CCR 3 Meet 216

NEW YORK STATE ADVISORY COMMITTEE ON THE

1 U.S. COMMISSION ON CIVIL RIGHTS

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3 IN THE MATTER

4 - of -

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6 Long-Term Shelter and Nursing Care
for the Minority Elderly.

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9 MINUTES OF PROCEEDINGS held at the T. J.

10 Dulski Federal Building, Conference Room 31, 111 West

11 Huron Street, Buffalo, New York, on Monday, October 29,

12 1990, commencing at 9:00 A.M.

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14

15 BEFORE: WALTER OI, Chairman.

16 RICHARD COX

17 PAULA CIPRICH, ESQ.

18 SETSUKO NISHI

19 TINO CALABIA

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jec/sh/

1 CHAIRMAN OI: Good morning. My name is
2 Walter Oi. I chair the New York State Advisory
3 Committee to the U.S. Commission on Civil Rights.
4 With me this morning are Dr. Richard Cox, Attorney
5 Paul Ciprich, Dr. Setsuko Nishi and staff members,
6 Dr. James Cunningham and Tino Calabia.
7 The eleven members of each of the
8 Commission's staff advisory committees are residents
9 of different areas of their respective states and
10 they serve as the local eyes and ears of the eight
11 commissioners in Washington, D. C.
12 The Commission and its 51 state advisory
13 committees inquire into issues pertaining to
14 discrimination or denials of equal protection based
15 on race, color, religion, gender, age, handicap, or
16 national origin, or in the administration of justice.
17 Let me welcome our panelists and other
18 guests who for several weeks have put up with the
19 uncertainly of knowing whether any of us would meet
20 her in Buffalo today. The Committee and I are
21 appreciative of your patience, but the uncertainty
22 which increased day by day in the last two weeks,
23 was, as you know, reflective of the larger
uncertainty related to the passage of a federal

1 budget for the current fiscal year.

2 At any rate, our panelists this morning
3 have been invited to share information and their
4 views on long-term shelter and nursing care for the
5 minority elderly. We are looking at the older
6 population in New York State's minority communities
7 and to what extent these elderly may or may not
8 enjoy equal access to long-term shelter such as in
9 nursing homes or to facilities such as hospices.

10 Because of your work with the minority
11 elderly, our Committee is gratified that you have
12 volunteered to provide information and offer your
13 views today. I should add that the press was
14 informed of the forum and any members of the
15 audience will have a reasonable opportunity to offer
16 comments as well.

17 The proceedings are being transcribed, and
18 the transcript will be maintained in the offices of
19 our Washington staff in accordance with the Privacy
20 Act. Let me explain that for access to information
21 provided by you and stored in Washington, you may
22 contact the Commission's solicitor at the address
23 shown on the agenda.

Federal also requires that all persons

1 refrained from degrading or defaming any individuals
2 when providing information. At the same time, all
3 persons presenting information have the right not to
4 be reported or photographed by the media. Should
5 you wish to exercise this right, please let us know
6 so that your request can be accommodated.
7 We anticipate issuing a summary report of
8 this forum. It will be based on the transcript,
9 supplementary interviews and any other relevant
10 information now in our staff's files or obtained in
11 the coming weeks. Having stated these requirements,
12 let me welcome our guests and our audience.
13 Would Deputy Speaker Eve and the other
14 guests on Panel I please come forward?
15 I'm going to ask Prof. Cox of the
16 Department of Political Science at the State
17 University of New York at Buffalo to chair the
18 discussion this morning.
19 MR. COX: Mr. Eve, are you ready to give
20 your oral testimony.
21 ASSEMBLYMAN EVE: Yes, I am.
22 MR. COX: Let me repeat something that
23 Prof. Oi has said, if you have documentary material
to be included in the further record, you can

1 certainly feel free to give it directly to Tino at
2 this meeting or to send it to an address that we
3 will give to you to be sent to Washington.
4 ASSEMBLYMAN EVE: Good morning. First of
5 all, I appreciate your holding your meeting in
6 Western New York and giving some of us an
7 opportunity to share with you some of our concerns.
8 I apologize for being late because at 8:00 o'clock
9 this morning we were meeting at the District
10 Attorney's office to discuss the violence and crime
11 in the near east side which is the prodominantly
12 African-American community and we have all of the
13 law enforcement people there, from the federal
14 government down to the Chief of Police for the City.
15 I also would like to ask for the record.
16 They gave me the statistics of violent crimes in the
17 City of Buffalo by precinct and you will see that
18 the precincts that have the greatest violence in
19 crime, are basically in my assembly district which
20 is the predominantly African-American and the
21 numbers are astronomical. That's another major
22 problem of minority elderly, is that many of them
23 who live in communities where there is great
violence, drug abuse, poverty and subsequently they

have many, many problems.

I'm not sure just where to start to talk about the problems facing minority elderly in New York State. You name it, they've got it worse.

When I say that, I am speaking of African-Americans like Tino, Native Americans and Asian Americans.

I will be holding public hearings in the City of New York the week of November 13th in which those three or four groups will be speaking before us and giving us an indication of the problems and solutions that they see to meet the needs of the minority elderly there in the City of New York.

Whether or not it's health care, social services, housing, lack of recreation, in-home services, nursing home admissions, if you go down the list of the elderly, what the elderly need, the minority elderly suffer a greater need. The problems are particularly acute for the frail and the most vulnerable of all society. African-Americans are the fastest growing population in New York State and many of them fall into this category. The national average of frail and very vulnerable elderly is 6%. The minority community

1 in New York State, that is 36%. That's 4-1/2 times
2 the national average.
3 What does it mean to be in this category of
4 frail and very, very vulnerable? It means that in
5 most cases they have no pension, the vast majority
6 have a total income of less than $6,000 annually.
7 It means that you don't get to go south or west for
8 the winter months, you are stuck in the cold and
9 depending upon social services to survive in an
10 often cold and insensitive world.
11 Since you are 75 or older, and I must note
12 that because of oppression, racism, many minorities
13 are vulnerable much earlier than 75. The life span
14 of African Americans in New York and in particular
15 Harlem was less than Aman and Bangladesh. So, the
16 life expectancy of many minorities is considerably
17 shorter and so they become very frail and very
18 vulnerable much, much earlier.
19 Many minority elderly in New York State
20 have a tremendous acute need for in-home services.
21 They are sick and the chances are because of
22 governmental policies at all levels, both federal,
23 state and local, they may get even sicker.
Unlike the average white senior citizen,

1 many minority elderly do not have personal
2 physicians. Many take their pains and hurts to
3 understaffed and overworked hospitals and community
4 clinics if they are able to get there. Very often
5 they don't even see a doctor until it's an
6 emergency. While the patient is suffering in the
7 emergency room, the hospital is figuring out what
8 Medicaid will or and will not pay. The bottom line
9 is the same, no pay, no stay.
10 Medicaid patients are often pushed out of
11 the hospital as far as possible, out of the hospital
12 sick and alone into their homes. They are often
13 drafty, substandard housing where they can add
14 pneumonia to their list of potential ailments. The
15 result is a near crisis and in-home services
16 throughout New York State for minority elderly.
17 Minority elderly need home care at four to five
18 times the rate of white seniors.
19 Government in many areas are concentrating
20 their efforts on the wrong end of the spectrum. We
21 shouldn't wait until the elderly get too sick to
22 take care of themselves, spend more money on the
23 front end is what we need to do on prevention, on
education, decent, safe, affordable housing and on

1 early detection.
2 Instead, minority elderly are often trapped
3 in a downward spiral where they can't get proper
4 care at the hospital or at the home, their health
5 deteriorates to the point where they cannot stay
6 home and they need nursing home or other long-term
7 care.
8 Again, that's another place where I'm very
9 pleased with your hearing today, where the needs of
10 the minority elderly in New York State are
11 especially critical. The state has published
12 several years ago a report that clearly shows that
13 minorities are in fact discriminated against in
14 admissions in nursing homes here in New York State.
15 If you are white in New York State, your chances are
16 about three times better than an African-American
17 trying to get into a nursing home. The same thing
18 is true for basically all minorities.
19 I could go on in talking about the problems
20 of minority elderly in New York State, including
21 food stamps, lack of insurance, lack of SSS
22 outreach, transportation, isolation. Many elderlys
23 live like prisoners and the information I will share
with you about the high crime in very small

communities means that many of these elderly cannot go out in the evenings and there are examples of some of them being trapped who were not well and money is being taken and stolen from them.

Today I hope and I am sure many of the speakers and I am glad that you have some of the most prominant people in Western New York testifying before you today, have been involved in the issue of minority elderly for a very, very long time but we must also look at these issues without looking at them with blinders. It is a total picture I hope you will look at and begin to unravel these problems and to weave a network of services that meet the needs of minority elderly.

We can't keep leaving the elderly in general and the minority elderly in particular, unprotected because public policy is unfair and misdirected.

Our Committee, and I would just like to end on this, we started our first hearing in Buffalo and this is a Committee of the New York State Assembly that I asked to be established. The speaker told me he couldn't give me any more staff, that I would have to take on this responsibility with my existing

1 staff and we have taken it on. We are attempting to
2 go throughout the state and I would welcome the
3 Commission if they would love to be with us as we go
4 to New York City for hearings in three of the
5 boroughs in which we are inviting people from all
6 five boroughs to participate in and I was in New
7 York this week setting up and ensuring that we would
8 have participation from all of the minority groups
9 there in the City of New York and I welcome you to
10 join with us. We are inviting all of the
11 Congressmen, all of the City Councilmen, all of the
12 State Legislators there in the City of New York to
13 participate with us and we would welcome your
14 participation.
15 Thank you so very much.
16 MR. COX: I'm going to suggest that because
17 I understand that you may have to leave early, that
18 we entertain questions from the Advisory Committee
19 members or anyone in the audience.
20 I would calculate that we can have, given
21 the number of speakers, 15 to 20 minutes a person
22 through the morning. You have taken of your time so
23 I think it's appropriate that we have some
questions, please.

PROF. NISHI: Yes, thank you very much for your presentation. First of all, I would like to request that the report that you referred to pertaining to the admission of minorities to nursing homes, if that be submitted to our attention.

ASSEMBLYMAN EVE: I would be very happy to get it for you.

PROF. NISHI: It's sounds very interesting.

I would like to ask whether you have any documentation pertaining to the equitable use of public monies through HUD and so on in long-term care?

ASSEMBLYMAN EVE: I don't have that that per se but the State Department of Aging may have that information. We know that a lot of the dollars are limited. This is what we are finding, many programs are made available but minority communities were not organized to take advantage of those resources. Whether or not it was a community service act and which I sponsored in 1978 and a lot of other programs, as this minority population is growing in elderly, 48% of the increase in this state is minorities, it is in fact growing by leaps and bounds and all of the dollars have been used up.

1 The agencies will tell minority groups,
2 what do you want us to do, take them from the other
3 agencies that are using these resources in their
4 communities because they have been doing it a long
5 time?
6 That's a major problem. Any new dollars
7 for the aging, and we are going to be recommending
8 this on the state, they must be targeted resources
9 for this very, very, I'm telling you, hurting
10 population and one of the recommendations I think
11 will come out of our hearing is a fund, a
12 discretionary fund given to the State Department for
13 the Aging to target it into those communities that
14 do not have the services that other communities have
15 and provide more outreach in making many of those
16 people trapped in their communities, aware of the
17 services that are available and that's a major
18 problem. Many people are not aware of it.
19 PROF. NISHI: When those that are managing
20 these long-term facilities make the decision as to
21 whom they should admit, despite the use of public
22 money, is that permitted?
23 ASSEMBLYMAN EVE: It is not supposed to,
okay, it is not supposed to be.

PROF. NISHI: Is there any monitoring of that?

ASSEMBLYMAN EVE: Very little. From our experience, you have to understand, New York is a very diverse state and I'm a member of the Episcopal Church and there are Episcopal nursing homes. There are Jewish nursing homes, there are various ethnic and religious nursing homes and that in fact they do make priorities with their own religion, their own ethnic -- it is not legal. It is not legal to a degree but it has been the practice and it's been like that for years and years and years.

PROF. NISHI: It shouldn't be permitted.

ASSEMBLYMAN EVE: No, it shouldn't be. One of the things we are trying to do in this community, there is a church group, Grace Tabernacle and they are now embarking upon a very ambitious job of creating an African-American run nursing home and I must commend my colleagues from Western New York. We have provided, I would say $300,000 to $400,000 as a delegation to assist them in developing this nursing home which is culturally sensitive.

You have to understand that many groups, ethnic groups, like for example in Boston, the

1 Italians opened up a nursing home because they
2 wanted to have that kind of sensitive cultural
3 facility and I don't blame people for trying to take
4 care of their particular elderly group but
5 government in the private sector must also say, how
6 do we encourage and assist other groups that do not
7 have this sophistication and resource to also get
8 into this business to provide a culturally sensitive
9 nursing home for their particular community,
10 including diet.
11 I saw this example in Boston in this
12 Italian food, they use their particular religion and
13 it is something that exists and it will continue to
14 exist in New York State and one of the ways in which
15 we need to do it is to open up and we also need to
16 be aggressive in trying to provide for other groups
17 who would like to develop culturally sensitive
18 facilities for their particular groups. We should
19 encourage that.
20 MR. COX: May I ask one question? The
21 American Disability Act which was just passed,
22 explicitly exempts religious organizations from
23 compliance with Title I unemployment. Wouldn't the
same sort of provisions apply to nursing, private

1 nursing homes?

2 ASSEMBLYMAN EVE: I believe you might be

3 right. I don't want to say that it is but we have

4 raised this issue. Constantly the statewide report

5 shows that minorities couldn't get into these

6 nursing homes. I have met with the nursing home

7 association in this area trying to open up. I

8 personally got involved with a number of minorities

9 trying to get them to nursing homes and because of

10 who we are, we have been somewhat successful but

11 people working on their own in many areas, have not

12 had the same level of success. We need more nursing

13 homes. The state as you know limits the number of

14 nursing home beds. In this area, we need many, many

15 more than what the State of New York will allow.

16 CHAIRMAN OI: It may come under Title III

17 of the Act which deals with services that are public

18 in nature and you might want to look at that.

19 ASSEMBLYMAN EVE: Thank you very much. One

20 of the things that we have done in the New York

21 State is that we have a special needs category

22 within nursing homes and that's how we are able to

23 get this minority nursing home hopefully established

because there is a special need that has been

1 established by virtue of the minorities not having
2 access to other nursing homes. So, we have been
3 working to try to establish this. There is only one
4 other there in New York City and with the large
5 minority population, I'm in hopes that we will be
6 able to develop for Afrian-Americans like Tino,
7 Asians and Native Americans and the Native Americans
8 on the Reservation, I visited some of them are
9 probably treated worse than the minorities off of
10 the Reservation. So, we have a significant problem
11 here in New York State.
12 MR. COX: Are there any other comments or
13 questions from the members who are present? We said
14 we would welcome those if you would like to make
15 them.
16 (No response.)
17
18 If not, I think we will move along because
19 we do have a large number of persons to take.
20 Thank you very much, Mr. Eve, for coming
21 and being with us.
22 ASSEMBLYMAN EVE: You have some of the best
23 experts here; two people that will be testifying
shortly have done a lot of research for us and with

1 us.

2 Thank you.

3 MR. COX: Next on the list is Arthur Cryns,

4 who is the Senior Research Professor,

5 Multi-Disciplinary Center on Aging at SUNY, Buffalo

6 which is, as most of you know, I guess, is the

7 graduate center here in Western New York of the SUNY

8 system and I will simply take a moment here while he

9 gets organized and have him give his presentation.

10 DR. CRYNS: Thank you, Mr. Chairman.

11 What I would like to use my time for is

12 essentially, Mr. Gorey who is a research associate

13 and myself, have spent some time in essentially

14 doing two things: To review the existing literature

15 nationally on the utilization of health care

16 services by Black and white elders and when we speak

17 of Black and white elders, we basically want to

18 refer to the population 65 years and older. We also

19 have done a number of studies in New York State

20 itself pertaining to health care use by

21 African-Americans as well as by white populations

22 and we would like to use these particular, these two

23 data bases to discuss with you essentially what we

know about the comparative differences between Black

and white elderly and their access to and their need for and their need of health care facilities, health care services including long-term services as well as the kind of social support needs that are often health related.

Our testimony will aim to provide this Commission essentially with the available imperical information concerning the differences between Black and white US elders in terms of their demand and use of primary health care support services. That is basically the objective that we set ourselves.

Looking at the national picture first of all, we have here on one table which is quite a voluminous kind of table with lots of information, to get essentially a quantitative summary of Black and white differences in access to geriatric and gerentilogical health care services as reported in the current available publications on this matter.

As you may notice, we compare the outcomes for Black and white and then we also give a so-called odds or relative risk ratio on these data in terms of which of the two groups is more or less disadvantaged.

When you look at, for instance, under

1 nursing home use, by way of example, the United
2 States Department of Housing and Human Services in
3 1985 did do a comparison of admissions to nursing
4 homes per thousand individuals within each
5 population group and we did find that the admission
6 rates of 27 for whites and only 10 for Black which
7 means in effect that the relative or the ratio is
8 that nursing homes are being used practically almost
9 three times as much by white population, by the
10 white elderly population than by the Black elderly
11 population.
12 When we go to the issue of hospital use,
13 admissions to hospitals per thousand, the number of
14 days that individuals spent, have spent in the past
15 year in hospitals, you will again see how the
16 relative -- how the odds ratio does tend to favor
17 whites by a ratio of on the average of 2-to-1. In
18 other words, there is a 2-to-1 advantage for whites
19 in accessing hospital care.
20 When it comes to physician contacts, we see
21 again how there is a considerable -- how this is a
22 significant advantage again in terms of access to
23 physician care by whites over Blacks, 1.5 across all
these variables verus 1 only.

1 At the very bottom of the table we also see
2 how some of our research has asked the question of,
3 did it ask individuals whether they experienced
4 difficulties of any kind in accessing health care.
5 Great difficulty in obtaining health care was
6 reported by practically the double proportion of
7 Black elders when compared to with their white
8 counterparts. So, in terms of access, access to and
9 utilization of basic primary health care services,
10 whites always have the distinct advantage over
11 Blacks. The data there are indicative of the amount
12 of advantage.
13 Now, I also want to draw your attention to
14 some other rather disturbing data trends which are
15 not that easily discernible by when you compare, for
16 instance, where people do get their medical care, we
17 do see on Table I, how, for instance, the chance
18 that a Black individual does receive medical care
19 from what we would call the public dispenseries of
20 health care, that Black individuals do that at three
21 times the rate of whites. Whites have much greater
22 access to private health care.
23 We also found, for instance, in the
literature of hospital mortality rooms admitted, how

1 Blacks have a 3-to-1 chance of not surviving a
2 hospital admission and now we are talking still
3 about the 65+ population.
4 So, in terms of, let's say, the national
5 literature that does do actual comparisons of Blacks
6 and whites in terms of accessing health care, there
7 is a very distinct and a very significant and a
8 consistent advantage that accrues to the white
9 elderly population.
10 Now, of course, this data may be
11 interesting in terms of their descriptive, let's
12 say, importance but the question, of course, could
13 be asked, what is the reason why we have these
14 differences in access and utilization of health care
15 services. It could be that white elderly are in
16 greater need of these services. So, one of the
17 things we did was, trying to ascertain purely on an
18 imperical basis, what the national studies tell us
19 about the relative state of, let's say, physical
20 well-being of Black and white elders and the studies
21 that compared them basically do indicate that the
22 assumption that the white elderly access health care
23 services in greater numbers, significantly greater
numbers than Blacks do, because they may have worse

1 health conditions is not supported by the facts. In
2 effect, Table 2 very clearly indicates that when it
3 comes to impairments of chronic or disability in
4 nature that makes a person in need of health care
5 services, that here again that what we do see is
6 that Blacks do have more disabilities, more
7 functional impairments and, in effect, do have a
8 greater need for health care services by a rate, of
9 course all of those studies, of 1.4 to 1.
10 So, Blacks basically in this case
11 identified as the more disabled group, the one in
12 greater need of services and yet as Table 1
13 indicates the access to services is practically at a
14 rate that is half of that of the white population.
15 The data very clearly indicates that.
16 We also have looked at the factor of what
17 factors do co-variate particularly with the
18 utilization of health care services and one of the
19 factors, of course, is income. All studies that
20 have attempted to relate income with the utilization
21 of health care services, indicates that that is a
22 very powerful co-variant of service utilization.
23 What we see here in terms of economic
resourcefulness and not-so-surprising a fact, Black

1 elders when compared with white elders, do have an
2 impoverishment rate that is better than 2-to-l over
3 the white population.
4 Now, it was in the literature, there is an
5 interesting argument that seems to suggest that
6 Black elderly access health services of any kind
7 less extensively than whites do because they have
8 more of an informal support system that in effect
9 functions as a substitute for formal care for these
10 Black elderly people but the rational being that
11 family friends and maybe even neighbors take care of
12 their needs and thus there is no reason for these
13 elderly to access the formal care system in these
14 great numbers. Often reference is made to the fact
15 that cultural differences between Black and whites
16 and that the Black family has a greater capacity to
17 carry what we would call unproductive or dependent
18 passengers. The argument is that in the Black
19 family, the family will support and elderly
20 individual or member better than the white family
21 will do on the average.
22 Our research indicates that is not the
23 case, that the research suggests that Blacks have
greater and more extensive social supports in

1 plae than whites is not supported by the facts. As
2 you see, the ratio is that it is practically the
3 same. So, family, neighbors coming to the aid of a
4 dependent elder is not greater for Blacks than it is
5 for whites. So, you cannot use that as an argument
6 for saying this is the reason why elderly Blacks do
7 not access the formal care system in as greater a
8 number as whites do.
9 So, in summary then, we basically would
10 like to state and I want to basically make a
11 quotation here from our report here that, in
12 summary, it may be stated that although
13 African-American elderly were found to have greater
14 needs for health care and health related support
15 services, they accessed services at approximately
16 half the rate of their white counterparts. However,
17 this Black-white difference in use of formal
18 services cannot be explained by greater Black access
19 to various sources of informal services. However,
20 Black-white differences in economic resourcefulness
21 may very well be implicated into the explanation of
22 those differences. Being impoverished at the rate
23 of twice that relative to white elders, all the
Blacks may be less able to pay for the out-of-pocket

1 deductibles of insurance premiums generally
2 associated with health care consultations and we
3 also would like to say that the review of the
4 national literature seems to suggest that not much
5 has changed over time or that what we find here
6 seems to be rather difficult for all regions of the
7 country. So, we are not talking about specific
8 effects that are localized in time or in place.
9 I would like to move on now to the studies
10 we personally did on health care use in New York
11 State and Mr. Eve had already made reference to the
12 fact that in the studies we did on African-American
13 elderly in New York State including the central
14 cities, mainly New York City, Rochester, Albany,
15 Binghamton, Buffalo and Syracuse, that we
16 essentially asked here the question, who are the
17 frail or dependent elderly.
18 For that effect we used a so-called index
19 of vulnerability and which we basically and
20 fundamentally used objective criteria measures to
21 define frailty. What we asked, we defined a person
22 as vulnerable or as frail, when he or she is highly
23 dependent upon the health care system because of
health conditions of chronic disabilities, where

1 the person quite often is in need of special
2 services at home if he or she wants to be maintained
3 in the home and in which the person also quite often
4 has unmet needs in the area of Social Services
5 delivery that are related to health care. For
6 instance, transportation to and from physicians or
7 to the loci of medical services is involved here.
8 Now, we did have a 17-item criteria measure
9 here and if people met three or four of those, we
10 identified them as vulnerable. Now, what did we
11 find? Within our Black sample which is our
12 African-American state sample, we did find that 26%
13 of all Black elderly have to be identified as
14 vulnerable by our own operational standards.
15 Applying this same standard to the white population,
16 we found that the percentage was only 6. So, it is
17 indeed so that vulnerability, frailty as
18 operationally defined by a number of measures, is
19 4-1/2 times as high in the New York State elderly
20 Black population than it is within the white
21 population which is a very important finding.
22 Now, I would like to briefly go on to talk
23 only about the vulnerable elders in both samples,
the Black and the whites and the questions we asked

1 here was, how are they faring in terms of their
2 access to services and speaking for the vulnerable
3 elders only, we find, for instance, that in terms of
4 nursing home use, the vulnerable whites use nursing
5 home services five times as much than do Black
6 elderly, by two criteria measures, admission and for
7 being on a waiting list for nursing homes.
8 In terms of hospital use, we also see that
9 white elderly are admitted to hospitals at a rate of
10 1-1/2 times that of Blacks.
11 In terms of in-home service, in-home
12 service use, nursing care, personal care, meals
13 delivered and those kinds of things, that the
14 chronically disabled white often needed in order to
15 maintained, that whites again have almost a 4-to-1
16 advantage in terms of accessing those particular
17 services.
18 When you, however, look at the unmet
19 support needs in terms of having transportation,
20 having help with food shopping, meal preparation and
21 for getting food stamps, we see here that unmet
22 support needs are now, the Blacks are more again at
23 a disadvantage because we see that Blacks
practically better than 1-1/2 times the rate of

1 unmet needs is being represented by Blacks than it
2 is by the white elderly. This is an important
3 finding because we assume that vulnerable elders
4 basically are equal in need and we even have
5 evidence to that effect of an imperical nature when
6 we compared our vulnerable subsamples relative to
7 the kind of health conditions that made them health
8 care dependent or frail, we do see in effect that
9 the vulnerable Black elders do not distinguish
10 themselves in any way from the white vulnerable
11 elders.
12 In other words, it is not a difference in
13 need that makes for this difference in access to
14 services by these two particular subpopulations. It
15 is a very baffling fact to find that two groups that
16 basically have equal needs, nevertheless have these
17 large and consistent differences in access to health
18 care services that could alleviate their particular
19 needs.
20 We also took a look at the socio-economic
21 reasources again and informal social support and
22 here we see an interesting phenomenon and that is
23 that when we took the total samples, we see, for
instance and it is clearly indicated and generally
supported, that in terms of the vulnerable elders

1 again, the vulnerable elders, the Black and the
2 white vulnerable elders are very much the same.
3 They have refined, for instance, that economic
4 resourcefulness of these two particular
5 subpopulations is in favor of Blacks rather than
6 whites, that in terms of health care coverage,
7 particularly Medicaid dependencies, there is only a
8 very slight preponderance of Black Medicaid
9 dependency over white for the vulnerable
10 population. When you compare that with the total
11 populations, there we see how these particular
12 indicators are again showing a much higher
13 presentation of Black over white elders.
14 So, again, we can see here that it is not,
15 let's say, economics and/or Medicaid dependency that
16 made for the differences in outcomes.
17 The data that we have collected seems to
18 suggest that there must be other reasons than need
19 that explains the differences in the utilization of
20 primary and of long-term health care services by
21 Black and white elderly. Frankly, the studies that
22 we have done, neither any one of the studies that
23 have been done by others, can give you at this
particular point in time, what the specific

1 impediments are that makes Blacks at a disadvantage
2 over whites. We only have certain speculative kinds
3 of assumptions about what causes these kinds of
4 differences but, in effect, there is no
5 systematically generated knowledge on those scores.
6 Relative to recommendations, we would like
7 to and I would like to take the liberty here to
8 essentially read our own report. It's fairly short
9 and using my time, I think I am using more time than
10 I should but we have a number of recommendations to
11 make relative to service delivery and I will read
12 that because it's stated much better than I could
13 paraphrase it.
14 Relative to service delivery, we, on pages
15 7 and 8, we have indicated that the first
16 recommendation we would like to make is that the
17 proper criteria for equitable allocation of health
18 care and related resources ought to be need-based
19 rather than population-based. For example, it is
20 often argued that if Blacks represent 15% of the
21 general elder population in a given service domain
22 or catchment area, any provider agency serving that
23 area would demonstrate equitable service delivery,
if 15% of its caseload would be comprised of Black

1 patients or clients. However, such argument is
2 based upon the fallacious assumption that the need
3 for service is the same for all population groups.
4 Our research and the available professional
5 literature on the subject clearly and consistently
6 indicate that African-American elders access aged
7 services less extensively than do their white
8 counterparts despite the fact that their service
9 needs are frequently multiples of those recorded for
10 the latter.
11 The second point we would like to make is
12 that the key word for service delivery to minority
13 elders appears to be outreach. The proportion of
14 community residing Black elders who are to be
15 categorized as vulnerable is 4-1/2 times that of
16 white elders and thus, constitutes a significant
17 portion of that populatin. As demonstrated, by its
18 very nature, vulnerability identifies elderly who
19 are least able to get out and access needed services
20 and who are less likely to have available to them
21 the kind and volume of informal supports that could
22 conceivably substitute for formal services.
23 In this context, it may be worth noting
that nearly 2/3's of all vulnerable Black elders in

New York State admit to unmet needs in transportation and that nearly 1/2 of them, 42% have unmet needs in their ability to purchase basic food stuff. What we seem to identify here is a relatively large subpopulation of high risk elderly who live shut-in lives and are generally unknown to the service bureaucracies that could alleviate their needs.

We also have some recommendations relative to legislation.

We feel that a national health insurance plan is needed that has as its primary benefit, guaranteed access to care for those with demonstrated needs. However, if such provision is currently beyond the latitude of acceptance of our legislative bodies, the very minimum that ought to be considered is a halt to the continuing erosion of benefits under the federally-funded Medicare and Medicaid and other health care programs, a process begun in the 1980's and continuing unabated in the 1990's.

