achieve a high quality of life
    - Have a billing structure that is sustainable—home visits, enabling visits and nursing visits are reimbursable
    - Health centers can deliver services on site, off sites
    - Health centers have electronic medical records which facilitate the communication of medications, care plans, immunization records and test results which can be accessed in the home and in the health center.

- In 2006 58% of residents were uninsured. This number clearly reflects that residents do not know and/or have not access the health care system. The majority of residents should be eligible for assistance programs. Through intervention prior to a catastrophic event health centers can help enroll residents in assistance programs and start the course of preventative care.
- In housing sites that have on site health care, there has been a remarkable increase in residents that access care:
- 34% increase in diabetic visits
- 35% increase in asthma visits
- 40% Increase in contraception visits
- 23% increase in hypertension visits
- 32% increase in Health Supervision 0-11 yo visits

Clearly the above statistics show that residents need care and will access care if given information in a culturally competent, accessible manner. With the increase of supportive home health aides that are peers, understand and know the residents, their lifestyles and barriers, residents will feel more comfortable in accessing care.

3) Challenges and obstacles associated with facilitating home health care services are:
    - Gaining acceptance by seniors that do not want strangers in their homes
    - Working with the "if it ain't broke, don't fix it" mentally. That is, helping residents to practice preventative care vs. waiting until a crisis occurs.
    - Residents may be unfamiliar with the health system, new treatments and medicines, and services available
    - Clients often lack supporting documentation to assist with medical assistance applications, have a lack of supportive family, and have cultural and/or linguistic barriers
    - Clients often have environmental barriers to receiving care and or getting better (lice, rats, fleas, lack of phone, fresh air, clean water, lack of food)
    - Clients often do not keep current on their eligibility for assistance programs thus making interruptions in services frequent

4) Challenges and obstacles that residents face in accessing home health care services are:
    - Little access to transportation thus resulting in waiting for an ambulance ride to an ER
    - Paranoia about accepting assistance
    - Many residents will not access care to due bad weather, darkness, etc. making keeping appointments nearly impossible
    - Language barriers
    - Lack of societal engagement

- Physical disability—the very fact that it takes so much energy just to get dressed and leave the facility to get medical care
- Fear of new places/people/ideas
- Money to get drugs, transportation, etc.
- Knowledge of qualification for services
- Denial that they need assistance because of their personal desire to maintain their independence
- Lack of telephone/documents

5) The legislation will lower the cost of elderly and disabled health care through:
    - Emphasizing compliance with care plans while giving the resident the assistance to comply with the care plan
    - Tying the resident to a medical home
    - Enabling the patient to "age in place" and maintain their health status and independence as long as possible, thus avoiding costly nursing home admissions
    - Assisting residents adhere to care plans that will increase compliance with treatment protocols.
    - Prevalence of chronic illness is double for almost every category in black women in housing vs. black women in the community. Therefore, diabetes, hypertension, and asthma have many more unnecessary ER visits and inpatient admissions because of the prevalence rate. Simply by aiding residents with these illnesses alone would save the system money.
    - Through review of medications, increased compliance with care plans and working with clients with co-morbidities the cost of care and transportation of care will decrease.
    - Currently the system requires an "identifiable event" which is usually a crisis event. Through putting the emphasis on prevention and avoidance of the "identifiable event" residents will maintain their health in their own homes longer. Quality in the right place, at the right time, at the right level of care. A review of ED visits shows that more than 40% of hospital ED visits is for unnecessary, non-emergent conditions. Through training the home health aide to work with the care team this number of avoidable ED visits can be reduced.
    - Because of the delayed entry into care, the condition is worse requiring more resources. Through early intervention, education and compliance there will be decreased falls, increase in diabetics under control, decrease of Chronic Heart Failure and Chronic Obstructive Pulmonary Disease presentations in EDs, and earlier intervention with senior that have depression/dementia.

Through this program, people will be put to work that largely otherwise would not work. These are neighbors and friends that care about their neighbors and understand their needs. Through creating a community that cares about their community, health status will increase, satisfaction with living in a housing community will increase and the overall health status will increase. The pilot program of community health centers started in 1966 has shown over and over again that residents are the best ones to design programs to meet their health care needs. Now, the community health center movement is the safety net of the nation. We need to take this next step to provide early access, supportive services for our most vulnerable.