HARLEM UNITED

Testimony of Jacquelyn Kilmer, Chief Executive Officer
Joint Legislative Hearing on Solutions to the Disproportionate Impact of COVID-19 on Minority Communities

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Thank you for the opportunity to provide testimony on recommended solutions to the disproportionate impact of COVID-19 on minority communities. My name is Jacquelyn Kilmer, and I am the Chief Executive Officer of Harlem United.

For the last 30 years, Harlem United has worked tirelessly to address the issues and concerns of underserved communities in New York City. Our mission is to provide healthcare, housing, and supportive services to those most in need, fighting for our communities' right to access these services equitably, without barriers of racism, stigma, or discrimination.

As a community based organization that started in the basement of a Harlem church in 1988 at the height of the AIDS crisis, today we provide a full menu of essential lifesaving services to Black and Brown communities historically excluded from culturally affirmative healthcare, dignified housing, and social services that extend an economic hand up. We provide primary care, dental and behavioral health services as a Federally Qualified Health Center with a Healthcare for the Homeless designation. We also provide supportive housing with almost 700 units across the City, prevention, and testing services, which encompass substance use treatment, syringe exchange, and harm reduction services. We ensure that clients in need also are supported by intensive care coordination, hot meals and pantry supplies, peer support, and more.

Each year, Harlem United engages over 10,000 clients across all of our programs, provides supportive housing for about 1,000 formerly homeless people, conducts almost 24,000 medical visits in its community health centers, and provides more than 20,000 hot meals and pantry supplies to low-income New Yorkers. Over 80% of our 320-strong staff reflect the communities we work with and bring lived experience and first-person cultural reference to the work they do. We reach our clients where they are, through on-site and mobile outreach services in the neighborhoods where they live, work, and play.

Harlem United's geographic service area and client population come primarily from neighborhoods in Central and East Harlem and the South Bronx. These areas include communities historically underserved and disproportionately impacted by COVID-19, with

infection rates of double the averages in more privileged areas of New York City. In addition, communities of color are at increased risk for experiencing serious illness if they become infected with COVID-19 due to higher rates of underlying conditions compared to whites[1]. Our clients identify as 64% African American and 35% Latino, with high rates of multiple chronic conditions, such as diabetes or hypertension. Nearly one-third are HIV positive and an estimated one-half are diagnosed with a serious mental illness or substance use disorder, which often interfere with their ability to maintain basic needs, such as food and shelter. Compounded by these disheartening medical conditions, 62% of the clients we serve outside of our community health centers were identified as homeless. For those patients of our community health centers, the numbers are even higher, with 71% identified as homeless.

Harlem United's commitment to healthcare equity over the last three decades has taught us important lessons about how to reach our clients and support them in accessing the services they need. We have developed an integrated program model that prioritizes hard-to-reach clients through one-stop co-located service provision, mobile services, neighborhood outreach, and partnerships with both traditional and innovative community organizations, such as churches and night clubs, respectively. Our experience helps to give us insight both into the impact of the pandemic on the communities we serve and on ways that the impact may be mitigated.

RECOMMENDATIONS

To mitigate the effects of COVID-19 on underserved, communities of color, it is important to consider both short and long term solutions.

Short term solutions, of course, are those more immediate actions that need to happen in order to stave off even more devastating damage to communities of color due to contagion and the ensuing societal and economic effects. Longer term solutions are those needed to address the inherent biases and barriers in the current healthcare system to ensure that all people have equal access to quality, affordable health care.

Immediate Needs:

Testing

We need to prioritize testing (both diagnostic and antibody) in the hardest-hit communities. That testing needs to be made available in a way that provides easy access in these communities without overburdening hospitals. Community health centers are on the front line in the communities that need to be served and are able to alleviate the burden on hospitals overflowing

[1] Artiga, S., Garfield, R., & Orgera, K. (2020, April 7). Communities of Color at Higher Risk for Health and Economic Challenges due to COVID-19. *The Kaiser Family Foundation.* Retrieved from kff.org.

with the more severe COVID-19 cases. We are uniquely positioned to be the first level of care, either in our brick and mortar facilities or through the use of mobile testing units deployed throughout the community to guarantee that all people have access to testing.

In addition to community health centers, other community based organizations located in and serving communities of color should be considered as viable alternatives to the traditional health care settings (whether clinics or hospitals) to provide testing and immediate connection to care as needed. For example, clients who access the services of syringe exchange and other harm reduction programs could be tested in those locations and immediately linked to care either within the same community based organization or in other health centers in the community using the services of care navigators. We know from our significant experience in HIV and STI testing that we are most successful in reaching people when we go out into the community and meet people where they are. We know that people can be reached in non-traditional sites in a way that cannot be duplicated in more traditional settings, particularly for people who are uncomfortable or unwilling to go to a clinic or other more traditional healthcare settings.