A substantial proportion of African-American elders fall into that class of US citizens that we could call the near-poor. Not being

1 able to qualify for Medicaid coverage, they also are
2 the ones who cannot afford payment of supplemental
3 Medic-gap insurance premiums or other out-of-pocket
4 deductibles frequently associated with
5 governmentally regulated forms of health care.
6 It is reassuring to know that in the new
7 federal budget agreement, modest provisions have
8 been made to come to the aid of this particular
9 group of citizens.
10 Relative to the RUGS and DRG's, we will not
11 make the following recommendations: The nursing
12 casement reimbursement system, RUG, does not seem to
13 have had the effect it was intended to have, that
14 is, to increase admissions to nursing homes of
15 minority and other elderly not able to pay when they
16 are sick. Moreover, by mandating flat rate
17 reimbursements for medical conditions treated the
18 hospital prospective payment system, DRG, as
19 currently constituted, may in effect have a
20 discriminatory impact upon the medically underserved.
21 Research indicates that elderly Blacks have
22 a significantly greater number of co-morbid
23 conditions than do whites, and thus, are at greater
risk of falling victim to complications when being

treated for a specific illness or health condition. Additionally, they have less access to ongoing medical care as evidenced by a routine patient-doctor relationship with a personal primary care physician, they are thus more likely to be more severely ill when finally coming to the attention of the health care system. Both the RUG and the DRG programs should be comprehensively evaluated for their effects upon the quality of health care delivered to the nation's poor and minorities.

We also would like to make a plea for research because we know very little, really. It may become evident that the current status of knowledge about African-American elderly is limited and fragmented. From a scientific viewpoint, what is needed most is a representation of all minority elders in currently ongoing studies in numbers sufficient to draw scientifically valid generalizations about them. As Table 8 indicates, the currently national health studies of older populations do not seem to do so. The proportional representation in these surveys of African-American elders ranges from 6.6% to 10.7% of the total respondent samples being studied.

1 Attention has also been drawn to the
2 necessity of longitudinal rather than cross
3 sectional epidemiological studies of all Black
4 elderly populations. Only in this manner can one
5 ascertain true age changes in the health conditions
6 of this group and obtain a sufficiently detailed
7 informational data base about its health-seeking
8 behaviors and the specific impediments it encounters
9 in obtaining the services needed.
10 That basically is the presentation we would
11 like to make on the basis of the imperical
12 information that is currently in use.
13 MR. COX: Thank you very much for your
14 extensive preparation and presentation. Because we
15 are constrained by time here, I would like to
16 suggest a very brief question or two before we move
17 on because we do have this document that will be
18 inserted into the record.
19 Is there anyone who really feels the need
20 for that at the moment because otherwise, I would
21 like to move on to Mr. Acker but thank you very
22 much, Doctor.
23 Daniel Acker is the branch President of the
NAACP of the Buffalo branch and here he is.

1 MR. ACKER: Thank you. Mr. Chairman and
2 members of the New York State Advisory Committee,
3 thank you for inviting me to appear here today.
4 I have written a paper entitled "Health
5 Justice for Low-Income Families, Especially
6 Minorities." Alone, among the industrial
7 democracies of the world, the United States provide
8 no guarantee of equal access to medical care and
9 hospital service to its people. Today more than 10
10 million Americans who live below the poverty level
11 have no way to cover the cost of needed health
12 care. African-Americans suffer most. Adequate
13 health care is not a privilege of the few in a
14 democracy. It is a right of all and including poor
15 people.
16 The economic prosperity of the past decade
17 did not extend to all segments of our American
18 society. While some of us gained even higher levels
19 of income, others were reduced to poverty. In other
20 words, the gap between the rich and the poor is
21 wider today than it has ever been.
22 I am a member of the Board of Managers of
23 the Erie County Medical Center. We do not turn
anyone away regardless of whether one has money.

1 A large number of these persons who take advantage
2 of the health services at the Erie County Medical
3 Center are minority elders. Alzheimer's Disease
4 affecting the elderly and the AIDS affecting
5 everyone, poses many unsolved problems for all of
6 us. Research funds are very limited to deal with
7 these particular diseases. Therefore, new drugs and
8 medicines are very slow coming into use for these
9 affected persons.
10 I contribute to the private research on
11 Alzheimer's and other diseases and that is a very
12 small amount of money coming from the government to
13 treat these diseases and in fact, the outstanding
14 research institutions like the Cleveland clinic and
15 the other institutions do not have a cure for
16 Alzheimer's disease which is affecting many people
17 between the ages of 60 and 80.
18 One of the encouraging things that has come
19 along recently is minority health training. The
20 Senate passed S-606, the Disadvantaged Minority
21 Health Improvement Act of 1989 on November 20th,
22 1989. The Bill establishes an office of minority
23 health within DHS and authorizes $10 million for the
year of '91, $12 million for the year '92 and $15

1 millions for the year '93. The Bill also authorizes
2 the secretary to make grants to public or private
3 non-profit groups to support health information and
4 education services. Finally, the Bill authorizes
5 the secretary to make grants in capital
6 contributions to help professional schools in order
7 to increase loans and scholarships to disadvantaged
8 students.

9 Economic justice for women, especially
10 elderly and minority women, most women work most of
11 their lives in low-paying jobs with few benefits and
12 no future. These working poor women struggling to
13 make ends meet as well as to become independent and
14 productive, need support and advocacy. Single
15 parent families headed by women are the poorest in
16 the country. Poverty threatens to entrap an
17 inordinate number of African-Americans and Hispanic
18 women in permanent underclass. Poor women are not
19 only present in all of our communities but also in
20 many of our churches. They present the church with
21 painful and urgent needs and opportunities for
22 admission advocacy.

23 The plight of the Black male is even
worse. I attended the national meeting of the NAACP

1 in Los Angeles in July and that was a seminar on the
2 plight of the Black male. Also attended the state
3 conference in Long Island on October the 12th, 13th
4 and 14th in which there was another seminar on the
5 plight of the Black male.
6 The Black male is the only human species
7 who will have a shorter life span in 1990 than in
8 1980. The Black male, 25% is probably in prison.
9 Many are the last ones hired and the first fired.
10 So, the medical attention of Black males is very
11 important.
12 I hope that this panel will take into
13 consideration that not only in the City of Buffalo
14 but throughout this nation, minority persons are
15 very much in need of health money to do research and
16 also to carry on healthful programs that are going
17 to be of help to all of us in this community.
18 Thank you very much.
19 MR. COX: Thank you, Mr. Acker. There is
20 time for a question or two. Yes?
21 PROF. NISHI: Yes. Thank you very much for
22 your presentation.
23 Sometime ago, the research indicated that
Blacks, African-Americans who attain the age of 65,

had a longer life expectancy than do whites which was an unexpected kind of finding. Is there any indication of that today?

MR. ACKER: I dispute that finding.

PROF. NISHI: I know. When that first --

MR. COX: Dr. Cryns?

DR. CRYNS: It is true. It is true. It's gone the so-called cross-over effect but only pertains to Black elderly who reach the age of 65.

PROF. NISHI: Correct. That is what I have seen.

DR. CRYNS: And the issue here, of course, is those are basically elderly which you would almost say have stainless steel chromosomes to reach that age.

MR. ACKER: Stainless steel chromosomes.

DR. CRYNS: That is right.

MR. ACKER: Not many of us have those.

DR. CRYNS: So, what we also know though is that frailty and vulnerability afflicts Black elderlys earlier. In other words, it's only the super healthier that will become -- that will reach 65 years of age and older and then also, often in better physical condition.

1 PROF. NISHI: I know a decade ago this was
2 very clearly established in research but I didn't
3 know whether this still pertains.
4 DR. CRYNS: It does still pertain but it
5 also pertains to a very small group, a very small
6 number of individuals.
7 MR. COX: What are the numbers, roughly,
8 magnitude, in other words?
9 DR. CRYNS: I could not answer that without
10 having to really guess.
11 MR. COX: On a national basis, how many?
12 You don't know?
13 DR. CRYNS: No.
14 MR. ACKER: Let me also add that actually
15 when you speak of the African-American male, he may
16 not even reach that age. He may not reach that
17 because the African-American male has the shortest
18 life span and when you talk about 65 and above, most
19 of the African-American males do not live that long.
20 MR. COX: That is at age 20 but the African
21 males that reach 65, they live longer than white
22 males.
23 MR. ACKER: Yes, but look at how small the
number is.

1 MR. COX: I realize that.
2 PROF. NISHI: That is correct.
3 MR. ACKER: That's a very small number
4 because the thing of economics is so important,
5 getting a job. A job is not only a paycheck. A job
6 is therapy. A person who works, feels that they are
7 pulling their weight in the boat, that they are
8 doing things to help themselves and their families
9 and not depending on others. So, therefore, being
10 denied a job has a very devastating effect on not
11 only African-Americans but everybody but we know
12 that in our society, their Civil Rights bill has
13 just been vetoed and we were not able to override
14 the veto, you know. We got 66 votes and should have
15 gotten 67 in order to override the veto of the
16 President but we find that the Supreme Court has
17 turned back the clock on Affirmative Action, on
18 medical aid and many things. Therefore, things are
19 worse today than they were 10 years ago.
20 Thank you very much.
21 MR. COX: Any other questions? I think we
22 can move along to the next speaker.
23 Thank you very much, sir.
The final person for this particular first

1 part of the morning is Dr. Deborah Richter. Is she
2 here?
3 DR. RICHTER: Yes.
4 MR. COX: Who is a member of the Physicians
5 For a National Health Program and Citizen Action and
6 she is going to make her presentation now.
7 Thank you.
8 DR. RICHTER: Thank you. I am a practicing
9 physician here in Buffalo at two health centers, one
10 is the Geneva B. Scruggs Health Center and the other
11 is the Mercy Health Center, both of which serve
12 largely minority populations.
13 I'm here today for two main reasons: First
14 of all, I believe that health care is a right, a
15 human right and not just a privilege which is a
16 phrase I know you have heard before.
17 Secondly, because I believe this, the
18 inadequacies of the current health care service
19 system are even more disturbing to me. I should add
20 that again, I am a member of the Physicians for a
21 National Health Program which has drafted a proposal
22 before you for a national health care program for
23 the United States.
Let me say a few words about health care as

1 a human right.

2 As a nation, we have long taken for granted
3 that education is a universal human right but the
4 same cannot be said for our approach to health
5 care. In practice, either by accident or design, it
6 is not granted that health care is a right.

7 Cost is usually cited as the limiting
8 reason but it can be shown that our failure to take
9 care into account as a human right, to approach it
10 instead piecemeal is in the long run far more costly.

11 There also is the fact that we are in the
12 minority of those nations able to provide health
13 care to their citizens, largely the industrialized
14 nations. Only two in today's world do not provide a
15 form of universal health care: The United States
16 and South Africa.

17 What I've called and others call a system,
18 is not a proper system at all. It is a hodgepodge
19 of parts, some of which function brillantly and are
20 unrivelled anywhere in the world. Others of which
21 function so poorly that they are only rivelled by
22 the most disadvantaged nations.

23 To those of us working on the inside, it
often looks more like an ad hoc mess. Some of it

1 works, but a lot of it doesn't. What works is
2 played up in ballyhooed in the press, in the news,
3 magazines and on TV but what doesn't is largely
4 ignored. There are plenty of statitics about how
5 bad it can be, for example, the abysmal infant
6 mortality rates in inner cities, no better than in
7 developing nations, nations which are incapable of
8 investing even a tiny portion of what we invest in
9 health care.
10 So, what the so-called system does, in
11 effect, is create a class system vine for medical
12 care. What defines the system is simply money for
13 those who can pay, medical treatment can be
14 excellent but for those who can't it is carried out,
15 if it is carried out at all, in circumstances that
16 militate against good treatment.
17 I can, any practicing physician can,
18 provide plenty of stories illustrating what I'm
19 talking about. Some of them are horrific. I am
20 only one doctor, of course, but multiplying my
21 experience by the tens of thousands of doctors and
22 other health professional practicing medicine in
23 this country and you get a clear picture condemning
our so-called medical care system.

1 Human suffering, grief, pain and misery
2 come with the territory in medicine but it is
3 heartbreaking and terribly upsetting, the fact that
4 our current system magnifies these unnecessarily.
5 As if all the misery weren't enough, there
6 is the cost in dollars. We know how much the health
7 care system costs. It is exorbitant and
8 accelerating but consider the hidden costs. Poor
9 health and sickness have a high cost for society.
10 Huge sums are lost in productive workers unable to
11 work and in those able to work but for complicated
12 reasons of health coverage cannot afford to. It's
13 sensible not to work, else they put their family at
14 financial risk. If it sounds a bit crazy, it is.
15 Here is another kind of figure. Congress
16 and the President and his administration just spent
17 months and months wrangling over saving the nation
18 $40 billion to $50 billion. Now, I know many of us
19 know where our so-called health system wastes almost
20 one and a half times that much yearly, to the tune
21 of $69 billion.
22 Besides the grim human costs I've outlined
23 and the financial costs, the so-called system does
this: It creates minorities and disadvantages them

in terms of health care. They are, large portions of the elderly, the poor and let me add, you don't have to be very poor to feel the effects. You can be working, holding down a full time job and still be unable to achieve reasonable access to health care. This is a large group, 15% of the US population is uninsured. Now, another by no means negligible group are college students. Figures indicate 1/3 of them have no health insurance and a larger portion of the rest have inadequate health insurance.

Now, I'd like to speak briefly about what adequate health insurance is. Imagine this: You or anybody else, no matter what their financial situation, whether they are working or not, whether they are students or relatively poor, are entitled to all possible medical care that can be characterized as necessary and standard. That phrase "necessary and standard," includes almost everything you could imagine needing, primary care, acute care, preventive care, long-term care, prescriptions, dental. There are exceptions. Don't expect coverage for nose jobs, facelifts, breast enhancements but you get the idea.

1 Now, it works this way: You visit the
2 doctor. He or she treats you or perhaps you are
3 hospitalized. You never see a bill or asked to pay
4 co-payments or deductibles or anything of the kind.
5 It is financed basically through income tax. Now,
6 this may strike fear in the hearts of Americans but
7 we have to keep in mind that we are already paying
8 taxes toward our messy, inefficient health care
9 system. The point is, what I am describing is
10 universal access to comprehensive health care
11 insurance, no strings attached.
12 Now, this access if no mere dream. It
13 happens that such an interesting system is operating
14 next door in Canada and has been since 1985. The
15 same year we instituted Medicare and Medicaid, two
16 programs that worked but not all that well. By no
17 means do they provide universal access and
18 comprehensive care.
19 Now, some surveys indicate that 50% or more
20 of our country's physicians believe that some kind
21 of national program has become necessary and up to
22 75% of the people of this country think so, too.
23 They think they deserve this human right to health
care. It must be obvious to everyone by now that

1 the present so-called system is collapsing of its
2 own weight. It is out of control in many areas. No
3 one bothers to deny that costs as escalating out of
4 control. They are running two to three times the
5 inflation rate each year.
6 Now, of course, to those with money to pay
7 for what they want it may seem a little less
8 alarming than that. However, conditions have gotten
9 so bad no one is exempt. Who hasn't seen stories in
10 the national press and on TV about the dangerous
11 conditions in emergency rooms in some of the best
12 hospitals around. I won't bother with details but
13 everyone knows that the main reason for this is
14 overcrowding of emergency rooms by those with no
15 health insurance and thus nowhere else to do for
16 medical care. The thing is, any of us may then land
17 smack in the middle of an emergency room that barely
18 can cope with the overwhelming demands made on it.
19 Troubles don't lie and wait for you in
20 emergency room breakdowns. You lose your job and
21 you lose your health insurance. Lose your health
22 insurance and any routine maintenance treatment or
23 medications such as high blood pressure medicine,
medicines for heart trouble, for asthma, to name a

1 few, suddenly cost you full price and compete with
2 food and rent in the household budget.
3 Some idea of how widely the failures of the
4 present system and its runaway costs have penetrated
5 society is that those of us wanting to really do
6 something about this mess find ourselves in the
7 enviable position of attracting unexpected allies.
8 Five or ten years ago, who would have thought major
9 corporations and national unions, for instance,
10 would be siding with the reformers, but they are; to
11 name a few, United Electrical Workers, Communication
12 Workers of American, Steelworkers and Mine Workers.
13 My personal experience is that all you have
14 to do is let out the word you're willing to work for
15 health care reform and you're flooded with offers of
16 aid, help and so on. What this tells me is that
17 this is an idea whose time has come. It permeates
18 our society from top to bottom, from politicans to
19 corporation executives, to unionists, to workers, to
20 minority groups, to people on the street, to the
21 young, the old, and all but the very, very few who
22 remain untouched by this crisis.
23 Still, nothing is unanimous. This is a
democracy and there are groups that oppose meaningful

1 change, groups with vested interests in keeping
2 things as they are and I'm sure you know as well, as
3 I do, but for starters, we can mention the insurance
4 industry, profit-making hospitals, some physicians
5 whose delicate sense of greed outweighs their
6 mission to care for the sick and ailing and
7 naturally the AMA. Although let me point out that
8 the AMA no longer represents, nor speaks for the
9 majority of physicians in this country.
10 Now, there is another important point to
11 make here. The foes are pretty much out in the open
12 and that's to the good. Potentially as dangerous
13 but far less obvious are attempts, well meaning
14 attempts to patch up the current system in various
15 ways. It's not patchable. Devising this or that
16 program to fix things can only make them worse in
17 the long run. By worse I mean certainly most costly
18 but also probably less effective. Medicaid and
19 Medicare are two examples of very early attempts to
20 patch up the system, and while they work for a time,
21 more or less, by now they are showing strains and
22 beginning to fail in bigger and bigger ways. It
23 should be obvious that a practical reason for this
eventual failure is that they pit one group against

another. They put a patch here by removing a patch over there.

The real problem is that the so-called system is rotten to the core. It does not provide what it must, which is a system of universal access, comprehensive coverage, and a simple method of paying for it. Anything less, mini-systems that try to discriminate around universal comprehensive coverage breed administrative obesity. Too many people doing too many inessential tasks overload and sofficate the system and the cost is very, very large. That figure that I mentioned is $69 billion. If our system ran as efficiently as the Canadian system does, that is how much we'd save in administrative costs alone each year and that's close to one-quarter of our annual budget deficit this country is running these days.

Now, many of us have come to believe that for these reasons only, a radical solution will finally work. By radical I mean replacement of the current non-system with a universal access, comprehensive insurance program, financed not by dozens, hundreds of wasteful bureaucracies but by a single paying arrangement. A program similar in

1 many, but not all respects to the Canadian system.
2 Now, right away let me say that the Canadian system
3 is not socialized medicine. It is a system mandated
4 at the federal level, financed by taxes at the
5 federal level, administered at the state or local
6 level or in Canada the provincial level but that is
7 all.
8 In that system, patients seek out preferred
9 doctors and health care more or less as they do in
10 our present system, though they actually have more
11 freedom of choice. Their comprehensive insurance
12 doesn't bind them in the ways most of our insurances
13 do.
14 Doctors and other health professionals work
15 pretty much just as they do now in this country.
16 The big difference is the way they are paid and how
17 much they are paid. The patient doesn't pay them,
18 the government does.
19 To begin with, because huge staffs are not
20 required to deny payments for medical treatment or
21 otherwise figure out who and what should be paid,
22 enormous administrative savings result. Secondly,
23 because everyone is eligible for medical care, there
are no hidden costs to society, those costs in our

1 system associated with significant populations
2 failing to get the right kind or any kind of health
3 care.
4 Thirdly, eliminated is the psychological
5 wear and tear on patients and families trying to
6 straighten out bureaucratic muddles. Polls show
7 that 95% of Canadians prefer their system to ours,
8 not surprising.
9 Anything less isn't going to work. An
10 attempt, well meaning, is being conducted in
11 Massachusetts, but it isn't working. It is
12 bankrupting the state government. There are other
13 proposals, Unicare is one of them that try to patch
14 up our current system. Chances of their working in
15 the long run are equally slim.
16 Those who have studied this very carefully
17 say that operating a program similar to Canada's and
18 this country would in fact cost no more than our
19 present system. No matter what scare stories you
20 hear and you will hear them, every indication is
21 that it is much easier to keep cross in check. The
22 reasons are that one, the system is administratively
23 much, much simpler and less costly and two, doctors
and hospital budgets are regulated by a single agency

1 rather than all over the place and by competing
2 agencies as is here.
3 Support for this view comes from the Wall
4 Street Journal which recently reported that we pay
5 72% more than Canadians do for the same amount of
6 service. That was on September 7th, 1990. Some in
7 Congress agree. Last year a Congressional committee
8 reported that national health care insurance
9 modelled after the Canadian approach would ensure
10 all Americans access to high quality, affordable
11 health care.
12 Finally, as I said, I have provided you
13 with copies of the proposal for a national health
14 care program published in the New England Journal of
15 Medicine, January 12 of 1989, last year. It gives
16 details of the program that the committee will find
17 interesting I'm sure but missing is the long-term
18 proposal. This has been drafted and will be
19 published next month.
20 Now, in summary, we can say that Canada
21 ensures all of its citizens equal access,
22 comprehensive coverage for less money and the data
23 showing better health statistics, better infant
mortality rate, better morality statistics and

1 Canadians on the whole like their health care system.
2 This country is fully capable of
3 instituting a health care system similar to Canada's
4 that provides universal access, comprehensive
5 coverage to all of its citizens regardless of their
6 ability to pay.
7 Thank you.
8 MR. COX: Thank you.
9 Paul Ciprich.
10 MS. CIPRICH: I would just like -- you
11 mentioned some figures here in terms of the way that
12 this would be funded would be through income tax.
13 That is currently the way that the health care
14 system is funded and you cited a $69 million savings
15 figure.
16 DR. RICHTER: Right. The $69 million
17 savings figure basically is a comparison of Canada
18 which spends 12% of the health care dollar to
19 provide health care, where we spend 22%. The 10%
20 savings per year would be equivalent of $69 million.
21 MS. CIPRICH: Is there a study that was
22 done that supports that?
23 DR. RICHTER: I can get those figures for
you.

1 MS. CIPRICH: You could submit that to the
2 Committee?
3 DR. RICHTER: Yes, I can.
4 MS. CIPRICH: Okay.
5 MR. COX: Professor.
6 PROF. NISHI: The Canadian system, of
7 course, has been a matter of -- has been a matter
8 of long-standing interest to the United States and I
9 wonder whether you are able to cite any studies
10 which indicate that this universal health care
11 system has reduced inequities among socioeconomic
12 categories of people in Canada as well as
13 racial/ethnic minorities?
14 DR. RICHTER: I can't cite -- I mean, I
15 could look into that information and get that
16 information to you.
17 PROF. NISHI: That, of course, is the
18 particular focus of this hearing.
19 DR. RICHTER: Right. I understand that.
20 PROF. NISHI: And it would be, of course,
21 very helpful to us if we know what the experience of
22 Canada has been.
23 DR. RICHTER: Yes.
PROF. NISHI: In producing greater

1 equities, not only better care generally but better
2 equity among various segments of its population by
3 race, ethnicity, gender and class.
4 DR. RICHTER: Yes. Well, just in -- I
5 mean, in terms of that, the infant mortality rate is
6 significantly better than the United States. Those
7 are statistics. I will look into that for you in
8 terms of that but to keep in mind that in Canada --
9 CHAIRMAN OI: Do you know the difference of
10 the Native versus the white, because that is the
11 basic racial difference in Canada.
12 DR. RICHTER: Do I know the difference in
13 the statistics?
14 CHAIRMAN OI: Yes.
15 DR. RICHTER: Not offhand.
16 CHAIRMAN OI: Health care outcome.
17 DR. RICHTER: Not offhand.
18 CHAIRMAN OI: How are we going to close the
19 gap, though? Canada spends about 8-1/2 to 9% of its
20 gross national product on health care. We spend 12.
21 DR. RICHTER: Right.
22 CHAIRMAN OI: Take away that 10% you are
23 down to 10.8%. Where are we going to get the rest?
Are we going to reduce salaries?

1 DR. RICHTER: Reduce salaries to
2 physicians? Absolutely.
3 CHAIRMAN OI: And nurses.
4 DR. RICHTER: And nurses. Well, as far as
5 the nurses, I don't know the exact figures on that
6 but in terms of physicians, primary care physicians
7 on the whole, now that includes pediatricians,
8 family physicians and some surgeons, on the whole
9 make on par to Canadian physicians. It's the high
10 salaried or the high income physicians, the
11 specialists that would make significantly less.
12 The study recently done shows that American
13 physicians make 35% more when you take the whole
14 group of physicians but if you break them down into
15 categories, primary care physicians and such, would
16 probably make on par and the reason is that the
17 difference in administrative costs and the
18 administrative hassles that they have to go through,
19 hiring someone in their office to figure out the
20 billing procedures and the Xerox copying and the
21 computers and whatever else.
22 CHAIRMAN OI: And malpractice.
23 DR. RICHTER: Exactly, malpractice and
there is no doubt that there are still problems

1 that have to be dealt with and that being
2 malpractice being one of them and - -
3 CHAIRMAN OI: You are talking about a 20%
4 cut in earnings.
5 DR. RICHTER: Yes.
6 CHAIRMAN OI: That is a huge cut.
7 DR. RICHTER: That is a huge cut.
8 CHAIRMAN OI: Is it going to fly?
9 DR. RICHTER: Well, there is no doubt and
10 the insurance, I think the insurance industry is
11 actually a large obstacle because they will be
12 totally phased out within three years of the
13 institution of this. Basically the private health
14 insurance, that duplicated coverage of what the NHP,
15 the National Health Program would be not legal. So,
16 you could cover - - you could have insurance for a
17 facelift and a nose job but you couldn't have
18 insurance for well-baby checks and mammograms and
19 that sort of thing. It's not going to be easy.
20 There is no doubt about it.
21 But as a nation, we have really little
22 choice but to institute a form of cost control
23 because as we heard testimony today, patching up the
system here and there just isn't working as Medicare

and Medicaid do not provide the health care needed for in particular the elderly. It only covers 49% of their expenses. It doesn't cover prescription drugs. So, many of them go without prescriptions because they are on a fixed income and end up in the hospital with a stroke or a heart attack.

So, we end up paying in the long run anyway because we end up paying for them when they spend down to Medicaid and they become basically the government's burden.

MR. COX: Any other questions or comments? Please, those of you who are present in the audience, feel free to make a comment or raise a question. If not, I think what we will have Tino do is to bring the next group of panel participants up to the table as a group.

Thank you very much, Doctor.

We are going to take about a five-minute break.

(WHEREUPON, proceedings recessed for five minutes.)

MR. COX: Could you just announce that?

MR. CALABIA: We hadn't heard from

1 Michael Carter, the Chief of the Investigations
2 Division of the Office of Civil Rights of the United
3 States Department of Health & Human Services but I
4 assume he is not coming here. He is located in New
5 York City and he probably faced the same kind of
6 budget problems we had. Although he didn't call, I
7 am making that assumption.
8 I note, too, that in this afternoon's
9 panel, the HUD, Regional HUD person who is also
10 located in New York City did call to say that
11 because of the budget problem, they wouldn't be able
12 to come. So, I would assume the same case applies
13 to him as well.
14 In addition, I only heard about a half hour
15 ago that Lucy Velez, one of the speakers on the
16 prior panel was ill and so obviously was not here
17 but in addition, though, we have some testimony from
18 the National Association for Hispanic Elderly which
19 gives a kind of bird's eye view of the national
20 picture which I will share with the people here. We
21 have copies here.
22 What we are introducing now is the
23 governmental panel which basically consists of two
agencies.

1 MR. COX: Yes. I have a request from Marie
2 Baker who is on our left here, she was to speak in
3 conjunction with Tai Kang who I believe is not here
4 and has asked to speak first because of some
5 pressing affairs she has to attend to apparently.
6 So, then we will move on to the other two gentlemen.
7 Please.
8 MS. BAKER: Good morning. My name is Marie
9 Baker. I teach at the State University College at
10 Buffalo. However, today, I represent the statewide
11 Committee on Minority Elderly from the State Office
12 for the Aging. Livingston Francis is the Chairman
13 of that group and asked me to come today to express
14 our interest in this issue as well as our concern
15 about the minority elderly.
16 I will not repeat some of the statistics
17 which were very similar to those presented by Dr.
18 Cryns and Mr. Gorey but I just want to say that we
19 are concerned and our committee has been following
20 the minority elderly in New York State, looking at
21 the representation of minority elderly,
22 participation in various government funding agencies.
23 This morning I have to leave to take care
of one of those minority elderly people who is 80

1 years old and who is moving this very moment from a
2 large house to a very small apartment but I just
3 wanted to agree with Dr. Cryns and Mr. Gorey in
4 terms of those kindsof things that they have
5 experienced about the lack of access for minority
6 elderly.
7 Dr. Kang may appear in a few minutes. He
8 was to join me here and perhaps he will have some
9 other information but if I can be excused, then, I
10 would like to leave.
11 I just wanted to let you know that the
12 statewide committee wanted to have a representative
13 here this morning and I am it but I must go to take
14 care of my 80-year-old friend.
15 MR. COX: All right. I'm sorry we can't
16 have you longer and if Dr. Kang appears, we can have
17 that presentation.
18 Now, let me see, Mr. Carmello, I think we
19 will just go in the order then that we have the
20 people listed. You are, I believe, Director of the
21 Bureau of Health Facilities Coordination, New York
22 State Department of Health, correct?
23 MR. CARMELLO: That is correct.
MR. COX: And you are to make your

1 presentation now.

2 MR. CARMELLO: Thank you. Thank you for

3 inviting me to attend. I thought I would give the

4 group a brief overview of what the responsibilities

5 of the State Health Department are in this area and

6 then tell you at least two ways we want to overcome

7 what we consider obstacles in the system and perhaps

8 the group can take back to Washington or to whomever

9 you take this information back to, some of our

10 concerns to help us do our job better.

11 The State Health Department has overall

12 responsibility for ensuring that health care is

13 provided by the right kinds of organizations and in

14 the right way and to the right people and the Public

15 Health Law is our vehicle for doing that.

16 A piece of that vehicle addresses what we

17 are talking about today and that is that we want to

18 make sure that those health care programs are

19 provided and accessible without regard to race,

20 color, creed, national origin and so forth.

21 In terms of long-term care which is what I

22 will focus on, we have a specific responsibility to

23 conduct assessments on an annual basis. In New York

State there are hundreds and hundreds of long-term

1 care facilities. Each of those facilities must
2 admit patients without regard to race, color, creed
3 and national origin and we have a regular assessment
4 of what is going on in those facilities both in
5 terms of quality of care and a smaller piece in
6 terms of how they provide their services and to whom
7 and to how they make their admissions.
8 We do that for two reasons: The Public
9 Health Law and the Medical Facilities Code which is
10 our set of regulations, we use contain specific
11 references to the need to admit patients without
12 regard to their race, color, creed or national
13 origin but also we are the agent through our sister
14 agency social services, for Title VI of the Civil
15 Rights Act of 1964 and Title VI is the instrument we
16 use when we do our regular assessments.
17 Unfortunately, neither Title VI nor the
18 State rules talk about the payer and this goes along
19 with what Dr. Richter and the others have said. In
20 New York State and I am sure it's really true, I'm
21 not aware of any other state that it differs from
22 how we operate, if there are two individuals
23 attempting to get into a facility and one is private
pay and one is Medicaid, facilities have the right

1 to admit the private pay and that causes
2 difficulties because it winds up where facilities
3 have a certain percentage of private pay and then
4 probably a large extent, New York City, I think
5 Medicaid makes up almost 90%, 85 to 90% of the
6 long-term care admissions. Upstate is probably
7 lower. I'm sure it is.
8 But what happens is, because minorities are
9 a significant number of Medicaid, you wind up with
10 underrepresentation in many, many cases and it makes
11 our job difficult because if we allow, as we do
12 legally an individual to be admitted because they
13 are paying more, the Medicaid individuals are not
14 accepted as readily. Now, to our knowledge and I
15 feel comfortable in saying this, to our knowledge,
16 minorities are getting into facilities, long-term
17 care facilities. I'm not aware and if someone in
18 this room or in this panel knows otherwise, you
19 should please tell us about it, minorities are
20 getting in but what happens is they get into county
21 facilities much more readily. They get into private
22 paying facilities much more readily, frankly at
23 least in New York City. So, we wind up, though,
with underrepresentation or imbalances as you look

1 at the facilities and one of our jobs is to ensure
2 that those imbalances are caused not because of
3 discriminatory practices.
4 Now, one thing we tried recently in the
5 last couple of years, the Public Health Council is
6 the council that passes laws on establishment and
7 rules in New York State. It's convened by the
8 Governor, reports to the Commissioner of Health. A
9 while back we tried to get through what we called
10 Medicaid access regulations and it was our attempt
11 that for any number of beds, let's say you have a
12 new facility with 200 beds. That facility would
13 have to admit 75% of the Medicaid admissions in that
14 area as part of their admissions policy.
15 So, let's say in the area where they were
16 going to build, Medicaid was 50%, just to use a
17 hypothetical example. 75% of 50% is like 37-1/2%.
18 We would require that entity to provide admissions,
19 initial admissions to at least 37-1/2% Medicaid
20 individuals. This was our attempt, the
21 Commissiner's attempt, the Public Health Council's
22 attempt to try to even things out.
23 That regulation was taken to court. The
courts upheld the folks who sued the state and sued

1 the Public Health Council and the State Health
2 Department lost. We are appealing that. The middle
3 of November there is a second stage appeal and we
4 will see what happens but that was our attempt to
5 mandate Medicaid admissions almost on the same level
6 as private.
7 Another thing we have done over the years,
8 it was started by the Attorney General's office in
9 New York State, we tried to pass legislation, we
10 tried to get legislation passed through the
11 legislature, obviously, whereby we would prohibit
12 discrimination of any kind in admission, including
13 payer source or sponsorship. There was a bill which
14 would require a single waiting list be used because
15 that's the simple solution to it if we can do it.
16 If two people apply on the same day and their
17 medical conditions are the same, obviously if they
18 have different medical needs then the facility would
19 have the right to say they can or can't handle that
20 kind of patient but this law was designed to require
21 a first come, first serve kind of opportunity.
22 It was submitted by the Attorney General's
23 office years ago, I think over ten years ago and it
was not approved. It was not passed. Since that

1 point, the State Health Department has attempted
2 year after year to introduce the same legislation
3 but with the same results and it comes down to the
4 fact that private citizens I guess or money-making
5 organizations, because we have a number of our
6 facilities are profit-motivated, they have the right
7 to admit private patients and until we are able to
8 overcome those kinds of things, most of us feel it
9 is difficult to prove discrimination.
10 Frankly, we have had very, very few direct
11 complaints and again, if this panel or individuals
12 in the room, the organizations are aware of specific
13 allegations that an individual could not gain access
14 because of his or her race, color or creed or
15 national origin, that is something should be brought
16 to our attention because we do have the right to go
17 after facilities. We do find them deficient. We
18 have the ability to find them. Medicare and
19 Medicaid programs are both set up with the
20 understanding that individuals would have access to
21 those facilities.
22 So, there are some tools and some weapons
23 we can use if we can get substantial information
about discrimination. We certainly welcome any

1 comments or advice in that regard.
2 We worked very closely with the Division of
3 Human Rights and I guess the panel did not invite
4 somebody from the State Human Rights Division
5 because if we get indications of a problem that
6 doesn't address our concerns directly, we do refer
7 to the Division of Human Rights and Mr. Carter's
8 name was mentioned, Michael Carter. I work very
9 closely with Michael. He works for the federal
10 government in the Office of Civil Rights and as we
11 get indications that there could be a problem in a
12 long-term care facility, we deal with the OCR to
13 ensure that this facility turns around its program
14 if in fact it was doing it unknowingly which
15 sometimes happens. Sometimes the facilities are not
16 aware that how they are gaining - - how the
17 individuals gain access, let's say family members or
18 staff members of facilities have first preference.
19 Well, that could be an innocent way of
20 admitting patients but it turns out that minorities
21 who may not have staff or family that are there
22 already, would be given second opportunity. So, we
23 have tried to overcome some of those imbalances.
That really, frankly, is my presentation.

1 If someone would like to go through how we
2 do surveys and the kind of things we look for, I
3 would be happy to address the issue.
4 MR. COX: Yes. Why don't we have you say a
5 bit more, if I may direct the question here to the
6 point you touched on toward the end of your remarks
7 and that is, to your knowledge, there are few direct
8 complaints of specific discriminatory acts on the
9 part of admissions people.
10 MR. CARMELLO: That is correct.
11 MR. COX: Now, tell me, what agencies or
12 what persons receive such complaints, that is, where
13 would a person typically go where your agency in
14 turn would become aware of it and take action?
15 MR. CARMELLO: Well, the State Health
16 Department requires that long-term care facilities
17 post various documents and as you or I walk into a
18 facility, if we walked into a facility right here in
19 Buffalo --
20 MR. COX: Such as a nursing home.
21 MR. CARMELLO: A nursing home, that is what
22 I'm talking about. In New York State they are
23 called residential health care facilities but we are
talking about nursing homes, skilled nursing

1 facilities or Medicare and Medicaid. Those
2 facilities are obligated to host a human rights
3 poster right in the corridor, right in the main
4 lobby and our Civil Rights poster. So, if a family
5 member or representative is attempting to get
6 somebody into that facility, and they have the
7 feeling that they are being rejected is not because
8 of their needs but because of their skin color or
9 their religion or whatever else, there is a name and
10 number. I think my office number is on the poster
11 frankly and we welcome that kind of thing.
12 I have been in the bureau, I have been
13 Director for 13 years and I think we have had less
14 than five complaints, specific complaints that we
15 could follow up on and it makes it difficult to
16 really go over a facility.
17 Now, we have a couple of investigations
18 going on now around the state and I really can't go
19 into detail on those but we are working with the
20 special prosecutor where employees have come to us
21 and said, they think the admissions policies are
22 questionable and we had a so-called in and we used
23 that as our entree.

MR. COX: Yes.

1 PROF. NISHI: Yes. It is, of course,
2 remarkable that there have been so few individual
3 complaints with regard to possible discrimination in
4 admission to residential facilities. However, it's
5 a kind of a thing, given the present day practices,
6 that it's very difficult to identify when a person
7 has been discriminated against because there will be
8 a number of other reasons which may do the same
9 thing to disproportionately exclude persons of
10 minority background.
11 Is there any systematic way in which you
12 monitor the inclusion of these nursing home
13 facilities so that we can have some way to see
14 whether, whatever their existing practices are,
15 results in inequitable inclusion?
16 MR. CARMELLO: Well, what we try to do is,
17 our regular survey which in most cases is annual, we
18 have investigators, surveyors look through the
19 records, admission records. We require facilities
20 to keep what we call a patient referral. We require
21 that those documents be kept for 18 months which has
22 been a monumental headache for a lot of facilities.
23 Let me just back up because many of the
folks here may not realize that most of the

1 admissions to long-term care facilities come from
2 hospitals and its discharge planning which is the
3 key here and as you say, if a patient is ready to
4 leave a hospital, it's quite natural in my opinion
5 and I think it happens, that if it's a nice Irish
6 Catholic lady leaving, it's very possible that she
7 and her family will be told about facilities where
8 she would feel comfortable. If it's a Jewish person
9 leaving, they might steer them in a way that would
10 satisfy the family. Catholics the same way,
11 minorities the same way.
12 Many people feel that is not correct and it
13 isn't. Discharge planning is a very tough job in
14 this state and they are being pushed financially to
15 get patients out and they are being pushed by the
16 State Health Department and others to do the right
17 thing. Hopefully, a discharge planner will take
18 into consideration the family needs, the family's
19 interest, location and try to make a proper
20 placement.
21 But to go back to your immediate point, our
22 investigators are supposed to look at the
23 statistical information available and we have seen
an increase over the last several years. So, we

1 have last year's figures to look at and then we
2 compare them to the current ones. We look at how
3 activities are conducted. We make a tour of the
4 facility to see if minorities are represented at
5 all, number one and if they are, are there room
6 assignments, are there activities being given
7 without regard to their race or color or creed.
8 So that we don't -- we should call to
9 someone's attention and actually it would be me or
10 Mr. Campbell in the Buffalo offices here, his
11 attention if we see that a minority patient is being
12 housed with another minority and taken care of by
13 minority aides, whereas whites are treated
14 differently. That's the kind of thing we should be
15 cognizant of.
16 PROF. NISHI: Now, are those public
17 reports, the results of the survey?
18 MR. CARMELLO: Certainly my finals are
19 available. We have statistics going back eight or
20 ten years. Mr. Campbell has statistics in the
21 Buffalo area. Each area office and perhaps I should
22 give an overview, in New York State we have six area
23 offices, health departments and in each of those
offices, there is one in Albany, Buffalo, Rochester,

1 Syracuse, New York City and New Rochelle. From
2 those offices, they sprinkle out staff. We have
3 nurses going in, doctors, social workers, compliance
4 investigators. They go into the facility on a
5 regular basis.
6 Now, obviously they are primarily concerned
7 with quality of care given but a piece of their
8 responsibility and interest lies in admission and
9 services given to patients. So, we do have the
10 basis for it and I am as surprised as you that we
11 have very few specific complaints in this day of
12 letigiousness, it's incredible that we don't go
13 after more facilities.
14 PROF. NISHI: Well, I noted that I was not
15 surprised because this is a highly institutionalized
16 outcome.
17 MR. CARMELLO: That is true.
18 PROF. NISHI: And it's very difficult to
19 link it to specific intent to exclude.
20 MR. CARMELLO: That is correct.
21 PROF. NISHI: But I am interested in also
22 in, I understand that applications cannot include
23 indentifying information regarding to race,
ethnicity, et cetera.

1 MR. CARMELLO: No. That is not correct.
2 No, applications, in fact, I wish Michael Carter was
3 here. We have written to Michael to get a reading
4 because over the past several years, we have created
5 a document which is called a hospital and community
6 patient review instrument, HCPRI is the document
7 that all hospitals and doctors offices and home
8 health agencies use and there are two questions on
9 that document which refer to racial make-up.
10 So, we do have now, but it's interesting,
11 some individuals in some organizations have said we
12 are not supposed to ask that question and our
13 rebuttal is, we won't be able to really do our job
14 if we don't have the statistics. If we don't know
15 how many people have submitted HCPRI's, in what
16 percentage, it would be impossible to find out what
17 facilities are doing.
18 So, that is under review right now but we
19 are still using that document and it does contain
20 racial information and that's the document that is
21 supposed to be maintained by long-term care
22 facilities so that we can look at referrals and see
23 if there is 100 referrals of minorities and no
placements, that's obviously an alert to us to work

1 with that facility or the hospitals and find out why
2 minorities are not getting into this facility.
3 MR. COX: I think there is a question back
4 there? Yes?
5 DR. GOREY: I have a comment. Is that
6 appropriate?
7 MR. COX: Yes, please.
8 DR. GOREY: My name is Kevin Gorey, Center
9 on Aging, University of Buffalo.
10 I just wanted to comment, I'm not surprised
11 at all of the infrequency of a direct complaint
12 where racial discrimination is implicated because
13 even all the information that we presented, from a
14 methodological rigorous point of view, no one could
15 make a point that this is a direct effect of race.
16 There is a lot of covariance associated with race
17 that differentiate different groups of people and
18 take the example, yes, one common portal of access
19 to the nursing home is the hospital and we are
20 gaining information here, for instance, take a group
21 of vulnerable elders, those on ALC, Alternative
22 Level of Care.
23 When we take a look at people who are
equivalent in payer, their ability to pay, all

1 Medicaid people for instance, there are other things
2 that differentiate racial groups and there is a
3 whole host of factors that are relevant here.
4 Let's say, access to preventive care at a
5 younger age and so, we see among the ALC population
6 is that among those people, let's just say the same
7 comparison that we presented earlier, Black and
8 white, comparing equivalent ability to pay, there is
9 a profound difference between groups on, let's call
10 it the attractive versus unattractive type client
11 for a nursing home. That is the
12 difficult-to-care-for versus the
13 more-easily-to-care-for patient. The older African
14 American, I don't have the exact statistics with me
15 but a number of comorbid conditions, complications,
16 the unattractiveness of the picture for a nursing
17 home admitting a person and so, you know, that would
18 never - - even the people directly involved, the
19 family members may never identify that as, we are
20 being discriminated against on the basis of race.
21 MR. CARMELLO: The gentleman mentioned the
22 ALC, though. Let me just point out that, ALC which
23 is the Alternative Level of Care, I, in an attempt
to get more information not for this meeting but

1 for our ongoing interest in this issue, we did a
2 quick review and I am not a statistician but I was
3 curious if the ALC statistics would show a skewing
4 towards minorities. If there is 1,000 individuals
5 waiting to be placed in long-term care facilities
6 throughout a certain region, they are waiting in
7 hospitals, if minorities are not getting in, you
8 would think there would be a higher percentage
9 compared to the community and that's not true. The
10 statistics we have, they are even. When you throw
11 out all the other variables, minorities waiting for
12 ALC and other individuals, it's the same percentage.
13 MR. COX: Mr. Cunningham.
14 MR. CUNNINGHAM: I have two questions.
15 One, have you in the state or perhaps private groups
16 locally ever considered the use of testers in
17 discrimination provisions?
18 MR. CARMELLO: Yes, we have. There is some
19 legal complications as you know but frankly, that's
20 one of the things that, when the State Health
21 Department has that interest or that need for that
22 approach which frankly I have advocated myself
23 personally over the years, we worked through another
agency, either a special prosecutor or the AG's

1 office and I believe that's going on.
2 MR. CUNNINGHAM: So, there is actual
3 testing going on or what are the legal problems you
4 mentioned?
5 MR. CARMELLO: Well, if somebody doesn't
6 represent the Health Department, how do you do it?
7 I mean, if we have one of our own people do it, does
8 that smack of a set-up, entrapment, but I think that
9 is the way to go. To me, I'm not a lawyer but I
10 have been advocating that for a long time. Let's
11 try it a few places where we think, where we have
12 the impression that their admissions policies are
13 questionable. Let's try to get a minority in at the
14 same time as a Medicaid white person and make all
15 the circumstances the same, all the factors and
16 let's see what happens but we have not personally
17 tried it ourselves. I believe that other agencies
18 are doing that as we speak, frankly.
19 MR. COX: The gentleman in the back. Would
20 you identify yourself, please?
21 MR. CAMPBELL: I am James Campbell, Area
22 Adminsitrator for the New York State Department of
23 Health here with Mr. Carmello this morning and I
just wanted to comment a bit further on what he had

1 mentioned earlier about the Alternate Level of Care
2 patients that are backlogged. We have done some
3 reviews on this and what is shown is that there is
4 discrimination based on sponsorship and by that it
5 is the physical A or physical C patients which are
6 the low care need, low reimbursement patient which
7 tend to be backlogged and this is what is plaguing
8 the system right now which I think takes on what Dr.
9 Richter had said earlier.
10 MR. COX: Paula Ciprich.
11 MS. CIPRICH: You had made reference to
12 Medicaid access regulations that were struck down by
13 the court and I think that the way you presented
14 that is that this was an attempt on your part to
15 make the system more even-handed and remove perhaps
16 a covariant for discrimination. What was the ground
17 for striking down the regs?
18 MR. CARMELLO: Well, I happen to have it
19 right here and again, I'm not a lawyer but it was
20 the New York State Health Facilities Association
21 which is an organization representing a very large
22 chunk of long-term care facilities. They sued Dr.
23 Axlerod and here's the first paragraph.
You are a lawyer, right?

1 It's says, the first paragraph of this memo
2 which is an internal memo that I obviously don't
3 know if it's available to release to the group, but
4 I'm going to read the first paragraph.
5 The Appellate Division Third Department has
6 affirmed an adverse lower court decision which
7 declared the Department's Medicaid access
8 regulations are invalid as they constitute an
9 Affirmative Action Program that was enacted without
10 expressed legislative authorization and in violation
11 of the Public Health Law.
12 See, the Association challenged our right
13 to do that to assure the patient admission policy
14 provided for access to Medicaid eligible individuals
15 and just reading through the regulation, the
16 regulations, as I said before, were promulgated by
17 the Public Health Council pursuant to its authority
18 to consider public need and other pertinent factors
19 in considering establishment applications. We
20 require facilities to ensure that their Medicaid
21 admission rate was at least 75% of the average
22 Medicaid admission rate in the long-term care
23 planning area, each catchment area of the facility.
The regulations also provided for certain

1 factors which could be considered in modifying the
2 75%. So, as I summarized before, that is what we
3 are trying to do. We are trying to require
4 facilities to provide Medicaid access to X percent
5 based on their catchment area and that is what was
6 overruled.
7 MR. COX: On the grounds that there was not
8 specific legislative basis for it?
9 MR. CARMELLO: That's correct. So, then
10 that goes back to our other law and when, why don't
11 you speak on that issue?
12 MS. JOSPEH: I am Gwen Joseph from the
13 State Health Department. Basically, we were talking
14 in the car about the same thing. I recently
15 attended the Choices seminar for the past three
16 Saturdays and I was speaking to Mr. Campbell and Mr.
17 Carmello about the percentages of Blacks that were
18 there. We have had an increase, this is the second
19 year of having the program and it has to do with
20 long-term care and the alternatives that patients
21 have.
22 There were approximately 250 people each of
23 those Saturdays and I can say the first Saturday we
had 10 Blacks because I counted and maybe five to

1 eight the following Saturdays.

2 My point about the Medicaid admission rate,
3 just because a patient is Medicaid, we have no idea
4 how many Blacks are included within that rate. Take
5 this specific area. I don't know what studies have
6 been made to make a determination as far as because
7 you are on Medicaid, are you Black or vice versa.

8 So, it would seem to me that studies have
9 to be made to make that determination. Catchment
10 areas, are we talking Black areas as opposed to
11 white areas, as opposed to the nursing home that is
12 in Williamsville as opposed to the one that is here
13 in Buffalo?

14 So, those distinctions have to be made and
15 when you put into play the very fact that most
16 patients want to be near their family members. So,
17 I think more studies are going to have to be done to
18 find out what are we talking about, demographics,
19 what are we talking about percentage-wise and how
20 many Black elderly are there on Medicaid. Are they
21 being placed and where are they being placed?

22 So, there are many questions that come to
23 my mind that have no answers as of yet.

MR. CALABIA: You say that you have data,

1 numbers actually which indicate by rates and
2 ethnicity those who apply for admission with nursing
3 homes.
4 MR. CARMELLO: No, not applying, those that
5 are admitted. We have statistics on census. We
6 don't have applications.
7 MR. CALABIA: So, you can tell who is there
8 but you can't tell who is admitted and not allowed.
9 CHAIRMAN OI: Who were denied admission.
10 MR. CARMELLO: That is correct.
11 CHAIRMAN OI: Aren't the Medicaid data
12 available from the Social Security Administration?
13 Isn't that simply a run of the tape?
14 MR. CARMELLO: Oh, I would think so, yes.
15 CHAIRMAN OI: I would think so.
16 MR. CARMELLO: In fact, when we gather our
17 statistics of the folks who are in a facility, we
18 get it by payer source and we get it by racial
19 composition so that we can tell, of the 100,000
20 individuals in New York State that are in long-term
21 care right now, how many are Black, how many are
22 Hispanic, with a breakdown of Oriental, all that
23 kind of stuff. In fact, the Feds break it down to
Alaskans or Orlutes, we have a break in Simoans.

1 That's available. What we don't know is how many
2 have applied. That makes it difficult and --
3 MR. CALABIA: That is the point of what we
4 are talking about today. Do you know of any other
5 state that is attempting to do these kinds of
6 studies?
7 MR. CALABIA: Not really. I think frankly
8 New York State is probably ahead in this area where
9 we require a nursing home to keep every possible
10 referral because this, HCPRI form has to be sent by
11 discharge planners on a regular basis. They might
12 say send the same form on the same patient in five
13 times in a period before that patient is admitted
14 some place. So, these facilities keep thousands and
15 thousands of these documents.
16 MR. CALABIA: But again, these are only
17 patients that were admitted.
18 MR. CARMELLO: Referrals, no. You have a
19 referral and then from a referral you might have an
20 applicant and then from the applicant you have an
21 admission. It's that middle piece that we do not
22 have yet that, how many actual minorities are how
23 many minorities have actually applied and that is
the thing we all have to work on but even then, as

1 was pointed out, if they apply, there are so many
2 variables and so many clever ways that individuals
3 or organizations can keep them out. They can say at
4 this particular time, we cannot handle a patient who
5 needs a ventilator, something that is exotic at that
6 point. So, there are ways of getting around the
7 system.
8 MR. CALABIA: How often do you analyze the
9 data on who was admitted? Are they annual reports
10 or semi-annual?
11 MR. CARMELLO: Yes. We prepare a document
12 that we send to the Department of Social Services
13 who then sends it to OCR. We do it as a quarterly
14 report.
15 MR. CALABIA: Can we be provided with that?
16 MR. CARMELLO: Sure. I would need a
17 request in writing but I would be glad to send you
18 whatever you ask for. I would be happy to do that.
19 Now, Tino and I were talking the other day
20 about Title VI which is probably the document or the
21 instrument used around the country but even Title VI
22 does not talk about payer or sponsorship and if you
23 folks have anything to say, perhaps that is an area
you can move into. It's a touchy area and I'm sure

1 New York State is not unique, that if Medicaid is an
2 $80 a day cost and a private is $135, I am not sure
3 Congress or the State Legislators would say, you can
4 mandate that a facility take an $80 a day patient
5 before they take a $135 a day patient. That's the
6 key and until we overcome that obstacle, how we are
7 going to continually have this battle.
8 MR. COX: Mr. Cunningham again.
9 MR. CUNNINGHAM: Did you indicate at the
10 beginning of your presentation that Medicaid
11 recipients were being turned away from facilities in
12 favor of private payers?
13 MR. CARMELLO: Well, I think that is what
14 happens. You know, on a given day, if you were
15 Medicaid and I was private and we both applied to a
16 facility, that facility has the right to take the
17 private patient. As a natural consequence, they
18 would take the person paying $50 more.
19 MR. CUNNINGHAM: Are these facilities then
20 pretty close to capacity or facilities with several
21 open beds or whatever?
22 MR. CARMELLO: Well, see, that's the thing
23 about long-term care. In New York State, it's a
franchise system as you may or may not know. The

1 State Health Department controls the licensing on
2 these facilities. So, we, and that's another thing
3 that is my own personal pet pea so it's not really
4 official but I think if we open it up like any other
5 business, it would alter things but right now, we
6 restrict how many facilities and how many beds there
7 are going to be and most facilities have waiting
8 lists. I mean, it's a great business. People
9 complain about it but individuals are knocking down
10 the doors to buy nursing homes, I'll tell you that.
11 MR. COX: Let me just ask this, though: Is
12 it or is it not true that one factor in making such
13 a decision, of course, very likely would be the
14 differential in the payment rate but may it not also
15 have to do with the sometimes long time lag that
16 occurs with respect to processing a Medicaid
17 admission compared to somebody who has, so to speak,
18 cash-in-hand?
19 MR. CARMELLO: It's possible. I think the
20 Medicaid pending may be going to speak to that more
21 than I. I think if somebody is on Medicaid already
22 in a hospital, you know, their eligibility has been
23 established, I'm not sure whether that's a long
process to get into a facility but if they are

1 pending Medicaid, that is a little scarey for
2 facilities.
3 MS. JOSEPH: Well, I have done in the past,
4 admissions, approval of admissions into nursing
5 homes and it is up to the nursing home whether or
6 not they're willing to take a Medicaid pending
7 patient. We find that most of them will if they
8 have the bed available and then to speak on - - at
9 this seminar that I attended Saturday, they had
10 several of the administrators from various nursing
11 homes and the not-for-profit had to admit that in
12 order to accommodate patients that are Medicaid,
13 patients that are poor and the indigent, they had to
14 have a percentage of private pays and in fact, they
15 had said that a lot of these patients are balanced
16 on the backs of the private pays.
17 So, even the proprietary more but the
18 not-for-profit, a certain percentage had to be
19 admitted.
20 CHAIRMAN OI: Can I ask, what is the reason
21 for the restriction on entry?
22 MR. CARMELLO: Restriction in what way, sir?
23 CHAIRMAN OI: In a nursing home? If there
are people wanting to open new nursing homes?

1 MR. CARMELLO: Well, that is the Public
2 Health Law, 2,800 of the Public Health Law says that
3 if you and I wanted to open a nursing home, we have
4 to be approved by the Public Health Council.
5 CHAIRMAN OI: But why doesn't the Public
6 Health Council approve if they meet the
7 qualifications?
8 MR. CARMELLO: Oh, they would but the
9 qualifications involve need, charcter of competence
10 and financial feasibility and need is the key. You
11 would have to show that there is an unmet need in
12 certain areas, to prove that you can open a 200-bed
13 nursing home. You have to show that statistically.
14 CHAIRMAN OI: But why is that requirement
15 there? We don't ask McDonald's to show a need
16 before they open?
17 MR. CARMELLO: You are right. As I said,
18 my own personal opinion agrees with you but there is
19 a franchise system in this state and I don't know if
20 other states have the same experience.
21 CHAIRMAN OI: You don't know if other
22 states have the same sort of - -
23 MR. CARMELLO: I really don't. I really
don't.

1 MR. COX: Yes, Jim. Maybe Mr. Campbell
2 knows.
3 MR. CAMPBELL: I believe what they do in
4 response to the federal health planning regulation,
5 that you will find that members of the state with
6 what is called the Certificate of Need process but
7 let me go one step further than that. As Mr.
8 Carmello said, take for example in Western New York
9 which I am most familiar with, there are over 1,000
10 approved beds that have been waiting anywhere from a
11 year to two years for construction and as part of
12 this I would cite for you the financial
13 arrangements. In other words, securing HUD
14 mortgages and other types of environmental impact
15 studies which must be done that have lengthened the
16 lead time extensively.
17 At one point it used to be 18 months to two
18 years to build a nursing home, some ten years ago.
19 Now, one could figure at least a three-year to
20 four-year construction period and what I am saying
21 is, I am most familiar with one of the facilities
22 that is due to environmental problems in the area,
23 the structure was not approved and it has been
delayed over 18 months.