Scaling up and prioritizing testing in communities of color requires significant financial support for the community health centers and other community-based organizations where the testing would occur. With increased testing also comes a need for increased resources for follow-up to ensure that individuals testing positive remain connected to care and adhere to isolation protocols, including linking homeless individuals to available isolation units. Funding will be necessary for increased personnel costs to cover the additional staff necessary for testing and follow-up, testing training (including COVID-19 contact tracing training) for staff, testing kits, adequate supplies of personal protective equipment for staff, and cleaning and disinfecting supplies for the increased cleaning necessary to reduce the risk of contagion. In addition, it may be necessary for the community health centers and community based organizations to make renovations to their brick and mortar facilities and/or mobile units to keep staff and clients safe, such as the addition of plexiglass dividers to shield testing site check-ins or kiosks and space additions to waiting areas to accommodate social distancing requirements.

Regulatory and Payment Changes

It is time to reimagine the design and scope of community healthcare to make way for a more accessible mode of care for all patients, be they housebound due to disability, social distancing restrictions or personal preference, while ensuring that providers are adequately compensated for the services they provide. While certain rules and regulations have been loosened during this pandemic (for example, for provision of telehealth services), many of these modifications should be made permanent. Regulations surrounding remote service delivery of services such as primary care, behavioral health, and care coordination, should ensure that providers are reimbursed for services at the same rate as these services are reimbursed when services are conducted in person. In addition, regulations should be changed to allow for the provision of certain services, such as

diagnostic and antibody testing, outside of clinic settings and to allow providers to be reimbursed for services provided in non-traditional/non-clinic settings.

Technology Investment
We need significant investment in IT infrastructure and support in order to effectively move in-person services to virtual platforms. Mental health needs are on the rise, with mental health providers experiencing incredible increases in demand[2]. Our community is experiencing increased levels of grief, isolation, and anxiety, as well as everyday challenges around access to food, stable housing, and employment. Telehealth will enable people to stay connected to services, family, and society during social distancing periods of isolation. Generally, these costs have had to be foregone to keep the lights on for most community healthcare and social service organizations, which will require significant upgrades to meet this need.

Also, many individuals in low-income communities and shelters do not have access to necessary technology to be able to keep them connected to care through their case managers, therapists, and providers. In a recent internal survey at Harlem United, nearly half of our primary care clients did not have access to internet or smart phones, limiting their access to healthcare during this period of social distancing. Funding is needed to make technology available to all.

Medical Respite Facilities
We need to greatly expand the number of COVID-19 medical respite accommodations for convalescing or exposed community members requiring quarantine or post-hospitalization respite. This would be especially important for people living in shelters, temporary housing or other densely populated housing with shared bathrooms and kitchens to avoid contagion. This is a critical need for congregate housing, nursing homes and other live-in care situations. It is also a critical need for those people who live in multi-generational family settings, which is common in many neighborhoods in communities of color.

Long Term Needs:

The disproportionate impact of COVID-19 on communities of color exists because of the serious structural barriers to accessing quality, affordable healthcare, and historical treatment of people of color in the healthcare system which has led to distrust in the medical profession as a whole. Structural racism and socioeconomic injustice have intertwined to create issues of housing instability, food insecurity, and the inability to earn living wages which are only getting worse as a result of the pandemic. While we speak eloquently about social determinants of health, now more than ever, addressing social determinants of health must be more than just an aspirational

[2] Smith, V. (2020, April 21). How New York Is Battling a Second Crisis Alongside COVID-19: Mental Health, *CityWatch.* Retrieved from marketwatch.com

goal. In order to improve and maintain the health of marginalized communities, we must address access to housing, food, and employment. We must make quality, affordable housing, healthy food options and livable-wage jobs available to every New Yorker. This will take significant and ongoing investments from every level of government. We must also address the distrust of the healthcare system by ensuring that there are safe, affirming, compassionate places for communities of color to receive care.

Additional significant Medicaid enrollment is inevitable given the economic impact of COVID-19. Now is not the time for cuts to Medicaid or to the rates paid to mainstream or Special Needs Plans, or the rates at which providers are reimbursed. It is not the time to take a source of annual revenue (in the form of the 340B prescription drug rebate revenue) away from safety net providers.

Already, the nonprofit community-based organizations are working with extremely challenging financial limitations, with serious gaps in both the State and City budget which threaten FQHCs, HIV services, mental health services and supportive housing. Funding for existing programs should not be diminished, but rather increased, in ways that consider the future needs of our community. We damage our society's healthcare safety nets at our own peril.

As we face the greatest recorded unemployment rates in our nation's history, it is time to look at changing the way we think about employer-based health insurance. We need universal health care (a la the New York Health Act) like never before. This needs to be an achievable goal.

We must start to look at the systemic inequalities that are woven into the fabric of our society. This is a time for partnership and collaboration on a scale that we have not seen in America since The New Deal. We need substantive partnerships between non-profits, social service providers, and City and State (and Federal) government. We need to work together to provide services and resources during this unprecedented time and beyond, but we need adequate and sustained resources to do this.