1 Now, this has an additive effect. We are
2 short 1,000 beds in this community. Where do these
3 people back up? The 1,000 beds are on paper. They
4 are approved by they don't exist in physical reality.
5 Therefore, we have that type of shortage
6 and what is going to happen, the private pay patient
7 will always gets the best and, of course, the Blue
8 versus Whalen decision of some ten years ago, Bill,
9 I believe, knocked out our ability to take action
10 based on the financial sponsorship. We lost in
11 court.
12 MR. CARMELLO: But Jim, the answer to the
13 gentleman's question, there is a federal rule in
14 terms of - - that is something that the Commission
15 may look at, too, that a lot of states have
16 franchise systems because of that.
17 I guess it goes back to the same thing,
18 that we restrict the number of doctors. There are
19 some who feel that the more doctors, the more
20 expensive it's going to be. Perhaps if we opened
21 100 more nursing homes, Medicare and Medicaid will
22 skyrocket. I'm not sure but I never quite
23 understood that economic theory.
I've got to say, that our Commissioner is

1 the one that - - we restrict the number of
2 physicians in this state, is that not true?
3 DR. RICHTER: That we restrict them?
4 MR. CARMELLO: Yes, sure.
5 DR. RICHTER: In terms of medical schools.
6 MR. CARMELLO: Yes. Well, that's a
7 restriction. So, we are not saying if we have more
8 doctors, everything would be great because it would
9 be cheaper and more available. I guess the opposite
10 effect can work. So, maybe that's the reasoning.
11 I'm just presuming.
12 DR. RICHTER: Because the more doctors
13 there are, the more they perceive that they have to
14 maintain their income. So, they provide more
15 services and for example, a physician who has a
16 Medicaid patient, in order to make ends meet will
17 have the patient come back again and again and again.
18 MR. CARMELLO: A few X-rays and a few extra
19 prescriptions and perhaps that's the theory behind
20 franchising for long-term care facilities. I really
21 don't know.
22 MR. COX: Prof. Nishi.
23 PROF. NISHI: Yes. I'm intereted in the
institutions which are under religious auspices. Do

1 they also come under your requirement that they be
2 non-discriminatory?
3 MR. CARMELLO: Yes.
4 PROF. NISHI: And how is that enforced?
5 MR. CARMELLO: Here is what happens. As a
6 facility is approved through the Public Health
7 Council to be established, if their original
8 establishment contained language and legally adopted
9 that said choose Roman Catholics, Baptists, whatever
10 would have preference, they have a right to do that.
11 What we do is go back to the organization to see if
12 that organization discriminates.
13 For example, there are homes for Masonics
14 in New York State. There are a lot of fraternal
15 organizations. The key to our approach is do those
16 organizations discriminate. If they don't, the
17 organization which is the sponsor of this long-term
18 care facility, can carry out those mandates for
19 long-term care.
20 So, we do allow it and we do enforce the
21 same rules but you can give preferential treatment
22 if it's built into your original charter.
23 PROF. NISHI: Thank you.
MR. COX: Well, I think this is all been

1 very helpful and I thank you very much on behalf of
2 our group and the others here for having come.
3 I think we will move on then to our final
4 speaker for the morning because I'm not clear how
5 much time will be involved there.
6 Mr. Robert Mendez, I believe you are the
7 Commissioner of the Erie County Department of Senior
8 Aging Services, is that correct?
9 MR. MENDEZ: Correct.
10 MR. COX: And you are going to make a
11 presentation now.
12 MR. MENDEZ: Yes. Good morning. My name
13 is Robert A. Mendez. I am the Commissioner of the
14 Erie County Department of Senior Services. I would
15 like to thank the New York State Advisory Committee
16 to the U.S. Commission on Civil Rights for convening
17 this important forum.
18 The Erie County Department of Senior
19 Services has played a very important role in the
20 determination of needs among the
21 non-institutionalized African-American elders in our
22 community. In 1988 a report was released which was
23 the result of early planning and support by our
department with the State University of New York

1 at Buffalo and its multi-disciplinary center for the
2 study of aging. The most recent update of this
3 report was funded through a grant from the New York
4 State African-American Institute in Albany, New York
5 entitled "The Assessment of Health and Social
6 Service Needs of Older African-American Residents of
7 New York State."
8 It reflects on a statewide basis those
9 issues which we had earlier identified in Erie
10 County.
11 As an area agency on aging, our mission is
12 to plan and coordinate services designed to
13 encourage independent community living for our
14 seniors. Our wide network of services and our
15 frequent public forums to determine what seniors
16 both need and want simply strengthen our belief that
17 at home is where most seniors wish to be. For this
18 reason, my comments here today at a meeting that is
19 designed to address the issue of equal and adequate
20 long-term care institutional living for the elderly,
21 will focus on those services for community care.
22 Let me first present briefly the current
23 state of service provision to minority senior
citizens in Erie County as part of the programs

1 provided by our Department. Through contracts with
2 Buffalo Federation of Neighborhood Centers and St.
3 Augustine's Center, the Department offers
4 transportation, escort service, case management,
5 case assistance, errand and chore and friendly
6 visiting. In addition, a separate contract with St.
7 Augustine's provides home care to senior citizens
8 eligible for care under our state funded expanded
9 in-home services to the elderly program. A contract
10 with Friends to the Elderly also provides errand
11 chore services to seniors.
12 There are currently ten senior congregate
13 dining sites located in the 141st District. there
14 are Buffalo Urban Leagues, Commodore Perry Senior
15 Center, Concordia Lutheran Church, Fillmore-Leroy
16 Residents, 1490 Enterprises, Kensington-Bailey
17 Community Center, Kenfield-Langfield Senior
18 Citizens, Moot Senior Center, Ulinski Senior Center,
19 and William Emsley Y Senior Center. Seven of the
20 dining sites in the district are served an
21 African-American menu. Over 100,000 congregate
22 dining meals were served at the sites in the
23 district during 1989. This represents 16.8% of the
total meals served in the county.

1 The unduplicated number of seniors
2 participating in the congregate dining program at
3 sites in the district was 1,038 of which 670 were
4 African-American elders who participate in the
5 entire county congregate dining program. This
6 excluded people who attend on an occasional basis
7 and do not register.
8 Our Meals on Wheels program delivers meals
9 and operates 16 routes in that district. Over 200
10 homebound clients are being served, of which
11 approximately 140 are African-American elders. In
12 addition to the transportation offered by our
13 subcontract agencies, our Going Places vans also
14 operate in the minority community. In combining
15 both Department operated and contract agency
16 operated vans, in 1989 we determined that over 16%
17 of all of the Department's transportation services
18 went to African-American elders.
19 At the very core of all programs and
20 services which we designed are two important
21 features: Information and access. The concept of
22 information and access apply equally to entrance
23 into the institutional system as they do in our
community care system. In the development of case

1 management services throughout Erie County, our
2 design has led us to contract with agencies within
3 ethnic communities to foster a sense of trust
4 between the service providers and the residents of
5 that community. In completely assessing and placing
6 before individuals the many alternatives to
7 institutional care, we also are laying the
8 foundation for equal access to these institutions.
9 There is another underlying truth to be
10 understood. There simply are not enough long-term
11 care beds in Erie County to handle the needs of
12 those both eligible for and assessed at the level of
13 need. We also know that people in lower economic
14 groups have most difficulty in accessing long-term
15 care beds.
16 The Medicaid population has placed a great
17 demand on nursing home care beds. The situation has
18 been made more difficult by the fact that many
19 elders have lost their support systems. Families
20 have moved away, spouses and elders become dependent
21 on those of us in public service and community
22 agencies to act as their voices but we really aren't
23 here today to talk about what we know to be the
facts. Those facts have been laid out very

1 efficiently in the various reports to which we have
2 alluded to. If we are solve some of the problems
3 presented in the many, many documents, we have to
4 come to grips with the realities of joining the
5 community care system with a long-term care
6 institutional system. We have to talk to each
7 other. We have to become a presence in the
8 community for coordination and planning.
9 Currently the only formal link between
10 these systems with regard to the elderly is the New
11 York State Office for the Aging Ombudsman Program,
12 which provides volunteers who act as patient
13 advocates. This is fine for those individuals who
14 are already in the nursing home. However, what
15 about those in the community for whom we are
16 responsible. We also need to destroy some of the
17 myths about institutional care and provide
18 informational forms for individuals so that the fear
19 of this extension of community living is somewhat
20 alleviated.
21 I look forward to continuing dialogue with
22 presenters here today and with other community
23 leaders and again, would like to compliment the
Commission and the New York State Advisory Committee

1 for raising the level of consciousness in this very
2 important issue in our community.
3 Thank you.
4 MR. COX: Thank you. Now, certainly again
5 we are open to comments and questions to Mr.
6 Mendez. Walter?
7 CHAIRMAN OI: You cited some statistics on
8 the services that you are providing and from what I
9 could gather, a little over half of these are going
10 to Afro-Americans, right, or about two-thirds?
11 MR. MENDEZ: In this particular district,
12 yes, that we are citing, which is the primary
13 concentration of minority elders in the County of
14 Erie. Approximately one-fifth of all of our service
15 provided by our, particularly our department, is
16 provided to the minority elderly in the community.
17 CHAIRMAN OI: To the minority elderly.
18 MR. MENDEZ: Yes.
19 CHAIRMAN OI: And how do you get your
20 referrals here?
21 MR. MENDEZ: We get our referrals through
22 two types of systems: One directly through the
23 community-based agencies that we fund and two, by
direct contact with our department and we have a

1 public telephone and public information on referrals
2 and we also do a great deal of outreach out in all
3 of the various communities in the county. We have a
4 regular ongoing, what we call our MAP program,
5 mobile assistance program that we go out to all of
6 the senior citizen centers and any areas where the
7 seniors do have a population and go out and reach
8 out to the seniors and in addition to those who call
9 us directly.
10 MR. COX: Let me ask you, how your activity
11 joins up with that of the operation of Mr.
12 Carmello's?
13 MR. MENDEZ: Well, as I said in my prepared
14 remarks, this is one of the areas where we feel that
15 there must be a great deal of improvement on. We do
16 provide a great deal of community-based care. The
17 primary focus of our department is encouraging and
18 assisting seniors to be able to live independently
19 as long as possible before they need that next level
20 of care and that's one of the areas that we feel
21 does need to be improved, where do we go from Point
22 A to Point B. There is a gap there.
23 MR. CARMELLO: If I may, also, the State
Health Department has an ongoing dialogue in many

ways with the State Office for Aging and I assume you folks work for the State Office of Aging. So, there should be a connection at some level as we develop rules in terms of long-term care, whether they affect discrimination or not, various rules and by mandating by the Governor's directive and in some case by law, we have to work with the State Office for Aging to promulgate those requirements to make sure that they are involved in the decisions.

MR. CALABIA: Just to remind the Committee, that we did invite the State Office of Aging and their representative was only here for several minutes. Perhaps we should address further questions to them subsequent to this particular forum.

Mr. Mendez, you also said that, if I didn't misunderstand you, there is a definite need for additional nursing home beds?

MR. MENDEZ: From our perception, yes because we are working with seniors trying to keep them as independent as long as possible in the community and while this is a major task, at some point there are a great number of seniors who cannot be helped in their homes to any great degree and that

at that point, there is difficulty and linking them from that level of care to the institutional care has been brought up by many of the speakers here. For example, we have 1,000 beds in our Western New York area right now that they are on paper approved but they are not a reality. So, from our perception, we do feel that there is a need for more beds.

MR. CALABIA: So, does the planning group which Mr. Carmello referred to that has already agreed there is a need for additional beds, there is a 1,000 in the pipeline?

MR. MENDEZ: You would have to answer that.

MR. CARMELLO: That is correct.

MR. COX: What is the current number of actually available?

MR. CARMELLO: I don't know.

MR. CAMPBELL: There is currently in the eight Western New York counties, an inventory of around 10,500 beds. This represents - -

MR. COX: How many counties, eight?

MR. CAMPBELL: Eight Western New York counties, 10,500 beds. So, you are adding another 1,100, you are increasing by about 10% and of course,

1 these are in various stages of construction. There
2 is one actually under construction right now. The
3 lead time for building is anywhere from 12 to as
4 much as 24 months. That's going to construction
5 once you are approved. There is a three to
6 four-year period from the time of approval until the
7 doors open.
8 CHAIRMAN OI: Do you have any idea what
9 that cacacity was five years ago?
10 MR. CUNNINGHAM: Five years ago, the
11 capacity five years ago, don't hold me to the exact
12 numbers but actually the capacity five years ago was
13 probably around 9,000 beds.
14 CHAIRMAN OI: Are we just staying even,
15 even if we approve 1,000, you are behind.
16 MR. CUNNINGHAM: Based upon, again, this is
17 the whole science of health planning and
18 demographics of the aging and, of course, what we
19 are finding is, I go back ten years, I can go back
20 ten years - -
21 CHAIRMAN OI: The over 70-year gang is
22 growing faster than that, isn't it?
23 MR. CUNNINGHAM: Well, the other aspect is
that there is a reduced turnover in the beds. By

1 that I mean, people who are there tend to occupy
2 them longer. They are living longer because of the
3 amount of pressure there is in providing quality
4 health care to those people. They don't tend to
5 develop the same kinds of problems and the same
6 numbers.
7 CHAIRMAN OI: Is that adjusted for the age
8 at admission?
9 MR. CUNNINGHAM: I can't tell you whether
10 it is or isn't. It's a phenomenon that has
11 occurred, that now is going to be factored back into
12 the health planning process when you reduce turnover.
13 CHAIRMAN OI: So, the thousands you are
14 going to be behind, right. It's going to be as if
15 we destroyed 1,000 beds now.
16 MR. CUNNINGHAM: I can't say that at this
17 point without knowing what the turnover rates are.
18 CHAIRMAN OI: You know how much the
19 population of people over 70 is going to be.
20 MR. CUNNINGHAM: Well, I will tell you, the
21 1,000 beds are a start and there will undoubtedly be
22 other alternatives required beyond that. Now, as
23 you build support of housing which is an area that
there has been no reimbursement for and this has

1 been a real problem, a gap in the marketplace,
2 supportive housing as you would build that would
3 take the pressure off of the nursing home beds.
4 Now, why is their no support of housing? The answer
5 to that is, I believe, it's very simple. Although
6 there are people that can give you a much better
7 explanation than I, but let me tell you that under
8 SSI, we get what, $650 a month which is their
9 available allotment on which to live. You then move
10 to the health related level which is around $2,000 a
11 month and a skilled nursing facility which is around
12 $3,000 a month. You don't have the support of
13 housing in there at $1,500 or $1,600 where they can
14 get some health services.
15 It is nothing that is recognized by
16 Medicaid or Medicare for reimbursement purposes.
17 Therefore, we end up channelling people and many
18 times to the higher side.
19 MR. CARMELLO: Adding to that problem I
20 think, and this is not my particular expertise, but
21 recently the federal government, TICVA has
22 eliminated the category of intermediate care
23 facilities. Everything is a nursing home or a
skilled nursing facility. So, what Jim pointed out

1 is the higher level is there and the lower level but
2 there's really nothing in between and this could
3 turn out to be a problem.
4 MR. CAMPBELL: That is correct. You move
5 from the $650 a month SSI in a domicilliary level of
6 care up to a $3,000 a month nursing home bed. We
7 have just relicensed all our beds as nursing home
8 beds effective October 1st.
9 PROF. NISHI: May I ask Mr. Carmello, we
10 regret of course that the persons who were to
11 testify from the Hispanic American and Asian
12 Americans on behalf of their concerns was not able
13 to be present but I'm wondering in your experience
14 whether you are able to offer us some observations
15 about any inequities or special obstacles that they
16 may confront?
17 MR. CARMELLO: I really am not. It might
18 be interesting if Tino or one of you folks writes me
19 and asked me for a breakdown of it. I have to
20 admit, we don't do an analysis of Hispanics Asian
21 population now versus five years ago. So, I'm
22 really not aware there is an issue. In both
23 cultures it's interesting that there is a lower
number of percentage of individuals in facilities

1 than the percentage of over 65 because that is how
2 we attempt to attack the issue. We go by the 1980
3 and we are hoping to get the 1990 census early next
4 year but probably longer than that.
5 We provide to our area office folks who
6 actually go out and do the assessments, the census
7 figures of age 65 and older for various racial
8 groups and without being held to this
9 scientifically, I would guess that the percent of
10 Asians over 65 is higher than the percent of Asians
11 in facilities, considerably versus the other
12 category and I really think it's my own personal
13 opinion that it's a cultural issue of familial ties
14 and so forth, the same as the Hispanics. We found
15 in New York City, for example, a lot of the elderly
16 Hispanics go to Puerto Rico. They go back to Puerto
17 Rico or to other islands where they came from as
18 they reach a certain point.
19 PROF. NISHI: Well, there are a variety of
20 reasons why Asian Americans are not in such
21 facilities and one of them is that factor but that
22 is only one, of course.
23 MR. CARMELLO: Yes.
PROF. NISHI: But I hope indeed that we will

1 request those reports and so that such an assessment
2 could be made.
3 MR. CARMELLO: Sure.
4 MR. COX: Dr. Gorey, I believe had a
5 comment.
6 DR. GOREY: Just a brief comment just to
7 underscore a point that was made earlier. As was
8 outlined how we think about equitable access and
9 whether or not the industry is doing a good job with
10 that, population proportion is the criteria. The
11 underlying assumption there is that basically it's a
12 homogenious group of older people. They are all the
13 same and that the need is the same among all
14 different cultural groups, racial groups, et cetera
15 and I did a little bit of research here in New York
16 State and it concurs with that around the nation,
17 that that is clearly false. In my estimation and it
18 gets to the point that Dr. Richter made, that that's
19 the hope for a national health care plan, that it's
20 a need-based system, that it can start to control
21 for all these competing forces, race being just
22 one. If it's a need-based system, then it doesn't
23 matter if 15% of the older people in Erie County are
Black who needs care, whether it's 25% of Black, of

1 old Black people or whatever.

2 MR. COX: Any other questions or comments?

3 CHAIRMAN OI: Do your statistics also

4 extend to Native Americans?

5 DR. GOREY: No, sir, they don't, very

6 specific focused survey.

7 MR. COX: It's nearing 12:00 o'clock and

8 given the time that it may take people to eat lunch

9 and the various other things, I think if there are

10 no further pressing questions, we will adjourn for

11 this morning's session and convene at 1:30, is that

12 right, Tony?

13 MR. CALABIA: Right.

14 MR. COX: Thank you very much for your

15 attendance and your participation.

16

17 (WHEREUPON, the above proceedings were

18 adjourned for lunch.)

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AFTERNOON SESSION:

CHAIRMAN OI: Good afternoon. May I welcome you to this forum of the New York State Advisory Committee to the U.S. Commission on Civil Rights. My name is Walter Oi. I'm Chairman of the New York Advisory Committee, and joining me today are Prof. Setsuko Nishi, Ms. Paula Ciprich, who is an attorney-at-law her in Buffalo, Tino Calabia from the staff of the U.S. Commission on Civil Rights and Mr. James Cunningham who is the Chief Economist for the Civil Rights Commission, to join us today on this forum on implementation of the Fair Housing Amendments Act of 1988, discrimination and housing.

I want to state at the outset that we welcome your participation and no one to this forum has been subpoenaed; that the information is being provided voluntarily; that we do not want any statements that are demeaning of any individuals; that the materials that are being given here today are being transcribed by a court stenographer. It will be available with the usual privacy and Freedom of Information Act in the staff offices of the Civil Rights Commission.

1 If any of you have prepared statements, we
2 welcome to have them put in the record. If you want
3 to submit written materials subsequent to this
4 hearing, please feel free to do so to Mr. Calabia at
5 our Washington offices.
6 I'm going to ask Ms. Paula Ciprich to chair
7 the session this afternoon and if any of you have
8 any questions -- I think I covered most of the
9 basis. Did I leave anything out, Tino?
10 MR. CALABIA: No.
11 CHAIRMAN OI: So, let's get started.
12 MS. CIPRICH: Okay. I guess before we get
13 started I will just ask that before you speak you
14 identify yourself clearly and when we ask for
15 comments from the audience I ask that you identify
16 yourself to the court stenographer so he can get
17 your name.
18 Is Olga Diaz not going to be here this
19 afternoon?
20 MR. CALABIA: No, she called and she said
21 she had not been authorized as of Friday afternoon
22 to travel. She did provide us some data and I have
23 tried to work it up and I will share it with the
audience, members of the Committee as well but she

1 is not here.

2 MS. CIPRICH: Okay. We will then go

3 forward to Mr. Richard E. Clark, the Regional

4 Director of the New York State Division of Human

5 Rights.

6 MR. CLARK: Good afternoon. My name is

7 Richard E. Clark. I am the Regional Director of the

8 Buffalo office of the New York State Division of

9 Human Rights. On behalf of Governor Mario Cuoma and

10 our Commissioner Margarita Rosa, we welcome the New

11 York State Advisory panel to the New York State

12 Division of Human Rights.

13 Before I get to the topic at hand, the Fair

14 Housing Amendment of 1988, I think a brief

15 background of the Division involving Civil Rights is

16 appropriate.

17 Since 1945 New York State was the first

18 state to pass a law prohibiting discrimination in

19 employment. Since that time there have been 93

20 amendments to the New York State Human Rights Law.

21 Today we are involved in employment,

22 housing and commercial space, public accommodation,

23 credit, education and volunteer fire company

membership discrimination cases. These cases evolved

1 under our law on the basis of race, creed, color,
2 national origin, age (18 and older), sex, marital
3 status, arrest and conviction records and disability
4 (including alcoholism, methadone maintenance
5 treatment, AIDS and drug testing screening).
6 The agency is a statewide agency. We have
7 11 regional offices across New York State. Each
8 office has a certain number of counties within New
9 York State, which we are supervised to handle their
10 complaints. The Buffalo Regional Office covers the
11 four upstate counties of Erie, Niagara, Chautauqua
12 and Cattaraugus Counties.
13 Since 1974, on June 15th, 1974 signed an
14 act to amend the New York State Executive Law, in
15 relation to discrimination based on disability.
16 In September of 1974 the Flynn Act, as it
17 was called, was amended and it provided the Human
18 Rights Law to prohibit discrimination based on
19 disability and all fields to which our law applies.
20 The majority of the Division's experience has been
21 in the employment field since the passage of the
22 Flynn Act.
23 In 1988 the Fair Housing Amendments - the
Division's relationship with HUD, even thought the

1 majority of our cases have been in employment over
2 the years, there have been a number of cases filed,
3 housing discrimination cases filed through the New
4 York State Division of Human Rights. Many of these
5 cases are processed as per contract between HUD and
6 the Division in a timely manner, of which is 90 days.
7 Currently under the 1988 Fair Housing
8 Amendment's Act there is legislation pending and it
9 is currently being reviewed by the Governor's office
10 which will make New York State substantially
11 equivalent. We are equivalent relative to
12 disability discrimination but we are not relative to
13 familial status. It's ironic, today's panel is here
14 and we had a new housing complaint that came in
15 today and it's on the HUD form and the gentleman was
16 complaining about his familial status.
17 In effect, he also had no children and I
18 question whether or not he actually had jurisdiction
19 to file a complaint although he did allege race and
20 color. When he checked the form he said familial
21 status but wrote in no children. So, we will be
22 pursing the case.
23 As my secretary said to me, we probably, if
the Feds had marital status and he also indicates

1 that he's being denied housing based on his being
2 single, being a Black male single with no children,
3 and probably under our statute would be under
4 marital status but again, he checked the federal box
5 saying familial status.
6 Since the passage of the Fair Housing
7 Amendments I have had an opportunity along with my
8 other directors, colleagues, to participate in two
9 HUD training sessions; one in the spring of 1989 and
10 one in the spring of 1990. Both of these training
11 sessions have been sessions where the HUD personnel
12 out of Washington and New York will provide us with
13 training under the statute and also relative to the
14 types of cases that start to come in. I know this
15 past spring they gave us statistics where after the
16 passage of the Act in '88 up until '89, there were
17 relatively few cases, but just since January of '90
18 up until I think we met in June, there have been
19 almost twice as many cases that have been filed.
20 So it said to us that the many people who
21 have participated in this training, the populus of
22 the American public is fast becoming aware of what
23 the statute is about.
On the local level, in the last 60 days

1 our office has processed what we call in our
2 Division two special disability housing cases. We
3 say processed because we are merely agents of
4 investigations for HUD. We not making any
5 determinations in these cases, we are just
6 investigating the cases, attempting to consolidate
7 the cases. If consolidation fails, we will be
8 forwarding the case files back to HUD in a
9 particular format that they asked us to put the
10 cases together.
11 So, at the local office that's been my
12 experience and in talking with my headquarters in
13 New York we have processed probably -- it's rough
14 to say, maybe between 12 to 20 cases, which we call
15 special disability housing cases. Again, these
16 cases must be done in a specific time frame and it's
17 60 days we have to process these cases.
18 Regarding enforcement/advocacy, I think
19 there is a need for greater public awareness about
20 this new statute. These organizations like Housing
21 Opportunities made equal, the local Human Rights
22 Commission, in this area you have the Jamestown, New
23 York Commission, the Niagara Falls Commission; a new
organization that I participate with is the Fair

Housing Coalition. You have the Community Housing Resource Board. Then you have HUD, then you have the Division, and that's in front of a network which could probably be larger because a gentleman that I talked to this morning whose office is in this building and he was totally unaware of this forum and he's with the Eastern Paralyzed Veterans and again, these are people in terms of creating a network. They can get the information out regarding the statute to more people in the public.

We in our office in processing just the two special disability housing cases became aware that one - - well, there were two attorneys that were involved representing the Respondent were totally unfamiliar with the statute and we had to refer them to the appropriate place to find the regulations and the materaials about it.

Last week I participated, my agency held a conference in New York which is called EEO-2000. One of the panels dealt with people with disabilities. There was a publication that was just put together by the New York City Bar Association. It's called "The Rights of People With Disabilities." It is very comprehensive and it has all the Federal

1 and state statutes around the country which affect
2 people with disabilities.
3 I guess what I'm saying, the long and short
4 of what I'm saying I think is there should be one, a
5 better partnership with the federal government and
6 local agencies in disseminating information. I see
7 our role as law enforcement. I think we have been
8 in business since 1975 in terms of disability cases
9 and we are well aware of how to process them, but on
10 the other hand, I think the public needs to be more
11 educated as to what this statute really is because
12 in coming down the pike we have the American
13 Disabilities Act.
14 So, with these two acts, the Fair Housing
15 Act and the Disability Act there is a lot of new
16 legislation that will be coming and I think the
17 public to this point is somewhat unaware of what
18 this legislation is. I know the two attorneys were
19 unaware. The two Respondents were unaware and like
20 I said, our training makes us adepth of what we are
21 looking at. We have the regulations in our office.
22 I can call HUD on a tieline any time to get
23 information I need. If we have any type of problems
and they are good with local organizations and I

won't take their thunder away because they will be making presentations, but organizations like Housing Opportunities Made Equal, because they are a vanguard. We are somewhere in the trenches but I think Housing Opportunities Made Equal are even further in the trenches because they have more daily contact with the public and from H.O.M.E., as they are named, the acronym for their name, if they cannot resolve a matter, they will send it to our office and we then become the enforcers of the statute as per our agreement with HUD.

So, in conclusion, I would hope that this presentation for myself and the other panelists will suggest that the public needs to be better aware of the statutes as they come down disseminating publications like this or pamphlets to be designed by HUD or monies to be put forth to agencies like the Community Housing Resource Board or the Fair Housing Coalition, again to get more information out to the public.

Thank you.

MS. CIPRICH: Okay. I think we will take a few minutes here to have any questions. I think I will start with the panel up here first.

1 PROF. NISHI: Thank you very much. You
2 find any interconnection between minority status and
3 awareness of the disability, that is, the right of
4 disability? In other words, is there a greater
5 outreach need?
6 MR. CLARK: Yes, definitely.
7 PROF. NISHI: Among minority populations?
8 MR. CLARK: Oh, most definitely. I tend to
9 say all the time that the cases that we process in
10 the office, a number of times minority persons come
11 in talking about race, sex, other things, very
12 seldom does disability ever come up. During the
13 course of an investigation they might tell you about
14 their problems at work if it's an employment case
15 and that they have had illnesses and the illnesses
16 tend to - - they can still perform their duties of
17 their job but then it goes sort of to suggesting to
18 the investigator maybe there was discrimination
19 behind it, not based on what they allege but based
20 on their disability and we can't raise the threshold
21 and tell people this is what you should do but I
22 definitely think there should be more advocacy in
23 that area.
PROF. NISHI: The reason I question this

1 is that because depending on circumstances, what is
2 perceived as the basis for inequitable treatment
3 will vary but it has been our experience that
4 members of minority groups somehow get a double
5 whammy on this.
6 MR. CLARK: Well, I think that is the part
7 that you used to call it a double whammy. It's
8 interesting because they really don't understand the
9 second part of that double whammy, okay? They
10 merely see their race or color or sex again and they
11 don't see anything else. It's the same for these
12 other areas, too. I can take about age
13 discrimination. They will come and talk about race
14 and sex and age and really, age might be the factor,
15 but in this area I think -- we have a saying we use
16 around the office and it comes from a friend of mine
17 around town. She is an Affirmative Action officer,
18 and it's called "TAB," Temporary Able Body. We are
19 all TABs because we can leave out this room and slip
20 and fall down and become disabled and wind up with
21 somebody in a wheelchair or somebody that is
22 incapacitated and then we fall into the category of
23 persons with disabilities where we may be able to
function okay and perform our regular jobs but

1 again we now have disability and I think a lot of
2 people in the public don't really perceive that
3 until it happens and then they find themselves not
4 being able to negotiate into a bathtub like they
5 used to, not be able to go upstairs that they used
6 to, not be able to go through doors.
7 I had an incident where I had knee surgery
8 and tried to negotiate to get into the supermarket
9 between the post with the barriers and could not go
10 through it with my crutches and I realized, I said
11 what happens with a person with a wheelchair. They
12 can't get into a supermarket, you know, because of
13 that type of barrier.
14 PROF. NISHI: Do you have any documentation
15 or data regarding the interactive effect of various
16 sources of discrimination?
17 MR. CLARK: Not per se, Doctor. What I
18 could suggest and offer is a review of our annual
19 reports for several years and out of that you might
20 be able to glean information. You might be able to
21 make a correlation in statistics. As I said, all
22 large numbers come primarily in employment
23 discrimination, but hidden in that because I was
trying to pull some information out, how many of

1 those employment discrimination cases are disability
2 type cases, which again is a high number. We are
3 just starting to see the housing disability type of
4 cases come in and again, it's because of the Fair
5 Housing Amendment and Advocacy groups like H.O.M.E.
6 that are out there that are trying to assist people
7 that have these problems and the cases are now
8 coming in more.
9 PROF. NISHI: Thank you.
10 MS. CIPRICH: Dr. Oi.
11 CHAIRMAN OI: Can I ask, this report you
12 mentioned, right, the people with disabilities?
13 MR. CLARK: Yes.
14 CHAIRMAN OI: Where does one get a copy of
15 that?
16 MR. CLARK: I have requested several but I
17 think the Association of the Bar of the City of New
18 York, 42 West 44th Street, New York, New York,
19 136-6690. It says it was published in collaboration
20 with the National Register.
21 CHAIRMAN OI: Okay.
22 MR. CLARK: But the copywriter is the
23 Association of the Bar of the City of New York.
CHAIRMAN OI: Okay. You say that the

1 number of cases that are coming before your
2 attention now have increased sharply in the last six
3 months on housing discrimination?
4 MR. CLARK: Generally, yes, they have.
5 CHAIRMAN OI: Do you have any breakdown of
6 these? Are these children or are these access?
7 MR. CLARK: Two cases, the two, we call
8 them special disability cases, both cases we're
9 dealing with access, the two we just mentioned.
10 CHAIRMAN OI: Both were access?
11 MR. CLARK: Both were access. The other
12 cases that have come in --
13 CHAIRMAN OI: Now, these are rental or --
14 MR. CLARK: Yes, both of those were rental
15 cases.
16 CHAIRMAN OI: Okay.
17 MR. CLARK: The other cases that we have
18 been receiving are housing cases. They are not
19 disability cases, just general housing
20 discrimination cases on various grounds.
21 CHAIRMAN OI: Are those children or --
22 MR. CLARK: No, we haven't gotten any cases
23 with children as of to date. Again, New York law
doesn't cover -- New York, the Division of Human

Rights, okay, our statute does not cover families with children. There is legislation pending but there is coverage under the New York State Real Property Law.

CHAIRMAN OI: The Federal Fair Housing Amendments do not cover that, is that correct?

MR. CUNNINGHAM: Yes, they do.

MR. CLARK: They are covered by the Federal status, familial status. That's where legislation is pending right now. Well, not pending, it's been drafted and it's been submitted to the Governor's office for review by our agency and hopefully, if it is approved, then it will go to the New York State Legislature and then it will go through its committee process and our agency will be responding to that and within maybe the next legislative session we will have an amendment to our statute which will include familial status. That will then provide the protection that you indicated.

MR. CALABIA: Do you know whether your provisions on disability conform with the Federal provisions?

MR. CLARK: Yes. To date, we haven't had no problems. The Federal provisions go a little

1 further than our statute because on the question of
2 dealing with accessibility, and I know I sat on a
3 panel two weeks ago and it was a gentleman from the
4 Eastern Paralyzed Veterans and he talked more about
5 the new requirements that are coming up in March of
6 '91 in terms of building. We are not into that type
7 of thing under our state statute.
8 Under everything else I think we are
9 compatible, but as it relates to building
10 requirements for builders and those things which are
11 coming down the pike, under the Fair Housing
12 Amendments we are not sort of compatible but again,
13 I think those things will relate to our state
14 agencies because they do mention at the panel that I
15 was on, because I talked more about enforcement of
16 the statute, they were talking about accessibility
17 requirements and new buildings and how people have
18 to conform and I guess there are certain state
19 building requirements in monitoring under other
20 state statutes that would probably be in compliance
21 with the Federal Fair Housing part that deals with
22 accessibility.
23 MR. CALABIA: Another thing, here in the
State of New York, the New York State Attorney

1 General's office looked into discrimination and
2 housing, too, am I right, and could you compare
3 their role and your role? The reason I know about
4 this, I caught a very small New York Times article
5 that mentioned the New York State Attorney General
6 was following up on some cases and discovered
7 through testing that apparently, I guess it's some
8 part of the rental market was not responding
9 appropriately to minority would-be renters and Mr.
10 Abrams was filing suit.
11 What is the relationship of the State
12 Attorney General's office to your Division?
13 MR. CLARK: We're two separate agencies and
14 to that end I know he has a Civil Rights division.
15 How much it functions on this side of the state is a
16 question, okay? One time they did have a unit, they
17 were taking cases and I think they went into the
18 Federal Court and decided to disband the unit here
19 and basically, transferred their functions to their
20 New York City office. I know in New York they have,
21 in conjunction with our agency, worked on a couple.
22 I think the case you are talking about where the
23 Division and the Attorney General's office got
together with some testers and went into, I think

1 it was Long Island a few other places to send the
2 testers our and they came back based on that
3 information and made some cases, and I think also in
4 the models in advertising in terms of fair housing
5 advertisements, most of the models were white. The
6 Attorney General's office, in conjunction with our
7 agency again were involved but those cases were in
8 New York City.
9 MR. CALABIA: I see, okay, thank you.
10 MR. CLARK: Yes?
11 PROF. NISHI: I wonder, as I understand it,
12 the Buffalo Housing Authority is out of compliance
13 with regard to -- is it the Housing Amendments?
14 MR. CLARK: There is a general idea --
15 PROF. NISHI: Would you care to comment
16 with regard to that?
17 MR. CLARK: Oh, he might be able to better
18 answer that question, I think (indicating Mr. Gehl,
19 G-e-h-l). As a matter of public record I think
20 everyone in town knows that there are some problems
21 or alleged problems in the Buffalo Municipal Housing
22 Authority and again, he can speak to those things.
23 As far as the Division, we have had cases
over the years with regard to the Buffalo Municipal

1 Housing Authority, none of which, okay, strike the
2 note of what has been in the newspaper laterly, say
3 over the last year and a half. There are some
4 people that think we should have had those cases but
5 I beg to differ because I think the jurisdiction is
6 supposed to be with those agencies that are supposed
7 to monitor and we are not a monitoring agency. We
8 are an enforcement agency and to that end they
9 weren't monitored properly.
10 PROF. NISHI: So, you say you're an
11 enforcement as contrasted to a monitoring agency.
12 You do not provide any regular observation? There
13 is data with regard to compliance with law rather
14 than records of complaints that come to your
15 attention, is that correct?
16 MR. CLARK: Right, that's correct.
17 PROF. NISHI: I see.
18 MR. CLARK: We basically as the statute is
19 set forth, we are an enforcement agency of the New
20 York State Human Rights Law. We do have some
21 capabilities with computers now to give that type of
22 information, you know, over a period of time, the
23 types of complaints and someone this morning was
trying to ask me for some specific information

1 relative to complaints in Buffalo and Erie County
2 and I was telling them that our office services more
3 than just Buffalo and Erie County and it would be
4 hard for me to do that right now, but in time, I
5 know because we are computerized in the whole agency
6 that I will have that capability to separate the
7 types of complaints I have and sort of like pinpoint
8 those types of complaints.
9 PROF. NISHI: Thank you.
10 MS. CIPRICH: Do you only proceed in
11 enforcement when somebody comes in and registers a
12 complaint? Is that the mechanism?
13 MR. CLARK: No, we have authority under our
14 statute to initiate our own complaints, okay? As we
15 call it, initiated Division action. At times I can
16 make a recommendation based on something that I may
17 see, a series of things going on and recommend to
18 Division to look, first of all, at least, look see
19 what is going on and then based on looking into
20 something, if there is a need to put together a
21 complaint, I can then make that recommendation and
22 we, the agency, would be the complaining party, not
23 an individual. More often than not, all of our
complaints are from individuals.

1 MS. CIPRICH: So, is there a division of
2 your agency that gathers fact and goes out and
3 investigates?
4 MR. CLARK: No. Again, that is left to the
5 Regional Office. I have got something I am
6 preparing right now, not saying who, but just to
7 give you an example, it's not something in the
8 housing area, in employment, but something that I
9 have been monitoring for the last year and a half
10 and we have plaintiffs now and I'm going to start
11 putting that together because it sort of puts the
12 big picture together and I think the real disorder
13 is a systematic problem and that is what we will be
14 looking at as a whole, as the systematic problem.
15 MS. CIPRICH: Anybody from the audience?
16 MR. CUNNINGHAM: Mr. Clark, I'm James
17 Cunningham. In terms of enforcing accessibility
18 standards, would your office be responsible for
19 enforcing those and implementing those standards or
20 will you be working with this with some other state
21 agency?
22 MR. CLARK: Well, at this point right now I
23 haven't been given no specific direction. I guess
my only thought would be to call Mr. - - upstairs to

1 Eastern Paralyzed Veterans beause at the time that
2 we were making the presentation he had indicated
3 that they have a staff. I don't know if it is
4 nationwide or statewide, of 125 people with
5 attorneys, architects and other people like that.
6 So, my lead would be to talk to him if
7 someone has an accessibility problem and indicating
8 they don't know how to build a ramp, they don't know
9 what specifications, I would refer them to there.
10 That way they would get the appropriate information
11 and then be in compliance under the statute.
12 MR. CUNNINGHAM: Has any thought been given
13 as to how you actually assure compliance with this
14 law? Would it be a matter of having people walk in
15 your office and file a complaint that this building
16 is not in compliance, or the hallways are too
17 narrow, or would it be a more protected effort to
18 identify buildings that perhaps are still under
19 construction or that are about to be built that
20 might not be in compliance?
21 MR. CLARK: Based on what I heard while I
22 was on the panel, it would seem as though after
23 March 1991, and at this point right now, I don't
think the regulations that deal with accessibility

1 have come down yet and that creates one of the
2 problems because the audience that were on the
3 panel, the audience were builders and developers and
4 they wanted to know what the statute means, how it
5 was effective.
6 In listening to Mr. Black, he was
7 indicating, he explained some of the nuances that I
8 guess his office, his agency has been involved in in
9 drafting the statute and the regulations that have
10 come down so far, but it would seem as though on the
11 local level, the local - - what did he call it, the
12 gentleman who was chaired the panel? He was quite
13 knowledgeable about the accessibility standards. He
14 mentioned that he issues like the building permit
15 and things of that nature in the locality but he was
16 quite familiar with the extent that there was one
17 builder who raised a question, he has a complex
18 under construction right now, it would not be
19 completed by March of 1991. His problem is that as
20 you enter in like a five to eight-foot entranceway
21 but there is then three steps to go up and there is
22 like four condominium type apartments as Mr. Black
23 told him, you have to change that in your whole
design and the guy was saying like I can't change

1 it. He said that means we have to get a new site
2 plan, new this and new that and I could hear someone
3 moaning in the audience when he described how, I
4 guess their conventional door is 32 inches and would
5 now have to go to about 34 inches, which means that
6 hallways now have become larger, bathroom doors have
7 to become larger and builders were sitting there
8 moaning and I'm sitting there listening to them say
9 that this is going to have to be a radical change in
10 the whole architectural/building industry and after
11 that a few of them came up and I could hear some of
12 their conversations and they were saying, where do
13 we get help and Mr. Black, he told them in the
14 original drafting at the national level, your
15 national organizations knew it was coming down.
16 They could have been involved in all these
17 regulations. He said no one saw fit to raise these
18 questions until now when the legislation is here.
19 We are telling you what the regulations may do and
20 everyone is sitting there with their hands up in the
21 air saying, what do we do at this point?
22 From our point of view, two cases that I
23 had were, one was a landlord who was just being
obstinate with a gentleman who had two children who

1 were wheelchair-bound, okay, had MS, muscular
2 dystrophy, and he wouldn't allow him to park a van
3 in a ten-car parking lot. It was behind his
4 business and the hospital for the gentleman's
5 business was here, to park the van here so he could
6 have the van close to the hospital for the children
7 to go back and forth for medical treatment.
8 The second case was because a landlord, who
9 is again just being obstinate, wouldn't allow a
10 woman to put her own monies in to put a rampin for
11 wheelchair accessibility for her mother and he was,
12 you know, upping her rent to force her out so she
13 wouldn't put the ramp in and we thought we had him
14 to the point of settling it by she was still going
15 to put the ramp in but the ramp would be abated for
16 several months and it was a way to work off the
17 expense and the guy said no.
18 So, I guess that was my thrust of what I
19 was saying, that the information to the public needs
20 to get out there with what the statute is about. I
21 think a lot of people should say, oh, I don't have a
22 disability, it doesn't affect me and you know, they
23 keep on going about their business but they don't
realize at some point they may have accessibility

1 problems. Oh, one last thing about what you said
2 about building, and I thought this was strange. In
3 building, let's say a condominium or a series of
4 condominiums, one of the amenities that people like
5 is a sunken living room which Mr. Black indicated
6 that if you have sunken living room, you have to
7 have it such that it has to have accessibility, i.e.
8 wheelchair. It has to have a ramp but the person
9 might just want the sunken living. He said no, it
10 has to be designed as such to have a rampway so that
11 in the future if a person may buy the property, not
12 the person who built it but the people in the future
13 who may buy that property, and I thought that was
14 quite interesting.
15 MS. CIPRICH: Okay. I would like to move
16 on now, or is there any more?
17 MR. CALABIA: Just a minute. You mentioned
18 the Eastern Paralyzed Veterans as being with this
19 group. Does that mean they are a federal agency?
20 MR. CLARK: I think they are federally
21 funded. I don't know if they are a federal agency.
22 CHAIRMAN OI: I don't think so.
23 MR. CALABIA: The other question is, if you
are not the monitoring agency, which ones are the

monitoring agencies?

MR. CLARK: It would probably be -- I'm not sure which department. Let me ask. Would you have an idea, Scott, on the state level who would be monitoring on an accessibility question on the Fair Housing Act?

MR. GEHL: Scott Gehl from Housing Opportunities Made Equal. I don't believe anyone is.

MR. CLARK: So, on the state level, no. I would presume it would just be when you have housing inspectors, and that is one of the things they did ask is well, how are people going to monitor the new developments. He said you drive by and you look and you see, okay, and as they are building a complex or houses or series of apartment dwellings, you would look to see. Someone would look and see if they are accessible for the handicapped and also if there is a way he said like in the front, if you have a walkway, now, that has to be a certain diameter, okay, for wheelchair accessibility.

Like I indicated the example where you go in five feet and then you go up three steps, the little stairs, that may have to change, okay, to provide some type of entranceway. So, all these

1 things are by sight and I guess it would be through
2 like local, the local town or places that issue
3 housing permits to builders. They would also have
4 to be sort of monitors telling the builders your
5 plans are not in compliance.
6 MR. CALABIA: Thank you.
7 MS. CIPRICH: I would like to move on. We
8 have a number of people to hear from this
9 afternoon. The next person's name is Daniel
10 Symoniak, the Executive Vice-President of the
11 Greater Buffalo Association of Realtors.
12 MR. SYMONIAK: Good afternoon. My name is
13 Dan Symoniak. I'm the Executive Vice-President of
14 the Greater Buffalo Association of Realtors.
15 To give you a little bit of perspective
16 about the Greater Buffalo Association of Realtors,
17 we are a trade association of approximately 4500
18 real estate brokers, associates and mortgage
19 lenders. Our membership comes primarily from Erie
20 and Niagara Counties. Membership is involved almost
21 exclusively in the business of residential resale.
22 We do have some members who specialize in commercial
23 real estate but that's a very small percentage of
our membership.

1 We do have some members who do a fair
2 amount of leasing but again, that is a very, very
3 small percentage of our membership. We are
4 overwhelmingly involved in residential resale.
5 I have been with the Greater Buffalo
6 Association of Realtors for about 13-1/2 years now
7 and I would like to mention that one of the most
8 important points in terms of our involvement in fair
9 housing came with the signing of the Voluntary
10 Affirmative Marketing Agreement, an agreement which
11 we subscribed to with the local HUD office in 1979
12 and created something called the Greater Buffalo
13 Community Housing Resources Board. That is a board
14 that is made up of various people in the community,
15 several of whom are here with us today, and the
16 realtors and the greatest benefit of that has been
17 that it opened up channels of communication with the
18 people in the community involved with fair housing
19 enforcement that we never had before. That helped
20 to sensitize realtors to the problems of fair
21 housing in this community and it also helped provide
22 expertise that we never had readily available to us
23 before.
It is my sincere belief that at this point

in time there is an overwhelming moral commitment on the part of the members of the Greater Buffalo Association of Realtors to uphold the Fair Housing Laws in this country and I believe that that has changed somewhat in my 13-1/2 years since I have been here.

I think going back to the late '70's when I started, there was a significant portion of the membership who had not made the moral commitment to uphold the fair housing laws in this country. Basically their attitude was I'm not going to break them but I don't need to do anything to help uphold those laws. I think that might be due somewhat to the fact that many of those people were brought up and had formed their values prior to the Civil Rights Act of 1968, prior to events that we have seen on TV many times. If we weren't there ourselves, the march is in Selma at Washington, the desegregation of the University of Mississippi. So, there is a much different climate today than there was 13 years ago in terms of my membership.

The greatest problem I have today in terms of my membership is one of technical expertise. While the great majority of the people have the

1 moral commitment to uphold the laws, there is a
2 great or wilful act of technical expertise,
3 especially when it comes to identifying and defining
4 the technical classes. The overwhelming majority of
5 my membership, even today, thinks of housing
6 discrimination in terms of race. We have had a
7 number of incidents where people were guilty of
8 infractions based upon offerings to senior citizens,
9 based upon familial status, based upon using models
10 in advertising, people who thought they were
11 complying with the law but didn't have the technical
12 expertise to actually make good with their good
13 intentions.

14 What I would hope for is a renewed emphasis
15 on education. I realize as the Executive
16 Vice-President of the Association I have a
17 responsibility to inform my membership, but I think
18 there needs to be some assistance as well from the
19 Fair Housing agencies to help the members of the
20 Greater Buffalo Board of Realtors, Association of
21 Realtors, in terms of technical expertise.

22 As I say the greatest, single lead right
23 now I believe is in terms of identifying and
defining the protected classes, because we have had

1 incidents recently where people with the best of
2 intentions violated the law because they did not
3 understand the protected classes, and that is all I
4 will say for the moment. If I can answer any
5 questions, I'll be glad to.
6 PROF. NISHI: Has there been any source --
7 what would be the authoritative source in terms of
8 the technical requirements of the laws?
9 MR. SYMONIAK: That's a good question. I'm
10 not sure that I know that there is one authoritative
11 source.
12 PROF. NISHI: Would there not be a series
13 on the federal level as well as the state level and
14 your association is a trade association. Does it
15 provide any kind of programs for your membership in
16 terms of training as laws change?
17 MR. SYMONIAK: We do have an ongoing
18 series. There was a plan developed several years
19 ago called the Kiahoga Plan. It's a formalized
20 education course which we make available to all our
21 members and in fact, have incorporated part of that
22 into an oritentation mandatory for all members.
23 However, it doesn't go nearly into the
depth that is required to help everybody understand

all the protected classes and all the nuances thereof. We have been able to avail ourselves to the expertise of Richard Clark and Scott Gehl here locally but we still don't have, as you say, the definitive educational piece that covers everything. There has been some confusion between the overlapping of state and federal laws and perhaps the gaps therein, and at this point as we sit here today, we still have a major educational problem as far as our membership is concerned.

PROF. NISHI: But does your association conduct some training programs and other aspects of changing law with regard to real estate?

MR. SYMONIAK: Yes, we do.

PROF. NISHI: Yes. Is this an area which your Association might develop a program?

MR. SYMONIAK: Oh, absolutely. It's something that is one of our primary concerns. One of the missions of our Association is to reduce the legal exposures of which our membership, whether it is from misrepresentation, the law of agency or fair housing, but it seems that fair housing has been a particularly elusive educational objective for us and we even have difficulty with the attorneys.

1 We have gotten a number of attorneys to
2 represent our various members coming forth and not
3 being fully conversive with the law as it is written
4 today.
5 CHAIRMAN OI: You have not published a
6 brochure on this, what constitutes it?
7 MR. SYMONIAK: We have not, no.
8 CHAIRMAN OI: Are there any intentions to
9 do so or has the National Association of Retailers
10 done so?
11 MR. SYMONIAK: The National Association has
12 done so from time to time. The problem we faced in
13 New York is that the National Law and the New York
14 Law were not substantially equivalent. Now, I'm
15 under the understanding that in the not-too-distant
16 future that problem is going to be rectified, but as
17 of today, there is no definitive brochure and I'm
18 not so sure a simple brochure would be enough to
19 explain all the nuances of the law.
20 PROF. NISHI: In your relationship - - may
21 I?
22 MS. CIPRICH: Yes.
23 PROF. NISHI: In your relationship with
lending institutions, which of course are an

important factor in terms of fair access to housing, what has been your experience in the facilitation of and cooperation of lending institutions as it pertains to the Fair Housing Amendment which we are speaking of here in terms of family and disabilities? Are there special obstacles or difficulties in dealing with lending institutions?

MR. SYMONIAK: In the position that I am in, I don't come across those types of problems. I don't want to say they don't exist but in the position that I'm in, I am not exposed to those.

PROF. NISHI: Okay.

MR. CALABIA: Do clients or other people ever bring allegations of housing discrimination to the attention of your Association or if they don't, what would you do if they did? I mean, how would you handle that?

MR. SYMONIAK: We have never had an allegation of discrimination brought to us. If we did, we would refer it to an agency such as Richard Clark's that deals with that. We have similar circumstances where allegations, violations of the license law are brought to us that don't involve discrimination. We refer those to the Department

of State. Our position is that we deal with matters of violations of our Code of Ethics. We do not deal with allegations of violations of the law but rather we refer those to the proper legal agencies.

MR. CALABIA: Thank you.

PROF. NISHI: If I might pursue the content of the Code of Ethics. The Code of Ethics, does it make exquisite divisions with regard to non-discrimination?

MR. SYMONIAK: Yes, it does.

PROF. NISHI: By a variety of criteria?

MR. SYMONIAK: Yes, it does. As a matter of fact, those criteria will have to be updated by the National Association because I don't think that they contain the necessary protected classes that were recently ended.

PROF. NISHI: Yes. So, if an agency is found to be out of compliance with those ethics, do you have a way in which those violations can be corrected?

MR. SYMONIAK: Yes. We have a professional standard procedure in which the members are called in to a hearing with the complainant and after a proper hearing, a decision is rendered and the

1 decision, the punishment can range anywhere from a
2 letter of warning to expulsion from the organization.
3 PROF. NISHI: How often has the provision
4 or the state with regard to non-discrimination been
5 the basis of such a hearing?
6 MR. SYMONIAK: In my 13-1/2 years there we
7 have never had a complaint brought to us.
8 PROF. NISHI: Okay.
9 MS. CIPRICH: What does expulsion mean, by
10 the party being expelled?
11 MR. SYMONIAK: They will lose their right
12 and privileges. They will no longer be a member of
13 the Association.
14 MS. CIPRICH: Would that affect their
15 business?
16 MR. SYMONIAK: It could affect their
17 business profoundly. In our area we operate the
18 most Multiple Listing system and the overwhelming
19 majority of residential real estate in this area so
20 through the Multiple Listing system. So, to be
21 excluded from the Multiple Listing system, if you
22 are in the business of residential real estate,
23 would be a serious problem.
CHAIRMAN OI: And you must be a member to

1 belong to that?

2 MR. SYMONIAK: In New York State you must.

3 CHAIRMAN OI: The Association?

4 MR. SYMONIAK: Yes.

5 MR. CLARK: That's a different one.

6 PROF. NISHI: I'm not familiar with housing

7 residential pattern studies that have been done in

8 this area but nonetheless, in studies that have been

9 done generally, the finding has been that there has

10 been, contrary to our growing moral commitment to

11 fair housing, that there seems to be, at least for

12 African Americans, increased segregation. How would

13 you account for that in your assessment of real

14 estate brokers who are increasingly morally

15 committed to fair housing? The pure studies seem to

16 indicate increasing segregation, residential

17 segregation.

18 MR. SYMONIAK: In our area, and I'm hard

19 pressed to come up with any hard statistics at this

20 point as far as segregation or resegregation is

21 concerned and I defer to Richard or Scott at this

22 point. Do you have any numbers on segregation or

23 resegregation in this area?

MR. GEHL: Well, I think, you know, last

1 time I answered a question, I said I didn't know.
2 There is now a very high degree of segregation in
3 terms of the African American and his family
4 population within Erie County, a very high
5 proportion, and I don't have a number offhand, you
6 know, that live within the Cities of Buffalo and
7 Lackawanna.
8 We see in the city resegregation of a
9 census tract which were integrated for the first
10 time in the last census and it would be interesting
11 to see just how the data fall out. In terms of
12 explanations in terms of this now, that is something
13 that one can only infer from numbers and I don't
14 think now we have any explanations for what has been
15 occurring but yes, resegregation is occurring and I
16 think Richard, I would defer to.
17 MR. CLARK: Richard Scott. Yes, I would
18 concur with Mr. Gehl and we see it in a different
19 way and that the acts of violence or the acts of
20 bigatry to minority persons, particularly
21 Afro-Americans who move into a traditionally white
22 neighborhood, okay, the acts of bigatry and acts of
23 violence have increased.
We have a gentleman in my office who is

1 generally called a crisis intervention person and
2 basically that is his function and he has been quite
3 active in the past, okay, and even today we got a
4 call about something, so there has been that
5 segregation and people are moving out of those areas.
6 Buffalo is -- when I'm talking about the
7 city now, it is going through a rejuvenation and
8 housing building, okay, in the city proper and to
9 that end is mixed, but the neighborhood and most of
10 the housing buildings being done is particularly the
11 Afro-American community, okay, which raises a big
12 question to a lot of people; is this sort of like
13 the retake-over of the city, all right, particularly
14 surrounding the downtown area. I should say east
15 and west side because that's this side of town and
16 the other side. So, to that end, you find people
17 who are suburbanites and I know, my church is nearby
18 very close to downtown. There are people in my
19 church who live in the suburbs but they build a
20 housing complex with about 60 new houses about two
21 blocks away and some of the people in my church who
22 are white, okay, bought houses. They left their
23 houses in the suburbs and bought houses here but
they work downtown, okay? So, they were willing to

1 give up their houses out there due to the fact that
2 their children were grown up or gone away or
3 whatever. Now, it is more convenient. That area is
4 prodominantly a Black neighborhood, okay, but we see
5 the transition of that taking place. I don't know
6 if that answers your question or not.
7 MS. CIPRICH: Any questions from the
8 audience?
9 MR. HOLLANDER: My name is Tom Hollander.
10 I'm a real estate broker and I live on one of those
11 streets that everybody is concerned about and I see
12 the issues very differently than you. If you do
13 have someone who is financially qualified to buy a
14 house, please bring them to me, and the idea that a
15 real estate broker, at least in this community, is
16 directing people to a certain marketplace or
17 contributing to the resegregation, I don't think
18 that is a factor at all.
19 A real estate broker in today's environment
20 doesn't care where he sells the house this summer as
21 a general rule unless he himself has no knowledge of
22 that particular marketplace which is somewhat
23 regional as to how someone operates their offices.
We in our office have no thought about

1 showing a house in a particular market to a
2 particular kind of person or client. It is simply
3 finding houses that fit and that are appropriate.
4 What we are finding out is that we are somewhat
5 handicapped by the way the law is being enforced
6 through the ultimate testers, that today you can no
7 longer speak openly. I had a Black family in our
8 office the other day who indicated to me there were
9 parts of the suburbs that they didn't want to go
10 into because there was resistance they felt on
11 behalf of their children going to school and it's
12 not something that I was able to discuss.
13 In the rule, as our industry understand it
14 righ tnow, it's very explicit, you just don't talk
15 about these subjects. Whether the person may or may
16 not be a tester, you don't know. That's not really
17 the issue, it's just that you are not allowed to
18 address these subjects. Consequently you get into a
19 Catch 22 here as far as being a realtor is concerned.
20 CHAIRMAN OI: If you do, are you subject to
21 liability of any kind?
22 MR. HOLLANDER: If we do which part?
23 CHAIRMAN OI: If you talk about these

1 things.

2 MR. HOLLANDER: Oh, I think so.

3 CHAIRMAN OI: Are you?

4 MR. HOLLANDER: Yes.

5 PROF. NISHI: From who?

6 MR. HOLLANDER: I think there is definite

7 exposure if you are talking to a person who is

8 trained as a tester perhaps and what you might make

9 as a comment about your own feelings about what is

10 wrong, it could possibly be misinterpreted, end up

11 as a case. We just don't talk about the subject any

12 more.

13 CHAIRMAN OI: Could you give me an example

14 on both sides, one where, you know, the

15 information - - you know, suppose that you gave an

16 honest assessment that if you looked in this area,

17 to the best of your knowledge, the schools did not

18 discriminate, so forth and so on, and then you later

19 find out that to get into this group, they are

20 pretty discriminatory.

21 MR. HOLLANDER: I would have no way of

22 evaluating if the schools are discriminatory. That

23 is part of the problem.

CHAIRMAN OI: Okay. So, that, honestly,

1 you can honestly say you just don't know?

2 MR. HOLLANDER: That's right.

3 CHAIRMAN OI: But where you do have an

4 opinion, in what sort of instance would it be a

5 great given? Can you give me an example of this?

6 MR. HOLLANDER: I don't think you have

7 enough time for that today.

8 CHAIRMAN OI: Oh, okay.

9 MR. HOLLANDER: One thing is redevelopment.

10 PROF. NISHI: One example?

11 MR. HOLLANDER: Well, the example I cited

12 you.

13 PROF. NISHI: Okay.

14 MR. HOLLANDER: This is a lady who is able

15 to buy a house in the $250,000 range and I was

16 feeling it personal. I was really feeling

17 constrained about it because I could or could not

18 say.

19 PROF. NISHI: I understand..

20 MR. HOLLANDER: So what I find was, was

21 that I didn't have the kind of dialogue that I felt

22 was necessary to help me help her sell a house or

23 find a house or buy a house. I'm very restricted

today.

1 CHAIRMAN OI: And if a suit is brought
2 against you, you are held liable under which
3 statute, the Fair Housing Amendments?
4 MR. HOLLANDER: I would presume it would be
5 the Fair Housing Amendments. Not just the
6 amendments, I understand that this is what the panel
7 is here for, but the law of '68.
8 CHAIRMAN OI: Oh, okay, it goes back that
9 far.
10 MR. HOLLANDER: It is a problem for us.
11 You know, the real estate industry today is taught
12 that you are presumed guilty until proven innocent
13 and that is a horrible dilemma to be placed in.
14 MS. CIPRICH: I think we have one question
15 there from the audience. Could you identify
16 yourself for the record?
17 MR. JAY: Yes, David Jay. I'm Director of
18 the New York Civil Liberties Union. It seems to me
19 there are groups within our community that would be
20 readily available to work with the Board, Mr.
21 Symoniak. Now, you called it an Association. I
22 guess your changed your name. To give that
23 expertise and training to you people, perhaps a
particular point of view that you people might not

1 agree with, but I think that would attempt to give
2 the straight story. Mr. Hollander seems to feel he
3 can't say anything because he's terribly concerned
4 about that and I don't doubt that he is, and that is
5 a product of not having the information that he
6 needs.
7 So, I know Mr. McGrath is here from
8 Neighborhood Legal Services and they spend probably
9 30, 40% of their time doing that very thing for
10 lawyers and students and people like that, a group
11 such as that is well prepared to give counsel to
12 your group and small seminars or perhaps in a
13 general meeting or whatever. I know Mr. Clark and
14 his agency would be available and I know other
15 agencies that would love to work with you folks to
16 get these things out and talk about them.
17 MS. CIPRICH: Has the New York Civil
18 Liberties Union put anything together on the Fair
19 Housing Amendment's Act, do you know?
20 MR. JAY: I honestly don't know but I'm
21 certain they have something on it but it would be
22 repetitive of what other agencies have done. People
23 who do that day in and day out, there are fair
housing projects in the City of New York. I know of

1 various agencies.

2 MR. CLARK: Could I at this point --

3 Richard Clark again. There is something Mr.

4 Symoniak mentioned. A few of us involved in

5 Community Housing, in the Greater Buffalo Community

6 Housing Resource Board, I'm currently the Chairman

7 of that, okay, and that does work with the real

8 estate industry. Over the last few years we have

9 given seminars to the fair housing market on an

10 annual basis which has brought in a large number of

11 the real estate industry in the Western New York

12 area. Surprisingly, it's sort of like the E. F.

13 Hutton commercial, when we raise the question of

14 testing, everybody comes because they want to know

15 what are these guys talking about testing.

16 So, I think the comments that you heard

17 about being hesitant about dealing with someone when

18 they are in your office, the real estate industry in

19 this area is kind of gunshy about testers, okay, and

20 I think it's fair to say because we have had, I

21 think two successive seminars where we have dealt

22 with the question of the issue of testing and we

23 have had well over 300 realtors, 300 plus, okay,

where at one time we used to get maybe 50 or 60,

1 and when we put that specific topic out, they all
2 came out to hear what we had to say. So, you see --
3 MS. CIPRICH: I would like to move on
4 here. You have a question?
5 MR. SYMONIAK: I just have one last thing.
6 We began this problem with a conversation on the
7 question about integration and reintegration and I
8 have had a chance to think about it as a number of
9 people have spoken and I think it gets right to the
10 heart of what is one of the hottest arguments in
11 fair housing today and that is the controversy
12 between providing free and open choice and providing
13 integrated housing. I think today brokers see their
14 responsibility as providing a free and open choice
15 in housing rather than being responsible for
16 integration in housing and I think that is what we
17 are trying to do, is provide a free and open choice
18 today and if that does not result in integration, I
19 don't think that that is something that the real
20 estate industry can be held liable for.
21 CHAIRMAN OI: A legitimate position in my
22 opinion.
23 MS. CIPRICH: Our next speaker is Daniel
Quider, the Assistant Executive Director of the

1 Buffalo Municipal Housing Authority.
2 Mr. Quider?
3 MR. QUIDER: Good afternoon. My name is
4 Dan Quider. I am the Assistant Executive Director
5 for the Buffalo Municipal Housing Authority, and on
6 behalf of the Buffalo Municipal Housing Authority I
7 would like to extend our thanks for the invitation
8 to participate in this afternoon's hearing.
9 The Buffalo Municipal Housing Authority
10 currently administers 5,047 federally-aided and 973
11 state-aided conventional low-income housing units
12 for a total of 6,020 assisted units at 27
13 developments in the City of Buffalo. 8,194 persons
14 of low income call Buffalo Public Housing their home
15 in over 4,118 occupied units. Of these, 1,203 are
16 identified as non-minority, 31 as American Indian
17 and over 2,878 or over two-thirds are occupied by
18 African Americans.
19 The Buffalo Municipal Housing Authority is
20 perhaps the only agency in the City of Buffalo that
21 has undergone the degree of scrutiny and criticism,
22 I might add, as it has in the past year to two
23 years, dealing with its policies of administrating
its program. The news pile, if you will, is quite

1 extensive and I have forwarded copies of this to the
2 Commissioner for their review and I would like this
3 afternoon, if I can, to walk you through on the
4 Buffalo Housing Authority's compliance with Title VI
5 of the Civil Rights Act of 1964, which is perhaps
6 the hottest issue here locally dealing with the
7 conventional low-income program.
8 Back in 1983 the United States Department
9 of Housing and Urban Development conducted a Title
10 VI compliance review of the Buffalo Municipal
11 Housing Authority and found its project based
12 waiting list being non-compliance with Title VI in
13 order for the Housing Authority to establish a
14 unit-wide waiting list. This the Authority complied
15 with and introduced a concept known as Location
16 Preference in its preliminary application process.
17 What this allowed, and just in reference to
18 the last comment that was made, it allowed the
19 opportunity of choice by the applicants of Buffalo
20 Public Housing as to the three developments that
21 they would prefer to live in had they been given
22 that opportunity. This became the policies of the
23 Buffalo Municipal Housing Authority and it wasn't
until 1987 that HUD came through and did another

1 compliance review and found this practice to be in
2 non-compliance with Title VI of the Civil Rights Act
3 despite the fact that HUD had approved the previous
4 policies.
5 In any event, on August 19th, 1987 the
6 Buffalo Housing Authority approved an action plan
7 that would call for the elimination of Buffalo
8 Location Preferences and on September 24th of '87
9 the deletion was formally made from our policies and
10 we began administrating what is known as Plan B
11 under Title VI of the Civil Rights Act on our tenant
12 selection placement.
13 Under Plan B an applicant to public housing
14 would be offered as a first choice the development
15 with the greatest number of vacancies from within
16 our inventory. If they were to turn that down, they
17 would be given a second choice. That being from the
18 project from the next greatest number of vacancies
19 and a third choice would be given with a third
20 greatest number of vacancies.
21 Plan B was not a new process used in the
22 public housing industry. In fact, it was in 1967 I
23 believe that HUD had introduced the concept to the
housing industry and it was known then as the 1, 2,

3 Plan. That plan was subject to a great deal of criticism and controversy in its day and I might add even today as it is used, it is also subject to the same type of controversy.

In any event, it was in November of 1987 that the Senator Daniel Patrick Moynihan conducted his first hearings here in the City of Buffalo regarding the Buffalo Housing Authority Administration of its program, particularly as findings came to light that the Housing Authority was in non-compliance with Title VI of the Civil Rights Act and in the fall of '87, we were also informed by the HUD Regional Office that there would be yet another compliance review with Title VI to be conducted on the Housing Authority's program.

In April of 1989 the HUD Regional Office advised the Housing Authority that their formal review had been concluded and that there was in fact non-compliance of the Housing Authority program, in particular as it related to the use of location of preference in its very early years and that this resulted in a subsegregated program here in the City of Buffalo where 22 of 27 of the federally aided developments were racially identifiable or segregated

as we know it. The FHA was given three options to correct this situation to deal with the notice of non-compliance and the first being to present documentary evidence that the findings were actually incorrect. The second option, to prevent documentary information showing that there was a legitimate reason for the actions of the FHA, or a third option to request commencement of discussions for voluntary compliance and this was the option that was selected by our governing Board of Commissioners.

On April the 27th of 1989 by BMHA Board resolution this option #3 was formally adopted and the Buffalo Housing Authority commenced negotiations with the local HUD office and the Regional HUD office in Washington in terms of developing a voluntary compliance agreement to Title VI of the Civil Rights Act.

In September of 1989 the HUD transmitted a draft voluntary compliance agreement to the Housing Authority offices for its review. It went to the Housing Authority, went back and forth until finally we were given a final agreement on April the 24th, 1990 and the implementation date of May 1, 1990 was

1 used on the voluntary compliance agreement.
2 Let me draw attention to that, if I may.
3 There are presently some 300,000 authorities in
4 America that have, are undergoing voluntary
5 compliance agreements similar to the Buffalo Housing
6 Authority program. However, there is a distinct
7 difference. Voluntary compliance agreement used by
8 the Buffalo Housing Authority today which is very
9 soon to be implemented, is unique in that it
10 incorporates incentives that would result in
11 voluntary compliance not only by the Authority, but
12 by people moving into developments where their race
13 of ethnicticity is not concentrated.
14 It is a very bold experiment, if you will,
15 to be embarked upon by the Buffalo Housing Authority
16 and the HUD officials because it takes in part the
17 concept of magnets. We use the magnet school
18 program here in Buffalo and we are very successful
19 with it and it is that concept that is being
20 incorporated in this voluntary compliance agreement.
21 Many are of the opinion that the incentives
22 offered to individual applicants to public housing
23 and to those who reside within public housing are
not going to result in any effective measure in terms

1 of desegregating Buffalo Public Housing because they
2 do not go far enough. I am prepared today to share
3 with you some of those incentives that we will be
4 offering on an individual basis and on a development
5 basis.
6 On an individual basis the incentives
7 include child day care vouchers, adult day care
8 vouchers, adult domestic service vouchers, student
9 tutoring vouchers, college credits, educational and
10 other areas.
11 And on the hardware side, rehabilitation to
12 the unit to include a replacement and upgrading of
13 wiring to accommodate various appliances, brand new
14 stoves, refrigerators, washers, dehumidifiers,
15 humidifiers, ceiling fans with light fixtures, et
16 cetera, a very lengthy list.
17 Many have criticized these incentives in
18 the sense that they feel to relocate into a
19 development where your race or ethnicticity is not
20 concentrated would take much more than some physical
21 appliance or some voucher dealing with day care,
22 adult day care, education or job credits. They feel
23 there is a much broader course that would be needed.
Under our development incentives the Housing

1 Authority has developed a concept involving family
2 service centers. It is our hope that these family
3 service centers will address the concerns of many of
4 the critics and that we will be able to offer a
5 comprehensive package of services to individual
6 families who are willing to move into those
7 development in those areas where their race and
8 ethnicticity is not concentrated.
9 All of this is yet to be seen. As I
10 pointed out earlier, it is a very bold experiment
11 here in the City of Buffalo and we certainly are
12 turning to the community as a whole soliciting their
13 help and their input in achieving success with this
14 plan.
15 The Buffalo Housing Authority has made many
16 great strides beyond its traditional role of
17 administrator of a federal program, landlord if you
18 will, in trying to encourage residents to take
19 advantage of the programs that are available to
20 them. We have just embarked upon a new process in
21 our application procedure which refers to cross
22 listing with the Section 8 program here in the City
23 of Buffalo.
Although the Housing Authority does not

1 administer the Section 8 program as many other
2 programs do administer, we will and have begun a
3 cross listing at the encouragement of Secretary
4 Kemp. We have also engaged upon a very
5 comprehensive needs assessment in compliance with
6 Section 504 of the Rehabilitation Act of 1973, which
7 in turn in accordance with our transition plan would
8 result in many millions of dollars being spent in
9 our unit to accommodate those who are physically and
10 mentally disabled.
11 There are many other things that yet need
12 to be done. The Housing Authority is but an agent,
13 if you will, of the federal government. It can go
14 only as far as the federal dollars available to it.
15 We have unfortunately received word recently that
16 our modernization funds will be cut from some $13
17 million down to $330,000 which we feel would set us
18 back with some of the efforts that we have engaged
19 in, but nevertheless, with the existing resources
20 available today, we will continue to strive to make
21 open, fair and equal housing, housing opportunities
22 for all of our residents and applicants in Buffalo
23 Public Housing.
In conclusion, let me say that the Housing

1 Authority in the last two months in particular has
2 undergone very tramatic changes in its
3 administration. Some of the criticism in the past
4 perhaps was fair and we must take things as they
5 come in their reflections of our program in the way
6 in which it was administrated. Yet in many other
7 cases, it was unfair. All I can say at this point
8 is we are moving in a new direction. We have a new
9 Executive Director, new leadership on our governing
10 Board, and this Housing Authority will do everything
11 within its power to approve the opportunities for
12 all applicants and residents of the Buffalo Public
13 Housing.
14 I will be happy to answer any question that
15 the Committee members may have.
16 MS. CIPRICH: Mr. Oi.
17 CHAIRMAN OI: This incentives program is
18 one in which you are asking incumbent residents if
19 they would like to move or applicants?
20 MR. QUIDER: Both.
21 CHAIRMAN OI: For the incentives or to get
22 greater racial balanace? Is that the aim?
23 MR. QUIDER: The incentive is offered to
both applicants, those in occupancy, in both

1 applicants and residents in occupancy.

2 CHAIRMAN OI: Yes.

3 MR. QUIDER: And the goal, if you will, is

4 for compliance to Title VI of the Civil Rights Act

5 as defined by HUD. We do not pretend to sit here

6 and say that as a result of this Plan, we are going

7 to have a racially balanced program and in fact, it

8 is the feeling of the professional staff of the

9 Buffalo Housing Authority that you will not get a

10 program that is balanced.

11 If one were to define balance as equal

12 numbers of minority and non-minority people - -

13 CHAIRMAN OI: Well, what constitutes

14 compliance? I guess that is what I'm asking.

15 MR. QUIDER: Adherence to the agreement in

16 the opinion of HUD.

17 CHAIRMAN OI: No, but that is - - ha, ha - -

18 a pretty loose standard, isn't it? I mean, it

19 doesn't look like it is a clear set of lines that

20 one would operate within.

21 MR. QUIDER: Well, we have raised this

22 issue on many occasions in our discussions with HUD

23 and the response that we have is that compliance is

adherence to the agreement and we cannot take a

statistical profile or a racial snapshot, if you will, six months into the plan to measure our compliance or our success with the agreement.

In essence, we are at the mercy of HUD.

CHAIRMAN OI: And these vouchers, et cetera, are promises over a fixed period?

MR. QUIDER: There is a dollar amount fixed, $1,000 per applicant or per transferee and they will be permitted to divide that $1,000 in any manner that they wish between what we refer to as the hardware items and the software items being the educational or the child care guidance.

CHAIRMAN OI: And once you reach an agreement, the program is solved?

MR. QUIDER: I beg your pardon?

CHAIRMAN OI: Once you reach an agreement, compliance with the agreement, the program will be solved?

MR. QUIDER: Well, the volunteer compliance agreement is in effect for a three-year period and it may continue beyond that if HUD deems it necessary.

PROF. NISHI: What are your preliminary indications from this program as a response?

1 MR. QUIDER: Well, it is yet to be
2 implemented.
3 PROF. NISHI: Oh, it actually hasn't been
4 implemented as yet?
5 MR. QUIDER: Right. Although the agreement
6 is in effect, there are timetables built within the
7 agreement that allow for us to submit a new tenant
8 selection in the assignment plan to HUD for review,
9 and there is a process from there. We are expecting
10 that the tenant selection in the assignment plan
11 with a new set of rules, if you will, will be in
12 effect in mid-December.
13 CHAIRMAN OI: What is the average rental
14 rate now?
15 MR. QUIDER: $175.
16 CHAIRMAN OI: So, this constitutes about
17 5-1/2 months rent?
18 MR. QUIDER: It would be an amount equal to
19 that. However, we are not permitted by HUD to offer
20 any decrease in rent.
21 CHAIRMAN OI: Yes, I realize that. I
22 realize that. No, I'm just trying to get the
23 arithmetic straight in my own mind. I'm surprised
how - - you indicated that there are about 4200

units, 4100, about 8900 offices. That's a pretty small family size, isn't it?

MR. QUIDER: Well, you have a very large elderly population in Buffalo, in Erie County.

CHAIRMAN OI: Oh, okay. All right. Now, I understand where the numbers come from.

PROF. NISHI: The solutions are often tied to their historical origins of the problem. How did it turn out that the housing units under the -- the housing projects under the authority of the Buffalo Housing Authority became so segregated?

MR. QUIDER: Well, you know, there are many people who have different theories on this. We did offer at one time a project based waiting list and simply defined, if you were interested in living in a particular project, in a particular part of the City of Buffalo, you went there and you applied, and there is where your application would be processed and you would be waiting on other applicants to that particular development.

The City of Buffalo, it's no secret, is a community made up of many ethnic neighborhoods and people tend to gather in those particular areas. I don't know that that is a main factor, but I suspect

1 it had a lot to do with it. When HUD came out and
2 found that the Housing Authority was not in
3 compliance with Title VI, they directed us to change
4 that process. We went to a central waiting list.
5 However, we kept the locatio preference and the
6 choice of where one wanted to live.
7 In fact, it was 87% of all applicants
8 during that period were in fact housed based on that
9 location preference that was indicated. Again, I
10 think you would find a continuation of the desire
11 who were the Polish Americans to live in the Polish
12 community, the Hispanics in the Hispanic community,
13 Black Americans in the Black area in the City of
14 Buffalo, et cetera, and I would say in large part
15 this is the reason.
16 We do have a factor that we have made HUD
17 aware of where we feel that the voluntary compliance
18 plan will be impacted and that is that some 80, 85%
19 of the applicants on the waiting list tend to be
20 minorities on our family program and there is an
21 enormous need for outreach within the white
22 community to get white families to apply to Buffalo
23 Family Housing and I expect that that becomes one of
the greatest challenges in our efforts to succeed in

1 this program.
2 MS. CIPRICH: Any questions from the
3 audience?
4 CHAIRMAN OI: I have one more for you. Is
5 there any other evidence on turnover rates? Are
6 turnover rates higher in the segregated projects as
7 opposed to the ones that are mixed?
8 MR. QUIDER: I can't speak to that
9 offhand. I would tend to think that in our older
10 developments is where you would find the greatest
11 turnover rates, but there is so much happening in
12 Buffalo under the modernization program and we have
13 so many other problems with lead-based paint or
14 asbestos, that we have stopped placements. So, it
15 would be very difficult to determine that offhand.
16 MS. CIPRICH: Ms. Nishi?
17 PROF. NISHI: In the location of the
18 housing itself overall, generally speaking, public
19 housing has been placed in locations which have been
20 less desirable. That is, it was often left-over
21 land or areas in which there were already minorities
22 had been concentrated and did that contribute to the
23 patterns of segregation within the housing projects?
MR. QUIDER: I don't think, in my opinion,

1 in the City of Buffalo that that was as great of a
2 factor as it is, and rightfully noted, in many other
3 cities. I think that the biggest impact there was
4 the Housing Act of 1949 which turned over a lot of
5 the surplus wartime housing to the Buffalo Housing
6 Authority.
7 Here in the City of Buffalo we have but two
8 developments that were given to us under that
9 program and neither of which were located in the
10 industrial areas, at least in several areas. In
11 fact, LaSalle Courts and Langfield Homes are two
12 that are occupied by families and both of which were
13 prodominantly white at one time. Langfield Homes
14 now is of course predominantly Black.
15 PROF. NISHI: Thank you.
16 MS. CIPRICH: Okay, I would like to thank
17 our first panel. I think we will take a five-minute
18 recess here to stretch our legs.
19 (WHEREUPON, short recess held.)
20
21 MS. CIPRICH: Let me ask Michael Hanley,
22 Dennis McGrath and Scott Gehl to step up to the
23 front, please. The first speaker will be Michael
Hanley, Esquire, of the Greater Upstate Law

1 Project/Rochester.

2 MR. HANLEY: Thank you. Good afternoon.

3 The Greater Upstate Law Project is a law office that

4 works with local legal services programs that

5 represent low-income families and individuals on a

6 variety of poverty law issues including low-income

7 housing programs which is my specialization.

8 I'm here -- I know the main theme of the

9 afternoon session is the problem surrounding

10 implementation of the 1988 Fair Housing Amendments

11 and I think Susan Silverstein will be able to

12 address one of the particular legal issues that has

13 come up under the attention of the legal services

14 programs, but I have been involved more directly

15 with another case which raises another area of

16 concern under the Fair Housing Act and not just

17 under the 1988 Amendments but under the Act that was

18 existing prior to the Amendments and a provision

19 that continues since the Amendments.

20 So, I'm not addressing per se

21 discrimination under the Fair Housing Act Amendments

22 but more precisely violations in HUD programs under

23 Title VIII of the Fair Housing Act. The question

then is how can we be talking about violations if

we are not talking about discrimination and my point on that is that the Fair Housing Act in addition to prohibiting different types of categories of discrimination, imposes other legal duties on the Department of Housing and Urban Development in particular.

The primary duty which is imposed on HUD is that it administers its programs in a manner that further prohibits fair housing, and that is our concern. Dennis McGrath will address the particulars of the case that we are involved with in Buffalo, the Comer vs. Kemp case, and give us examples of the issues I'm talking about, but we thought it would be helpful if I could describe first the types of program administration concerns that we have that we think constitute violations of Title VIII.

When you speak of Affirmative Actions these days there is often a reaction. People tend to think that you are going to be talking about quotas and that is not our point and we are not saying per se that it is necessary to establish racial quotas involved in housing programs.

At a minimum, however, we will state that

1 there is a standard of compliance required by the
2 language that HUD administers its programs in
3 Affirmative Action for Fair Housing, that would
4 prohibit HUD from running its programs in a manner
5 that has the effect of discrimination.
6 Now, in Civil Rights litigation there are
7 many distinctions made between when a particular
8 conduct or activity has an effect of discriminating
9 or when purposeful or intendful discrimination must
10 be shown, but for our purposes my message is that
11 HUD programs need to be reviewed because of the
12 language in HUD that if they have the effect of
13 excluding minorities, that they are then - - that
14 HUD is not complying with its obligation.
15 In particular the category of problems that
16 I wanted to address is the problem created by
17 residency preferences within housing programs. I
18 know there has been a lot of attention paid to the
19 question of individual prosecution of Title VIII
20 violations and that was a big part of the requiring
21 of the rewriting of the Act in 1988, the different
22 mechanisms for enforcement for individual cases of
23 discrimination but the real problems are systematic
and the goal of the Act is not to create immigration

1 in housing but to create equal opportunity in
2 housing so that no family or person is denied
3 housing because of the traditional categories, race,
4 natural origin, et cetera, and the new categories
5 for familial status and disabilities, but the
6 existence of policies regarding residency
7 preferences in housing programs has the effect of
8 excluding people based on minority status, and
9 before an individual can address the question of
10 whether or not they are being discriminated against
11 because of their race, they have to have a housing
12 available to them and that is the problem.
13 Particularly, if you have a situation where
14 you have a community that has a very low minority
15 concentration and there are housing programs in that
16 area which include residency preferences, then the
17 effect of those preferences will be that there will
18 be no way for a minority family to be eligible to
19 dictate the housing and in fact, they may be
20 technically eligible. They may not excluded from
21 the programs, provisions from the programs'
22 particular requirements, but in practice the effect
23 of a preference when you have a limited amount of
housing is that it results in the total shut-out

1 really of minorities. I'm not saying that there is
2 anything wrong with the concept of residency
3 preference. If a residency preference is applied to
4 an area in which there is an equitable racial
5 distribution of an equitable ethnic distribution,
6 then you don't run into programs. The residency
7 preference is often promoted by local housing
8 developers and political persons as a way to ensure
9 that the residents of an area whose housing needs
10 have been identified are served by those housing
11 programs.
12 The problem arises when there is a
13 disproportionate segregation resulting from a
14 history of racial discrimination. In 1975 in a
15 school desegregation case that David Jay and a host
16 of other attorneys brought, the court determined
17 that the residential patterns, the occupancy
18 patterns in suburbs and the City of Buffalo did not
19 occur by accident. They were the product of years
20 of realtor discrimination, multiple listing agents
21 refusing to show listings to Black families and in
22 financing discrimination through mortgage loan
23 practices. Those patterns have created a situation
which has led, and not just in Erie County but in

other parts of the state as well, to
disproportionately low minority concentrations.

So, when programs come along such as the
Title VIII program which provided subsidies on a
finder's keeper's basis, families so that they could
go look for housing, if those allocations of Section
8 certificates are made to the areas in a manner
that takes into account the residency preferences in
minorities would never be able to get those
subsidies, and Dennis going to give you some of the
statistics on that in Erie County.

The problem is not just however in Erie
County. This issue was addressed and perhaps the
most well-studied case in the Chicago Housing
Authority's Public Housing Authority's case,
Gautreaux v.s The Chicago Housing Authority. That
case was filed over 20 years ago and one of the
important concepts that came out of it was the
Supreme Court of the United States recognizing that
in order to affect a remedy for public housing and
discrimination, you have to look at the vitality of
the housing programs available in an area and in
this case it meant looking at the Section 8 programs
in combination with the Public Housing programs and

1 that is the same issue that we are raising in
2 Buffalo litigation. The Gautreaux case obviously is
3 20 years further along and we should have the
4 benefit of learning from what worked in that case
5 and I presume we also would learn what didn't.
6 One of the things that worked was that they
7 set up when the Section 8 program was created in
8 1974 a special class of experimentation, if you
9 will, so that families from the Chicago Housing
10 Authority were identified and given the opportunity
11 and assistance to use Section 8's subsidies in areas
12 outside of Chicago. The concept of metropolitan
13 area relief has since been used in Boston and Dallas
14 as well. The point is that you can't desegregate
15 public housing.
16 If you have a program that's 80% minority
17 and a waiting list that is 80% minority and the
18 number of vacant units won't accommodate any kind of
19 racial balance, the only way to provide meaningful
20 values to people who have been living in that
21 housing and deteriorated conditions for years are to
22 give them additional subsidies and to let them move
23 from public housing which also creates an
opportunity for non-minority citizens to move into

public housing. The population of Erie County minority citizens or non-minority citizens who need affordable housing is frankly overwhelming.

The control families from the studies that have been done by Northwestern University and a variety of other studies which recently have been reported in the New York Times and other professional journals, indicate that the mothers who are minority mothers have gotten the finder's keeper's subsidies have been able to use it to find adequate housing in the suburbs, housing where they fit into the community in spite of concerns of people who would be offering residence, employment opportunities that they didn't have while they were in the city, and that their children had educational opportunities.

Some of them have been there long enough that they have been able to document that children of their families had gone on to higher education than in a much higher percentage breakdown than the control group who remained in the Chicago Public Housing Project.

I'm going to grapple with my remarks and let Dennis give you the particulars, but I do want

1 to say this, that I think the office of Fair Housing
2 and Equal Opportunity or HUD has good people in it
3 that try to do good things. It appears to me
4 however from my review of HUD programs and my
5 interaction office of program people, the program
6 level of HUD, that Fair Housing Equal Opportunity is
7 in a way the stepchild of my family. They don't
8 seem to have the clout that they should and I'm not
9 even sure that they are in a position to be as
10 aggressive as they need to be.
11 They have not addressed the residency
12 preference issue. I have had numerous conversations
13 with officials from Washington about this issue,
14 about whether or not they consider a residency
15 preference but has the effect of excluding
16 minorities in violation of Title VI and Title VIII.
17 They don't want to get involved in that issue. In
18 fact, it was almost the exact words I was given by a
19 senior official of the Fair Housing Equal
20 Opportunity, "We don't want to get into that."
21
22
23

1 "We don't want to get into that."
2 The other point about that is that I think
3 the coordination between the Office of Fair Housing
4 and Equal Opportunity on the program side needs to
5 be much greater. There is in many cases a nominal
6 review of Programs by the Office of Fair Housing and
7 Equal Opportunity. Program people don't worry about
8 fair housing considerations. To them, residency
9 preference is something that programs allow for and
10 they don't look beyond that to see what the
11 residency preference is, and similarly, it's the
12 Office of Fair Housing and Equal Opportunity that is
13 responsible for reviewing the overall housing
14 assistance plan for the city and I'm afraid that
15 from the experience that we have seen in Buffalo and
16 in other cities, they defer too much to the program
17 side. For example, the Community Development Block
18 Grant Program, the City of Buffalo has been
19 receiving Community Development Block Grant Funds
20 since 1974. It's part of the Housing Community
21 Development Act of 1974, which created the Section 8
22 program and yet the programs from the City of
23 Buffalo were administered in a manner where the

1 Section 8 program was not used effectively to
2 promote fair housing and simultaneously, this
3 disasterous situation that has been documented by
4 the Department of Justice and HUD with respect to
5 public housing of segregational patterns is
6 something that HUD has never used its leverage under
7 the Community Block Grant to push. They have the
8 ability under their own regulations when findings of
9 discrimination have been made, the Discrimination
10 Block Grant Fund on actions to be taken to correct
11 those actions. HUD has never exercised that
12 authority in Buffalo.
13 To give you more of an idea of the actual
14 impact of the overall housing programs, Dennis is
15 going to talk about their performance and benefits.
16 MS. CIPRICH: Dennis McGrath is an attorney
17 from the Neighborhood Legal Services in Buffalo.
18 Dennis?
19 MR. McGRATH: Thank you. Good afternoon.
20 Again, my name is Dennis McGrath and I am a staff
21 attorney with Neighborhood Legal Services,
22 Incorporated, a local legal services office here in
23 Buffalo. I'm with the Housing Unit.

1 We are currently involved in a litigation
2 here in Buffalo captioned Jessie Comer vs. Jack Kemp
3 and others. There are seven plaintiffs and ten
4 defendants. My office is cocounseling the act of
5 litigation with the Greater Upstate Law Project with
6 whom Mike Hanley is associated and with the NAACP,
7 Legal Defense and Education Law in New York City.
8 I'm just going to, I'll give you a brief
9 description of some of the basic points of the case
10 and then I will get into some of the things that
11 Mike Hanley has referred to and some of the problems
12 that we think this commission could look at today.
13 Litigation was filed in the United States
14 District Court in the Western District of New York
15 here in Buffalo on December 4th of 1989. It was
16 just a year ago. A couple of the primary points in
17 the litigation is that it challenges the
18 establishment of two separate Section 8 programs
19 here in Erie County. One of the programs which is
20 primarily minority serves the City of Buffalo. The
21 second Section 8 program, the other program, which
22 is overwhelmingly white, services the suburbs around
23 Buffalo with a consortium of 41 towns and villages.

1 The law office also focuses on ratial
2 steering in Buffalo's Public Housing Program.
3 It also focuses on the ratially disparate
4 conditions and services happening in the Buffalo
5 Public Housing Program.
6 It also focuses on ratial discrimination
7 and development of elderly public housing units in
8 Buffalo's Public Housing Program. It also focuses
9 on the failure of the City of Buffalo to comply with
10 Fair Housing Laws and the administration of its
11 Community Development Block Grant Program.
12 It also focuses on the failure of the City
13 of Buffalo and HUD to administer housing programs
14 here in Erie County and in Buffalo in a manner that
15 will affirmatively further fair housing.
16 And finally, it also focuses on the
17 conversion of state-financed public housing here in
18 Buffalo to private ownership of those public housing
19 units.
20 Here in Erie County like several other
21 counties in New York, there are two separate Section
22 8 programs that I mentioned before. One that
23 services the city and one that services the suburbs.

1 The City of Buffalo's program operates and
2 administers 2500 Section 8 certificates and
3 vouchers. Approximately 80 percent of its
4 participants are minority. Just a few blocks away
5 from the city's Section 8 program office is another
6 Section 8 program office which administers the
7 program, the Section 8 program for the county for
8 the 41 towns and villages outside of the City of
9 Buffalo.
10 The suburban program has its own allocation
11 of 2800 additional certificates and vouchers, and
12 only 4 percent of the program's participants in the
13 suburbs are minority. The City of Buffalo itself is
14 comprised of 30 percent minorities of the general
15 population, while the suburban areas are about 3
16 percent black or other minority.
17 The basic tenet of the case -- one of the
18 basic tenets of the case is that minorities are
19 excluded from the Section 8 program as to the way
20 the programs are operated. We believe that the
21 exclusion arises from two factors. First of all,
22 the Administrative Plan that the City of Buffalo
23 submits to HUD provides that Section 8 certificates

1 may only be used within the city limits. There is
2 some indication that that policy has been changed
3 but that policy, as far as we know, is still in the
4 current Administrative Plan of the Rental Assistance
5 Corporation, which is the administrator of the
6 Section 8 Program for the City of Buffalo.
7 Secondly, the Administrator Plan submitted
8 to HUD for the suburban Section 8 program provides a
9 local residency preference, as Mike indicated, for
10 families that are already living in any one of the
11 41 towns or villages in this consortium that I
12 referred to. It operates like this: A family from
13 the Town of Amherst, for example, one of our largest
14 suburban towns, which is a member of the consortium
15 and a main agency in the consortium, a family that
16 lives in Amherst would be given a preference over a
17 family from the City of Buffalo and could use its
18 subsidy, its suburban subsidy anywhere in the
19 county. Even though over 20 percent of the suburban
20 Section 8 waiting list is minority, because of the
21 local residency preference the percentage of
22 minority families which have actually been given
23 subsidies in the suburbs is only 4 percent.

1 When you combine the restriction of the
2 geographic area in the city, the program that I
3 referred to before, the Rental Assistance
4 Corporation with the local residency preference in
5 the suburban area, it's evident that a residency
6 pattern has been created that looks like a donut in
7 the City of Buffalo. Non-minorities living in the
8 suburban surrounding the inner city and the City of
9 Buffalo being comprised of minorities. The city
10 participants in the Section 8 programs are
11 effectively denied access to newer, higher quality
12 housing that is available in the suburbs and
13 consequently they also are denied educational,
14 employment, social and other services. The Section
15 8 program was never intended to restrict mobility.
16 The Section 8 program incorporates provisions
17 throughout its regulations and directives that
18 require the program to be administered in a manner
19 which promotes the widest possible geographic choice
20 of rental units. The HUD regulations specifically
21 require that Section 8 administrators must make
22 affirmative efforts to find apartments outside of
23 areas of high minority concentration. Nevertheless,

1 even the administrator of the Buffalo Program
2 conceded in a 1982 report that "Almost no blacks
3 moved into a predominantly white, non-impacted areas
4 of the city as a result of Section 8 participation."
5 In our litigation, the plantiffs have asked
6 that the waiting list for the two Section 8
7 programs, the city one and the suburban program, be
8 combined, that the geographic restrictions be lifted
9 from the city program, and that the local residency
10 preference of the suburban program be removed. As
11 Mike indicated, although the local residency
12 preferences are not illegal per se, they violate
13 fair housing laws when the effect of the preference
14 is to exclude minorities, which we are alleging in
15 our lawsuit. In addition, HUD regulations require
16 that when residency preferences are included in a
17 Section 8 program, the preference must be extended
18 to residents of any area in which the housing agency
19 is authorized to enter contracts. In New York that
20 elimination would preclude limiting the preference
21 to a particular municipality or even a group of
22 municipalities, as evidenced here in the Amherst and
23 the consortium.

1 In addition, plaintiffs in our litigation
2 have asked the court to re-order the waiting list to
3 give an "equal opportunity preference" to families
4 who have been adversely impacted, affected by
5 racially discriminatory practices in the past.
6 Particularly, the planintiffs in our lawsuit are
7 asking that the "equal opportunity" Section 8
8 preference be extended to families living in
9 Buffalo's heavily segregated housing projects, and
10 because of particular outreach requirements that
11 apply to public housing residents which have not
12 been complied with for many years. Plaintiffs also
13 ask that HUD allocate an additional number of
14 Section 8 subsidies to further desegregation. As
15 Mike mentioned, to look for metropolitan relief as
16 being one of the only ways to desegregate public
17 housing.
18 Just in conclusion, the litigation that I'm
19 talking about is merely a year old now and we have
20 had various motions and other arguments before the
21 court now locally here in front of Judge Curtin and
22 presently we are scheduled to hear a motion for
23 class verification in December of this year, which

1 is almost exactly a year to the day we filed the
2 lawsuit.
3 MS. CIPRICH: I think we will move on to
4 Mr. Scott W. Gehl, the Executive Director of Housing
5 Opportunities Made Equal and then we will have
6 questions after for all three.
7 MR. GEHL: Thank you. Scott W. Gehl,
8 G-E-H-L.
9 HOME is a not-for-profit organization
10 founded in 1963 to overcome those barriers which
11 prevent a fair and equal access to housing on the
12 Niagara Frontier. Today HOME has nearly 700 dues
13 paying memebers in Western New York. For the last
14 16 years HOME has worked under contract with the
15 City of Buffalo to provide comprehensive services to
16 city residents. Currently HOME also operates under
17 contract with the Town of Hamburg, the 33
18 municipalities of the Erie County Block Grant
19 Consortium, and the New York State Division of
20 Housing and Community Renewal. Last year HOME was
21 one of 32 fair housing agencies across the nation to
22 win first year funding from HUD's fair housing
23 initiatives program.

Each year HOME receives more complaints of housing discrimination than all other agencies, public and private, in Western New York.

Before offering comments on the efficacy of the 1988 amendments to the Fair Housing Act, let me attempt to describe the state of fair housing in Erie and Niagara Counties.

Despite the 27 years which have passed since the enactment of the Metcalf-Baker Act, I must report that housing discrimination is alive and well on the Niagara Frontier. From 1984 to 1989, HOME recorded 2,054 reported incidents of housing bias.

28 percent of these complaints involved familial status discrimination, 27 percent race, one percent religion, 3 percent national origin, 16 percent sex or marital status, 5 percent disability, and 8 percent age. HOME has also recorded verified incidents of discrimination due to source of income and sexual orientation, two classes not presently protected by either federal or state statute.

HOME finds that housing bias is a crime which does not respect municipa; boundaries. 57 percent of our complaints come from the City of

1 Buffalo, 36 percent from other Erie County
2 communities, and 7 percent from the surrounding
3 counties.
4 There are two specific situations I think
5 which help to illustrate the state of fair housing
6 in the metropolitan area.
7 The first involves Western New York's
8 largest landlord, the Buffalo Municipal Housing
9 Authority, and I think that Mr. Hanley and Mr.
10 McGrath have already described that situation, but
11 just basically, it is one of the extreme situations
12 or extreme segregation within 27 public housing
13 developments, 9 of which when we began this were 90
14 percent or better white, while 9 others were 90
15 percent or better in the minority. Additionally,
16 there were glaring inequalities in conditions at
17 white and minority developments, few minorities in
18 the BMHA payroll, and an appalling vacancy rate of
19 28 percent -- at the same time more than 3,000
20 families, most of whom were minority, sat on the
21 BMHA waiting list.
22 We have been through a long process, which
23 has gone on for years and Mr. Guiter of the Housing

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1 Authority described it to you to some extent. We
2 are hopeful now that the suit filed by NLS and the
3 Greater Upstate Law Project, as well as a new
4 administrator at the Housing Authority will make
5 some difference, but the tragedy remains that
6 they're visible problems were allowed to fester for
7 years at the Housing Authority, that millions of
8 government dollars were squandered in the interim,
9 and that thousands of area families were forced to
10 go without decent and affordable housing.
11 Now, the second situation that I cite
12 occurred early in 1989 when the Buffalo Common
13 Coucil debated a municipal fair housing ordinance
14 prepared by HOME. This bill, which went slightly
15 beyond federal and sexual orientation and lawful
16 source of income, and additionally narrowing
17 exemptions for owner-occupied dwellings, was
18 endorsed by 20 community organizations and enjoyed
19 strong editorial support from the Buffalo News.
20 However, the proposed ordinance also
21 generated a firestorm of controversy, which, in the
22 assessment of veteran City Hall reporters, exceeded
23 that of any other legislation in the previous ten

1 years. Investor landlords lobbied against the bill
2 -- claiming it would be unfair to prohibit them from
3 automatically rejecting "people on welfare". A few
4 council members made the bill's defeat a personal
5 crusade, shipping busloads of angry senior citizens
6 to public hearings.
7 Despite this maelstrom of opposition, on
8 February 7th, 1989, the Common Council passed
9 Buffalo's first fair housing law -- something that
10 cities like New York and Philadelphia had managed to
11 do 30 years before. 10 days later Buffalo's
12 ordinance was vetoed and the council voted to
13 sustain that veto.
14 There are probably not many cities in
15 America who can claim to have voted down fair
16 housing in the last year of the last decade; but
17 Buffalo, which calls itself the "City of Good
18 Neigbors" can.
19 As you well know, the Fair Housing
20 Amendments Act was a very long time in coming. The
21 Mondale-Brook Fair Housing Bill back in 1967 lost a
22 good deal of its potential strength when, on the
23 advice of Senator Dirksen, HUD's enforcement powers

1 were compromised away. Ironically, of course that
2 strategy was not successful in getting the bill
3 through Congress: Final passage came only amid the
4 wave of urban violence which followed the
5 assassination of Dr. King. Yet it took a full 20
6 years for enforcement powers to be restored to HUD.
7 Today HOME offers some anecdotal evidence abut how
8 those powers have been used.
9 Since the amendments took effect in March
10 of 1989, HOME has filed a total of 17 cases with
11 HUD. All involved either familial status or
12 disability discrimination -- as we have continued to
13 file other cases with HUD's substantially equivalent
14 agency, the New York State Division of Human Rights,
15 and Mr. Clark spoke about their experience.
16 Six of those 17 HUD cases were filed within
17 the past three months, and thus we can't fairly make
18 any assessment of HUD's ability to complete the
19 investigations within the 100 days stipulated in the
20 statute. However, in nine of the eleven other
21 cases, the 100 day statutory limit for
22 investigations was exceeded. Interestingly enough,
23 the only two cases HUD managed to resolve within

1 the 100 days were those that they dismissed.
2 Of the 17 cases filed, thus far six have
3 been resolved. As I said, two were dismissed
4 because they allegedly fell into statutory
5 exemptions. Four more were resolved by HUD
6 conciliation agreements. While HUD's investigators
7 understandably urge parties to settle complaints, in
8 a few cases HOME noted that pressure was placed on
9 complainants to settle for sums inappropriately
10 small in relation to the acts of discrimination
11 which occurred, and, you know, I think that any
12 victim of discrimination filing with a government
13 agency understandably defers to the person handling
14 his or her case and some advice was given and from
15 our standpoint, some very bad advice.
16 In one instance, a HUD investigator
17 actually urged a HOME client to actually withdraw
18 his complaint -- allegedly claiming that there
19 wasn't anything that HUD could really do about the
20 case. It was only through the diligence of HOME's
21 assistant director and the intervention of Charles
22 Martin, HUD's Area Director of Fair Housing, that
23 the complaint was reinstated and eventually resolved

1 by a conciliation agreement. This incident caused
2 HOME to express concern that HUD understaffing,
3 inexperience in processing cases, and the
4 administrative pressure to close cases in a timely
5 fashion might adversely affect a complainant's right
6 to fair housing, and we appreciate the receptivity
7 of Regional Director Seidenfeld and his staff to
8 such concerns.
9 In June of 1989 HOME had occasion to seek a
10 temporary restraining order in relation to a
11 complaint filed by HUD. During the two weeks that
12 followed, our agency received almost daily telephone
13 calls from HUD staff in both New York and
14 Washington, and an attorney from the Department of
15 Justice. On one particular day this single case
16 generated five phone calls to HOME -- from three
17 different federal employees in two different
18 cities. However, despite all the sound and fury, a
19 TRO was never obtained.
20 MR. OI: TRO?
21 MR. GEHL: A temporary restraining order.
22 MR. OI: Thanks.
23 MR. GEHL: Thankfully, I might add though,

1 that HUD staff did later negotiate an interim
2 agreement, which allowed our client to occupy the
3 unit; however, 15 months later, we still have no
4 signed conciliation agreement.
5 One of our first HUD conciliation
6 agreements involved the owners of a suburban
7 apartment complex, and by the terms of the agreement
8 because of the language, we specified also applied
9 to other complexes owned or managed by the
10 respondents. Three months after that first
11 agreement, HOME learned that despite the HUD
12 agreement, the respondents were nonetheless
13 committing the same discriminatory practice at
14 another complex. Accordingly, on June 18th, 1990,
15 HOME notified HUD of the violation of this
16 conciliation agreement and, one week later, followed
17 with a formal complaint. Knowing of the Attorney
18 General's role in pattern and practice cases and
19 supposed eagerness for such cases, on June 25th HOME
20 also directed a letter to the Department of
21 Justice. Depsite follow-up phone calls, we have yet
22 to elicit any response from them.
23 Ironically, HOME's first HUD case, filed on

1 July 5th, 1989, is still pending. This case
2 involved steering by a real estate agent. Because
3 HOME had no evidence of complicity by the landlords
4 involved, the complaint was directed only against
5 their agent. However, 7 months after filing, HUD
6 insisted that the complaint be amended to include
7 one of the two landlords; HOME reluctantly
8 complied. One month after that amendment, another
9 level of review at HUD decided that the landlord
10 should not have been included after all.
11 Accordingly, HUD required a second amendment --
12 undoing the first. And I remind you 16 months after
13 filing, this case is still unresolved.
14 In sharing these experiences, we do not
15 intend to criticize the good intentions of our
16 friends at HUD, who grapple with inadequate
17 resources to implement an admittedly complex
18 statute. However, we do offer the following
19 recommendations.
20 Firstly, on matters such as obtaining the
21 TRO or investigating violations of conciliation
22 agreements, there is a need for better delineation
23 of the roles of HUD and the Justice Department, and

1 for more effective communication between the two
2 agencies.
3 Secondly, there appears to be a need for
4 better training of investigators and other measures
5 to ensure "quality control" in the processing of
6 cases. While it is desireable for HUD staff to
7 promote conciliation, it is not appropriate to
8 advise complainants to withdraw complaints or to use
9 influence to encourage acceptance of token
10 settlements.
11 Thirdly, while the statute requires
12 notification of parties when an investigation is not
13 completed within 100 days, HOME has learned that
14 months can later pass without any further word on
15 the case. We ask periodic status reports -- say
16 every hundred days thereafter -- until a
17 determination as to reasonable cause has been made.
18 And lastly, HUD must be given sufficient
19 staff to fulfill its responsibilities.
20 Despite imperfections, the amended Fair
21 Housing Act has served to refocus public attention
22 on the problem of continuing housing discrimination
23 in America. By working cooperatively with its

1 substantially equivalent agencies and non-profit
2 fair housing centers, HUD can do a great deal to
3 help realize the unkept promise of fair houseing.
4 Thank you.
5 MS. CIPRICH: Thank you, Mr. Gehl. Would
6 anybody on the committee like to ask some
7 questions? We have about 10 minutes I think.
8 MR. OI: What is the principal aim that HUD
9 could perform to satisfy the Comer vs. Kemp case?
10 There's a series of allegations brought there but of
11 your three recommendations that you gave at the end,
12 how do we make those operational?
13 MR. HANLEY: Well, I will answer that. I
14 think the most important concept to be adopted is
15 the concept that people who were injured because of
16 housing discrimination are entitled to a remedy.
17 When Mr. Guiter was here, he talked about the change
18 of plans for admissions and what they hope it will
19 accomplish. There is no mention of what hope they
20 had or how that plan could affect people who had
21 been discriminated against for years and who lived
22 in substandard housing for years. Even if that plan
23 worked prospectively, there is no remedial aspect to

1 it.
2 The objective we are seeking in the lawsuit
3 is an infusion of housing subsidies so that families
4 will have an opportunity, not just to stay in
5 Buffalo Public Housing Projects, which by anyone's
6 measure will stay segregated or will stay
7 disproportionate minority, but will have the
8 opportunity that they should have been given between
9 1976 and 1990 to take other types of housing
10 subsidies, housing subsidies that don't restrict
11 them to a particular project, who don't restrict
12 them to a particular geographic area.
13 HUD has an allocation out of Section 8
14 subsidies that it uses to resolve fair housing
15 litigation. We would like to see the Buffalo
16 Housing Authority in the City of Buffalo, the New
17 York State Division of Housing, and many other
18 concerned bodies and citizens to support a request
19 to HUD that allocations be made from that national
20 pool for the Buffalo area.
21 MR. OI: Do you have an idea of what the
22 size of that pool is?
23 MR. HANLEY: It's 5 percent of the

1 Secretary's Discretionary Fund, and the actual
2 amount that it translates to on a national level is
3 small. I believe we did the numbers at one point
4 but I don't know now. It's like 3,000 I think
5 nationally. We would be hoping that they, over a
6 period of years on an annual incremental basis,
7 would be able to do an infusion of subsidies that
8 could be absorbed by the program administrators. We
9 would be looking at about 1,000 subsidies a year.
10 MR. OI: That is still very small, isn't
11 it?
12 MR. HANLEY: It is very small compared to
13 the need.
14 MR. OI: But that would be a token sort of
15 thing?
16 MR. HANLEY: Well, it would be important to
17 the families, and we are trying to be progmatic
18 frankly. We know that there is not a prospect of
19 giving fiar housing subsidy opportunity to everyone
20 who is discriminated against. In fact, a lot of
21 families may desire to stay in public housing. They
22 have friends. They have support from just
23 familiarity with local businesses, that is their

1 life. That is where they live. That is their
2 neighborhood. They don't want to move and we don't
3 think people should have to move as part of the
4 public housing litigation remedy.
5 So, if the subsidies were made available to
6 those who wanted it, we feel over a period of years
7 with annual allocations that that would be a
8 desirable starting point.
9 The other part of the suit that was in
10 recognition of the fact that there won't be enough
11 subsidies to help people move on to public housing
12 is to have HUD allocate sufficient funds to make
13 sure that the public housing projects are brought up
14 to a level of equalization, a level where the
15 projects that are disporportionately a minority will
16 have the same types of services and amenities and
17 quality of housing as do the projects that are
18 primarily non-minority. It's a fairly simple
19 request I think and the problem is the practical
20 restrictions of cost and actually scheduling repairs
21 and so forth. That needs to be done and so far they
22 haven't admitted the problem quite frankly. They
23 are reluctant to admit the degree of disparity and

1 services that has been confirmed by the Department
2 of Justice.
3 MR. OI: Have you followed at all the
4 privatization attempt in Chicago?
5 MR. HANLEY: With the Ellicott Mall?
6 MR. OI: With some of the public housing
7 projects there?
8 MR. HANLEY: Well, there is a proposal to
9 New York State for privatization of the Buffalo
10 Housing Authority's state financed public housing
11 projects, the Ellicott Mall, and we are concerned
12 that if those units are taken and turned into
13 private ownership, that unless the form of that
14 ownership is such that the units will be made
15 available to lower families, the 2,000 families who
16 are right now on the Buffalo Housing Authority's
17 waiting list, they will be the ones that suffer
18 because if the court agrees that the State and the
19 Housing Authority have an obligation to repair their
20 vacant units and their substandard units and provide
21 them to those families on the list, then those
22 families will no longer have that pool of
23 departments available.

1 MR. OI: Even with the 28 percent vacancy
2 rate?
3 MR. HANLEY: Well, there is a 28 percent
4 vacancy rate and there is about I think almost 1700
5 vacant apartments, something like that, but there
6 are more people on the waiting list than there are
7 vacant apartments. So, there is still a need.
8 There is about 500 units in the Ellicott Mall
9 project.
10 We are taking the opposition in the
11 litigation and we have taken this position with New
12 York State in discussions, that if there is nothing
13 wrong with privatization in the Ellicott Mall, it
14 would be a very good idea to have to convert it to a
15 high concentration very low income use to more of a
16 mixed use type of facility with larger, more
17 amenable units. However, our bottom line on that,
18 that issue, is that if you are going to remove units
19 from public housing that are needed by people on
20 public housing waiting lists, then you have to
21 provide something to make those persons whole. You
22 have to replace those units, either in the form of a
23 subsidy it could be used in existing housing, like a

1 Section 8 program or state legislation created, or
2 to build a new unit.
3 MR. CALABIA: Because of the absence of HUD
4 from this meeting, the regional HUD, we will be
5 writing to regional HUD and probably interviewing
6 them as well. Who in regional HUD should we address
7 this issue to?
8 MR. HANLEY: Well that is part of my
9 dilemma, I never know. It seems like we are talking
10 to the wrong person no matter who in the state. If
11 you talk to the Office of Fair Housing and Equal
12 Opportunity, they tend to refer you to the program
13 people. They say, well, this fits the regulations
14 of public housing, or this fits the regulations of
15 Section 8. They don't seem to have a thought. I
16 would say they would be the logical ones to address
17 a comment to, the logical ones to get responses
18 from, but the reality is that what is going to be
19 done in housing, in the public housing programs and
20 the other HUD programs, would be done by the
21 programs.
22 MR. CALABIA: Who then? Who by name on the
23 program side could we address that, our inquiry?

1 MR. HANLEY: I don't know to tell you the
2 truth.
3 MS. NISHI: Perhaps both sides.
4 MR. HANLEY: Pardon?
5 MR. NISHI: On both sides.
6 MR. HANLEY: Yes.
7 MR. CALABIA: Yes, I know both sides, but I
8 mean I would know from the fair housing side but I
9 don't know anyone from the program side.
10 MR. HANLEY: Yes. Frankly we have no
11 contact with the regional office other than besides
12 your office.
13 MR. CALABIA: Oh, in Washington? Actually
14 we are located in Washington.
15 MR. HANLEY: Well, in Washington, we have
16 very little interaction with the heads of the
17 Housing Program. We deal more with the local people
18 in Buffalo.
19 MR. CALABIA: Oh, I see.
20 MS. CIPRICH: Yes?
21 MR. CUNNINGHAM: James Cunningham. In
22 Washington, within FHEO there is an office in
23 Program and Development and that is headed up by

1 Larry Pearl and his job is to see to it that fair
2 housing and equal opportunity concerns are reflected
3 in programs and he may be a good person to contact
4 to see who to talk to in New York.
5 MR. HANLEY: On the Section 8, the program
6 person is a man by the name of Gerald Benoit, and
7 Madelin Hayes is one of the key program people.
8 MR. CALABIA: Are these regional HUD people?
9 MR. HANLEY: No, those are Washington.
10 MR. CALABIA: Oh, Washington, I see.
11 MR. HANLEY: Washington, D.C. had
12 positions. But the public housing programs that we
13 have have not interacted with Washington HUD.
14 MR. CALABIA: I have a question for Mr.
15 Gayle. With respect to the legislation which
16 failed, what particular provisions did the mayor
17 object to in that the county helped him sustain
18 vetoing?
19 MR. GAYLE: Well, it's so hard to choose.
20 There are concerns about provisions especially
21 related to two family owner/occupied homes which are
22 exempt from most federally state laws, save for one
23 enacted in the 19th Century. However, I think it

1 is accurate to say that there was also concern
2 expressed for the purpose of fair housing laws in
3 general. Only last Thursday I had the pleasure of
4 appearing in a public forum with the mayor and his
5 comment, his parting comment there was "I want you
6 to remember that I am always opposed to things that
7 HOME has done and I will continue to fight you."
8 MR. CALABIA: Setting aside the two-family
9 home provision, would the legislation be somewhat
10 similar to the federal legislation here, the federal
11 regulation?
12 MR. GAYLE: Well, I think it would be more
13 similar to the state statute which extends beyond
14 the federal legislation. The state statute, in
15 addition to the federally protected classes,
16 includes marital status and age. The proposed
17 Buffalo ordinance would have also included a lawful
18 source of income and sexual orientation.
19 MS. CIPRICH: Ms. Nishi?
20 MS. NISHI: To what extent is their
21 inclusion of minorities in decision making positions
22 in both the side of program as well as the side of
23 fair housing enforcement at HUD? We had of course

1 a notable Secretary of HUD.

2 MR. GAYLE: Well, I can only speak really

3 about the Buffalo Area Office. The Director of Fair

4 Housing there, he's a minority, as are I believe

5 three of his -- four staff people, and I don't know

6 about the regional level in New York.

7 MS. CIPRICH: Are there any other questions

8 for our panel? Jim?

9 MR. CUNNINGHAM: James Cunningham. Does

10 HOME do any testing?

11 MR. GAYLE: Yes, we do.

12 MR. CUNNINGHAM: What areas do you test

13 for? Do you look at just rental or are you also

14 looking at red lining and other types like that?

15 MR. GAYLE: Well, under HOME's contract

16 with HUD, we test in response to complaints

17 generally and most of those involve the rental

18 market. We also however have a component of the

19 project which is going to examine residential

20 lending by Buffalo area banks in terms of the

21 compliance with reinvestment. We don't specifically

22 test for discrimination in lending. There are some

23 real problems procedurally in who we lend to.

1 MR. CUNNINGHAM: Do you have this program
2 developed formally? Is it something that you could
3 share with us in a document, the plan?
4 MR. GAYLE: Our plans in terms of the
5 community reinvestment act portion or in our overall?
6 MR. CUNNINGHAM: I see. That's the
7 component that you will be looking at, lending bank
8 procedures?
9 MR. GAYLE: Yes.
10 MR. CUNNINGHAM: I see.
11 MR. GAYLE: And essentially it's not an
12 examination of --
13 MR. CUNNINGHAM: Not under the Fair Housing
14 Act?
15 MR. GAYLE: Yes.
16 MR. OI: The rental part of the testing
17 program is not written up in any way?
18 MR. GAYLE: Yes, our testing program is
19 written up, sir.
20 MR. OI: May I ask a naive question? I'm
21 not familiar with this testing program, but if you
22 find a landlord in violation, outright
23 discrimination, what steps do you take?

1 MR. GAYLE: Well, it will depend in large
2 part on what our client wants.
3 MR. OI: Well, who is the client in a
4 testing case?
5 MR. GAYLE: Well, the client is a bonafide
6 home seeker who has encountered discrimination or
7 who believes himself to have encountered
8 discrimination. If our investigation reveals that
9 discrimination did indeed incur, we may try to
10 consolidate the case, and what our client wants, be
11 it access to the particular dwelling as well as some
12 consideration in return for the discrimination here
13 she has experienced, plus some affirmative action,
14 or we may refer the complaint either to the State
15 Division of Human Rights or to HUD or in exceptional
16 circumstances, we may file directly in federal
17 court.
18 MR. HANLEY: I would like to comment about
19 testing. There is one other interesting aspect of
20 HUD's relationship to testing programs and its
21 attitude on them. HUD finances funds agencies such
22 as HOME to do the testing but it's very reluctant to
23 cooperate, I think, in having its own properties

1 tested, properties where there are indirect
2 subsidies under those programs that are supposed to
3 be providing subsidies for low income families.
4 There is a very simple problem and a very simple
5 solution. Most of the fair housing agencies have
6 been a hamstrung in trying to test a federally
7 subsidized project because you have to sign at the
8 time of the application affidavits that indicate
9 information about your family status and your
10 income. Most of the people cannot sign those
11 affidavits if they are in fact in a role of a
12 particular person other than themselves and are in
13 fact testing to corroborate allegations of
14 discrimination. So, HUD has refused to change its
15 policy with respect to allowing testers to submit
16 applications to subsidized housing programs. It
17 would be very simple for them to say that we will
18 not prosecute anyone for perjury or fraud for
19 falsely filing an application, for an application
20 for subsidized housing. It will go a long way to
21 improving the availability testing in subsidized
22 housing programs, which as I indicated before is the
23 primary source for many minorities, the

1 disproportionate minorities.

2 MR. OI: Are the results of these made

3 public, available? In other words, can I find out

4 how many trials home made and testing and where the

5 outcomes are?

6 MR. GAYLE: The results are reported.

7 MR. OI: Just in the aggregate?

8 MR. GAYLE: Yeah. Yeah, results of

9 individual cases only come to light if in fact it is

10 followed by legal action.

11 MR. CALABIA: Was it Tom Hollander, the

12 real estate agent, was he the one who spoke earlier

13 about the dilemma that he was facing?

14 MR. HANLEY: Yes.

15 MR. CALABIA: He's no longer in the room,

16 am I right?

17 MR. CUNNINGHAM: No.

18 MR. CALABIA: Given his predicament, how do

19 you respond to the implication that testing has had

20 a chilling effect on the agents when questions such

21 as his real client or presumed client are brought

22 up? I gathered that when he said well, I don't want

23 to move there becuase the schools are terrible and

1 my kids would be hasseled, and I gathered also or I
2 speculated that he wanted to say oh, no, the schools
3 aren't that bad but he didn't want to say anything
4 because this might be a tester and he could be hung
5 out to dry. How do you respond to that?
6 MR. GAYLE: Well, I think that the problem
7 doesn't occur when you say positive things, but the
8 problem occurs when you say negative things. I
9 think that Mr. Hollander's reluctance was well
10 founded. You find very often that housing providers
11 wishing to discriminate today will use very subtle
12 clues to discourage people. HOME in fact has a
13 brochure which deals with what we call rather
14 dramatically language of discrimination and there
15 are phrases like with children, with young children,
16 will you feel safe living on the street as busy as
17 this? Now, I have to be honest, in the winter, this
18 place cost a fortune to heat. You know, the issue
19 of course, I mean these facts may be objectively
20 correct but the issue is are they said to everyone
21 or are they said to only certain people to
22 discourage them? We have had instances where real
23 estate agents have essentially confided to minority

1 clients that, well, in the past minorities have
2 attempted to live in this community and there have
3 been problems. I think that, you know, any, you
4 know, reasonable client, you know, you can see that
5 as a red flag and perhaps that will discourage
6 them. The issue becomes -- the issue for our real
7 estate agents and other housing providers comes, are
8 they certain of the information they provide and do
9 they provide exactly the same information to
10 everyone? Those are difficult -- those are
11 difficult questions and it's a difficult issue to be
12 on top of all the time and frankly, when I have
13 spoken before the Board of Realtors, I have advised
14 people when questioned about matters of race and
15 ethnicity and racial composition to say simply I
16 don't know and to, you know, refer them to the
17 Municipal Planning Department or whatever, if they
18 are in search of, you know, objective census data.
19 I think that, you know, that's potential mind feed,
20 you know, for a real estate agent to walk in on.
21 MR. OI: Would you be willing to share
22 brochures with the committee on possible pending
23 reports?

1 MR. GAYLE: Sure.
2 MR. OI: Thank you.
3 MS. CIPRICH: I would like to ask our next
4 set of panels to come up please, Susan Silverstein,
5 Maggie Lee and Brian Black. We would like to
6 begin. Susan Silverstein, would you introduce
7 yourself?
8 MS. SILVERSTEIN: Yes. My name is Susan
9 Silverstein and I'm an attorney with the Monroe
10 County Legal Assistance Corporation, which is a
11 federally funded legal assistance office which
12 represents low income clients in Monroe County.
13 Although I am specifically going to talk
14 about the Fair Housing Amendments Act,
15 implementation of discrimination against individual
16 disabilities, my office also sees many, many clients
17 who are affected by discrimination based on their
18 familial status. We brought a case based on that
19 data but we would welcome questions about the
20 experiences that my clients have brought to us as
21 well.
22 Recently I and a colleague filed what we
23 think was the first affirmative case in the

1 country bring suit under the Fair Housing Amendments
2 Act against a landlord. There have been other cases
3 that have brought zoning related litigation. We
4 sued the Rochester Housing Authority for
5 discriminating in its application process primarily
6 against individuals with disability and I would like
7 to talk a little bit about that case just briefly,
8 its history, where it is. We received a very
9 favorable court decision from Judge Lattimer in the
10 Western District Court in Rochester and also the
11 implications that case has for other enforcement
12 against other types of landlords in addition to the
13 public housing landlord.
14 Public housing, I know that we housers tend
15 to throw around the various types of housing and
16 expect everybody to know what this means. Public
17 housing is housing that is directly subsidized
18 through the government and it is usually owned by
19 the local housing authority. Our case involved that
20 type of housing. Public housing usually comes in
21 what I think of as two types. There are housing
22 projects that are built for what we traditionally
23 stamp as families at least two people in a

1 household and those projects when they are built
2 usually have enough bedrooms to accommodate larger,
3 small to moderate larger families. They are usually
4 one to three bedroom apartments.
5 There have also been funding for what is
6 referred to as elderly housing. That is primarily
7 housing with studio apartments and one bedroom. HUD
8 defines elderly as both people over the age of 62
9 and people with a handicap or disability, and that
10 in and of itself has created some problems in that
11 single people with handicaps and disabilities and
12 people who are elderly are housed together in the
13 same physical projects. Whether that's a perceived
14 problem or an actual problem is over debate.
15 Our great clients who under a court order
16 are anonymous are Betty Roe, Debby Doe and Daisey
17 Kasim.
18 Debby Doe was a client whose only
19 disability was a mental disability. She was a young
20 person, probably about my age. She was paying about
21 68 percent of her rent, 68 percent of her income for
22 rent, and she applied for an apartment with the
23 Rochester Public Housing Authority. After I tell

1 you a little bit about all three, I will tell you
2 what the Housing Authority did when they applied.
3 Betty Roe was an older woman. She was
4 elderly and would have been eligible just on the
5 basis of her elderly status. In fact, didn't tell
6 the Housing Authority about her disability for it
7 weren't immediately relevant. In the course of
8 investigating her application they came up with the
9 documentation that she also had some physical
10 disabilities, primarily related to age, such as high
11 blood pressure, and came up with some documentation
12 that she had a history of family disability as
13 well. She had lived for 32 years in New York City
14 in her own apartment building and had just moved to
15 Rochester, so she had no recent housing history in
16 Rochester.
17 Daisey Kasim -- I should have mentioned
18 that Betty Roe was Hispanic and Debby Doe was white
19 and Daisey Kasim was black. We felt very good that
20 we were representing a very good selection of
21 plaintiffs. Daisey Kasim was also living in a
22 nursing home and according to the Housing Authority
23 they had never gotten an application before from

1 anybody who had been living in a nursing home, which
2 I thought was very surprising. They apparently felt
3 many people go into nursing homes and never come
4 out, and they just hadn't a clue as to how to
5 process their application.
6 In all three of these cases, all three
7 plaintiffs had a history of being tenants. They had
8 all either rented somewhere before, had currently
9 rented somewhere before. Their rental references
10 came back as being perfectly adequate. House
11 keeping inspection was done for the two plaintiffs
12 in the community. Those came back as adequate.
13 What the Housing Authority then did, believing it
14 was operating under HUD sanction procedures, did
15 what they call an investigation into their ability
16 to live independently, which is pretty much for them
17 an impossible issue. A person at the Public Housing
18 Authority whose job it was went into these people's
19 homes or the nursing home and subjected them to a
20 list of questions that were designed to determine
21 whether they could live independently. The
22 questions included things like how frequently do you
23 bathe, how frequently do you shampoo your hair, what

1 television programs do you watch, list all the
2 medications that you are on, and this questionnaire
3 was used just for applicants who are elderly or
4 handicapped. People who are applying for family
5 units were not subjected to those questions.
6 Needless to say, we found this offensive.
7 The Housing Authority justified this on the
8 basis of the fact that they didn't have people
9 living in their apartments who couldn't take care of
10 themselves and questions like how deeply do you
11 sleep at night -- I don't remember how they worded
12 that exactly. They justified questions like that
13 with well, what if there is a fire and this person
14 is handicapped, do they sleep? I mean I just don't
15 know. And they also justified it on the basis that
16 there was a HUD handbook that said they were
17 supposed to ask these questions of people. We
18 brought a lawsuit against them and philosophically
19 what our loss would represent was what we feel is
20 the motivating factor under the Fair Housing
21 Amendments Act that you don't judge people that are
22 handicapped any different than the people who are
23 not handicapped and what you are to look at is

1 whether or not the applicant is able to be a good
2 tenant, the words used in the regulations are
3 "capable of fulfilling their obligations of their
4 tenancy."
5 It seems pretty obvious to us, but in
6 continuing this lawsuit and working with other
7 managers and landlords in the area, I realized that
8 it is a pretty dramatic shift in the way these
9 housing providers are thinking about handicapped
10 people.
11 There were a couple of different areas that
12 we sued under the law in the regulations and in my
13 brief outline I listed some of them. We sued under
14 the Provision of Intrusive Inquiries, which like the
15 inquires in the sex discrimination case, just make
16 the inquiries themselves as per se discrimination.
17 You don't have to show it has a negative effect.
18 Just by asking a woman if you are pregnant is an act
19 of discrimination, asking someone for what
20 medications they take or giving a doctor's
21 statement, that is not something that is required,
22 giving a doctor's statement from an applicant or a
23 handicapped, or actually a medical release which it

1 could then use when they felt like it, it was a
2 doctor's statement. And the judge felt that that
3 was illegal discrimination. All these questions
4 were illegal under the Act.
5 In terms of other landlords that we see,
6 this is probably the biggest area of complaint that
7 HUD has gotten in our office. I would say that
8 every HUD subsidized project that I'm aware of in my
9 Monroe County is currently using an illegal
10 screening device at the initial stage and is asking
11 intrusive questions. We deal with that by doing
12 some training of some management companies but it's
13 a very piecemeal kind of thing. We need a client in
14 order to be able to approach a manager and so if a
15 person calls us, we try and then call the management
16 company. I guess I will talk about it a little bit
17 later, and I guess that raises the question of what
18 kind of enforcement is being done by HUD to get the
19 word out that this is no longer legal.
20 One of the other things that the Housing
21 Authority was requiring, which we call the
22 additional eligibility requirement, which is also
23 prohibited, is the fact that a handicapped person

1 proved that they were able to live independently
2 whereas a person who was not handicapped did not
3 have to prove that. And really, they were working
4 on the most outrageous assumptions about people with
5 disabilities that have occurred. I couldn't believe
6 it. We went to court and the Housing Authority said
7 to the judge, well, you know, your Honor, I think
8 you could accept it as given that people who have
9 families that apply for public housing have all
10 kinds of community resources and they are not going
11 to have these kinds of problems, the kind of social
12 problems that the handicapped people are and luckily
13 for the judge, he said, I beg to differ with you.
14 If you have ever worked with low income families,
15 they may have a few difficult social problems also,
16 but that was the comparable assumption the Housing
17 Authority was working under.
18 Also they were requiring all people with
19 handicaps to submit to what they called a
20 comprehensive care plan upon admission. We actually
21 went through this for Daisey Kasim's case. Her
22 application was accepted after some advocacy on our
23 part for the litigation before we got a decision.

1 We had 12 service providers at this meeting because
2 they required that every service provider be present
3 at the meeting. Every service provider had to sign
4 onto a contract saying that they were going to
5 continue to provide services when she was housed in
6 a Housing Authority apartment, and all kinds of
7 inquiries were made as to her financial abilities
8 and so on. It's an ironic note that I got a
9 complaint about her through one of the managers and
10 despite having held this meeting with 12 service
11 providers, none of them were contacted, including
12 the person they had identified in the contract as
13 being the contact person. So, we felt that those
14 contracts were being used to keep people out of
15 housing rather than to actually -- to be another
16 hurdle that people had to jump over rather than in
17 fact to provide services.
18 In terms of the three clients' denials,
19 when we did depositions, they came right out and
20 said that the plaintiff Debby Doe was denied because
21 of her high blood pressure and her mental disability
22 and they said one of the reasons that they felt she
23 wouldn't make a good tenant is that she wouldn't

1 admit that she had a mental disability. The fact
2 that she had lived for 32 years also in a HUD
3 subsidized project in New York apparently didn't
4 account for much.
5 And likewise, Plaintiff Doe, although it
6 wasn't explicitely denied because of her handicap,
7 she was denied because she made too many phone calls
8 to the application person and that she didn't always
9 understand what she was being told and she wanted to
10 have information in writing and it wasn't a policy
11 to give things in writing, so the clear issue was
12 going to be a problem with the tenant.
13 One of the issues that was not resolved by
14 Judge Lattimer which is still pending was a steering
15 issue which frankly, we really don't know what the
16 issues are. We are meeting Wednesday with the
17 Housing Authority to get more information about
18 those but one of the things the Housing Authority
19 was doing was making an eyeball determination of
20 what services you needed and referring the applicant
21 for special housing within its project, housing that
22 they called enriched housing or extended shared aid
23 program housing where they judged that you needed

1 services, they would refer your application to the
2 special floors that were segregated or buildings
3 where these services were provided, but not tell you
4 tha you were being referred to these special
5 apartments and then if the program denied you, they
6 will deny you for any Housing Authority problems.
7 So, we are still investigating that claim.
8 The court made it very clear that living
9 independently is a criteria for housing is dead in
10 the water, that this was absolutely prohibited under
11 the Fair Housing Amendments Act and what the Housing
12 Authority or any landlord should be looking at is
13 common tenants to fulfill the obligations of
14 tenancy.
15 Shortly after our decision, HUD sponsored a
16 conference in Washington where it brought together
17 people from its Fair Housing Enforcement Office and
18 people from its Public Housing Program Office trying
19 to get them to actually sit down in the same room
20 and discuss these issues, and it was really striking
21 the lack of a unified voice that HUD spoke with. I
22 think that the FHEO office, which I believe actually
23 drafted the regulations, understood what their own

1 regulations said but the programming office was
2 totally reluctant to embrace those regulations in
3 any wholehearted way, although they kind of had to
4 acknowledge that they had to abide by them.
5 In terms of this living independently
6 standard, the HUD handbook to this day still has a
7 requirement that the Housing Authorities perform
8 that investigation and give them permission to do
9 the mechanical inquiries and I think that HUD really
10 needs to quickly revise its handbook. I know at the
11 conference they said they would but I don't know how
12 quickly it will be. The Housing Authority
13 themselves were begging for direction on this from
14 HUD. I would say that most Housing Authorities
15 probably don't want to violate the law and be sued
16 but HUD really has not come down with that kind of
17 leadership to say here's how we are going to help
18 you screen people, here's the screening device that
19 should be used. The reactions that we have gotten
20 from the Public Housing Authorities are that you are
21 trying to deprive us of any means of screening,
22 which is not what we are saying. We really would
23 like you to have good and acceptable tenants for any

1 kind of housing so that housing could provide a
2 housing opportunity for our clients, but they don't
3 seem to understand the difference between screening
4 as applied to everybody versus screening of people
5 based on this illegal criteria.
6 At the conference HUD made it clear that
7 the regulations were to be followed by all the
8 Public Housing Authorities. What I found
9 interesting is that they were very willing to say,
10 state in kind of general statements like you have to
11 follow the law but when asked to comment on its own
12 handbook provisions, they were reluctant to say
13 don't follow the provision of page such and such,
14 which I didn't really understand because the
15 handbook provisions do conflict with the law.
16 Ironically the day that the decision came down in
17 Rochester, Secretary Kemp was in Rochester for the
18 day, one of the more gratuitous things that have
19 happened in my legal career, and at the airport he
20 was asked whether he would support our position and
21 was told -- he of course hadn't seen it, and he was
22 told this was a position upholding the Fair Housing
23 Amendments Act and he said "Of course I support this

1 position," and the Housing Authority shouldn't be
2 allowed to hide behind obscure housing manuals which
3 alienated the entire public housing community
4 because for them these public manuals are far too
5 obscure in their daily operating manual."
6 One or two other issues that I wanted to
7 touch on is that the kind of issues that have come
8 up in the public housing context I think arise
9 across the board in housing for people, individuals
10 with handicaps. As I said, every federally
11 subsidized project that I have been in contact with
12 also has an illegal screening device at this time.
13 One of our local projects, which is a
14 Section 8 project, is requiring every applicant to
15 submit a list of all their doctors. As we joke in
16 my office, does that mean you have to go tell him
17 who your gynecologist is when you apply just because
18 you are handicap, but that is the status of it now.
19 One of the reasons we brought suit against
20 the Housing Authority is we found it particularly
21 offensive that a property that was owned and managed
22 by an agency directly supervised by a HUD should not
23 be following its tenant regulations, and I think

1 that this is -- I think there needs to be a very
2 strong thrust of education for the community. I
3 don't think HUD private programs have a clue that
4 this law is out there or what they are supposed to
5 be doing. I think there are probably very well
6 intentioned landlords who just don't know. They
7 have not had experience with this and they don't
8 know that what they are doing is illegal and I think
9 if they knew, they would be open to changing their
10 policies. The management company that I trained,
11 which I guess they were managers from five projects,
12 they were very open to discussion on this issue.
13 They have had very many illegal practices but when
14 they found out, when I told them there there was
15 this law and I said that I was willing to meet with
16 them, they were willing to meet with us and I think
17 that would be the case with other companies as
18 well.
19 The one other thing I wanted to mention is
20 that to me I think the missing link in terms of the
21 housing discrimination end is the issue of
22 reasonable accommodations. That that is something
23 that hasn't yet been addressed. I mean we have

1 clients who can't get into housing because they are
2 just being denied because of some sort of disability
3 or mental health background or whatever and I don't
4 think landlords have begun to think through what is
5 a reasonable accommodation. In Massachusetts there
6 has been some cases where a judge has been willing
7 to throw out eviction cases. However, the landlord
8 has not reasonably accommodated somebody's mental
9 disability by allowing them an opportunity to get
10 some treatment before evicting them. And of course,
11 you know, while I am not going to address it today,
12 there is always the issue of reasonable
13 accommodation and physical I guess its adaptability
14 of physical space, but it's a reasonable
15 accommodation and it's policies and practices and I
16 don't think landlords know how to deal with that.
17 Then we have one landlord, again a HUD
18 subsidized project where the applicant was in a
19 wheelchair on the third floor of a walk-up building
20 without a working door buzzer. There was no way
21 that this woman could buzz anybody in. She
22 desperately needed accessible housing. They had a
23 policy of doing unannounced housekeeping inspections

1 and they rejected her application because they
2 wanted to do their own inspections and they couldn't
3 reach her all day and it took intervention from our
4 office to -- she had written them several letters.
5 It took intervention from our office to convince
6 them that perhaps in this case making a phone call
7 and arrangement with Social Service agency to be let
8 into the building was appropriate.
9 MS. CIPRICH: Let's go on then to Maggie
10 Lee, Housing Advocate. Would you introduce
11 yourself?
12 MS. LEE: My name is Maggie Lee and I'm
13 with the Western New York Indpendent Living Center,
14 and I thank you for allowing us to be here today.
15 We participate in an area which concerns
16 the disabled. We work on a daily basis with the
17 disabled. We are a not-for-profit advocacy
18 organization and our main purpose is to assist and
19 educate persons with disabilities to take control of
20 the events that influence their daily lives --
21 housing being one such event.
22 Every single day at the Independent Living
23 Center, there are numerous requests for housing

1 assistance. A hospital Social Worker calls
2 requesting an accessible, affordable apartment for
3 an individual with a spinal cord injury who is ready
4 to be discharged from a hospital. A mother of two,
5 who has a seizure disorder, and is living with
6 friends, as she cannot find a place to live. A
7 middle aged man suffering from a mental disorder
8 contacts the agency in hopes of an apartment when he
9 is released from his present living situation. The
10 lists go on and on as to the phone calls. Our
11 community provides limited housing options and
12 choices to those persons with handicapping
13 conditions.
14 As the Housing Advocate, I regularly
15 receive calls from individuals both physically and
16 mentally impaired. Our plight to obtain any housing
17 has been more than frustrating. Having access to
18 housing options reflecting the personal taste,
19 economic status and physical needs of all persons
20 with disabilities is very difficult. Unfortunately,
21 despite many advances in our society, many of the
22 negative attitudes and sterotypes still persist.
23 When one speaks of accessibility in housing, it

1 covers much more than just the accessibility of a
2 person in a wheelchair. It refers to everyone with
3 a disability. A person who is visually impaired may
4 not need architectural modifications, but may
5 require access to direct bus routes near employment
6 and shopping centers.
7 For persons who have mobility disabilities,
8 who use crutches or walkers, accessibility continues
9 to be a difficult problem since it requires
10 significant modifications to places that have steps,
11 narrow doorways and small bathrooms.
12 As the panel can readily understand,
13 fulfilling the needs and desires of those
14 individuals whom we all serve can be far from easy.
15 Accessibility is our key word. When I first took up
16 the position of Housing Advocate, I was amazed at
17 just how few accessible Emergency Shelters there are
18 in the City of Buffalo. There are only two
19 wheelchair accessible Emergency Shelters in our
20 area; one is for women and children and the other
21 one is for families and that is quite a ways out.
22 With the implementation of the Fair Housing
23 Amendments Act, the spinal cord injured patient will

1 be able to have a ramp at his residence to fully
2 meet his needs. The woman with seizure disorders,
3 dealing also with her children, will be able to
4 locate housing without having the fear of eviction
5 when she has a seizure, and the man with the mental
6 impairment will have the freedom to choose his own
7 apartment.
8 The Fair Housing Amendments Act is unknown
9 to the majority, if not all, of the individuals with
10 whom I work, and have worked. I feel that changing
11 the mind set of both the tenants and the landlords I
12 come in contact with is an extremely important
13 issue. Rarely have I been informed by anyone that
14 they have run into any discriminatory troubles. I
15 believe that many are intimidated, and they feel
16 that they have no right to advocate for themselves.
17 Hopefully, with further education, we can better aid
18 our clients, so that they will no longer need our
19 assistance. Thank you.
20 MS. CIPRICH: Okay. And Brian Black, would
21 you introduce yourself, please?
22 MR. BLACK: Thank you. My name is Brian
23 Black. I'm Associate Advocate and Code Enforcement

1 Specialist for Eastern Paralyzed Veteran's
2 Association.
3 I would like to speak specifically to the
4 implementation of the Fair Housing Amendments Act as
5 it relates to requirements for new construction.
6 Eastern Paralyzed Veteran's Association is
7 a chapter of Paralyzed Veteran's of America. They
8 are chartered by the U.S. Congress to serve the
9 spinal cord veteran but in the process do serve many
10 people with disabilities. I believe that we have
11 been one of the most significant supporters of fair
12 housing, we and our parent organization. Since its
13 inception, Paralyzed Veterans of America has
14 submitted to HUD detailed recommendations for
15 implementation of the Fair Housing Amendments Act.
16 Those now being referred to as Option 2 of the
17 designed guidelines that were published earlier in
18 Sierra. Eastern Paralyzed Veterans has been working
19 with code enforcement in the community on a private
20 level since 1989 to try to dovetail the requirements
21 for accessibility of fair housing into the existing
22 building code requirements, not only here in New
23 York State and New York City but throughout the

1 country. As a matter of fact next, or this Friday,
2 I will be meeting again with the New York State
3 Advocate for the disabled and are a member of the
4 Uniforms Code Council to try to hammer out some
5 language which will allow State and Municipal Code
6 Enforcement Authorities to enforce the Fair Housing
7 Amendments Requirements for new construction.
8 Very simply put, there are no state or
9 local enforcement mechanisms now in place to ensure
10 compliance with those new construction requirements
11 and this is true not only in New York State and New
12 York City but also in New Jersey and Pennsylvania,
13 which we cover, and virtually 95 percent of the
14 municipalities in this country who adopt modern
15 building codes such as the Uniform Building Code or
16 the Standard Building Code for the code to be used
17 within that jurisdiction. The problem that arises
18 in my experiences in New York State is that at this
19 time and on this date most, if not all, of the
20 construction that is currently being undertaken and
21 the design that is on the drawing board now will by
22 March 13th, 1991, be in violation of that, of the
23 requirements of the Fair Housing Amendments Act.

1 The problem is in a nutshell that the Fair
2 Housing Amendments Act is essentially a Civil Rights
3 act and unfortunately, we have yet to train our
4 architects, engineers and code enforcement
5 professionals to look to federal and civil rights
6 and anti-discrimination statutes before they look to
7 and start to design their buildings. They look to
8 the building codes. They look to the standards such
9 as the ANSI standard for handicapped design.
10 My experience, and I spoke as recently as
11 last Thursday to a chapter of the institute, of the
12 American Institute of Architects, that most of the
13 professionals in the design industry have never even
14 heard of the Fair Housing Amendments Act, much less
15 have a copy of the design guidelines. What would
16 then happen is that the industry will continue to
17 practice what Justice Brennan once called the
18 discrimination of benign neglect. They were not
19 intentionally discriminating against handicapped
20 people because they just don't know no better, then
21 what will happen is compliance and reinforcement
22 will be reenacted. They will design a building and
23 a code enforcement official will allow them to

1 design that building. The building will be
2 constructed and it will only be two or three years
3 down the road when a complainant comes along, says
4 there is not a ramp in front of that apartment
5 building and then the reactive complaintant process
6 takes effect. Unfortunately in those instances,
7 often times, especially in multi-family housing,
8 buildings are designed such that it is structurally
9 impossible to go back and retrofit a building to
10 meet the requirements of the Fair Housing Amendments
11 Act and those buildings will continue to
12 discriminate for their entire lifetime, 30 or 40 or
13 50 years for that. That's the problem.
14 Unfortunately, I think the answer is fairly elusive
15 at this point.
16 There is a question as to whether the
17 amendments, the design requirements for the
18 Amendments Act can be translated into building code
19 language and that is something that as I said, we
20 are attempting to do right now. Assuming that we
21 can do that, can we get the authorities having
22 jurisdiction, the states, the municipalities, to
23 adopt that language. I'm not sure if that

1 will occur or not, and if it does, there are
2 additional problems that ensue. For instance, some
3 of the requirements, for adaptable housing, both in
4 model building codes and the Fair Housing Amendments
5 Act, are in violation of other provisions in
6 building codes; things as essential as life saving
7 provisions of building codes, and we might have a
8 difficult time convincing code enforcement people to
9 adopt those changes carte blanche.
10 Finally, there is a question in my mind,
11 because the issue will become so complicated because
12 we will have New York State adaptability and HUD
13 adaptability and no adaptability, obviously the
14 issue of enforcement on a day-to-day level becomes
15 an issue. We may in fact need to simplify and
16 sometimes reduce the more restrictive requirements
17 within the state municipal authorities only to come
18 up with a package that is manageable by the local
19 code enforcement officials. My concern is that the
20 disability community might not take too kindly to
21 this.
22 Obviously a lot of discussion needs to
23 occur and at this point it would be premature to

1 make any guesses, at least until such time as HUD
2 comes up with its final guidelines, and hopefully
3 those will come out shortly, but at this point I try
4 to remind everyone, at least in my industry, that
5 the enforcement of those standards is not going to
6 occur as readily as we like.

7 MS. CIPRICH: I would like to open the
8 floor for questions?

9 MR. OI: Can I ask a simple question on the
10 enforcement side? It's a federal statute, the
11 building code, the building licenses have to be
12 issued. Does that mean that the state can violate
13 the federal statute or that the City of Amherst can
14 violate?

15 MR. BLACK: What the regulations indicate I
16 believe is that state or local authorities may adopt
17 language identical to or similar to the Fair Housing
18 Amendments Act. The problem is that the City of
19 Amherst people right now are charged under the local
20 and state law to enforce our building code and have
21 no authority to enforce the federal law.

22 MR. OI: There are laws now that --
23 apparently these are recent. A fellow told me he

1 wanted to put a sunning salon up in the second floor
2 of his building and was told that he would have to
3 install an elevator and so he decided not to open up
4 his sunning, tanning salon.
5 MR. BLACK: The problem is that we --
6 MR. OI: But now the question here is, that
7 that is clearly a municipal regulation that has been
8 passed within the last five years, right?
9 MR. BLACK: And to follow with that, what
10 we need to do is translate the federal regulation
11 into state or local legislation.
12 MR. OI: But that was not incorporated into
13 the federal statute that these have to be adopted
14 by?
15 MR. BLACK: No, it was not.
16 MR. OI: It was not?
17 MS. NISHI: Is there any part of the
18 program or enforcement of the Fair Housing
19 Amendments which would systematically work with the
20 buiders and enforcers of codes, of building
21 ordinances? It seems to me that in order to be able
22 to carry out such a federal statute since the
23 enforcement of building regulations, it's primarily

1 a local responsibility, that there should be some
2 systematic kind of linkage to the revisions of the
3 building codes.
4 MR. BLACK: I agree wholeheartedly.
5 MS. NISHI: Yes, that it needs to be --
6 that there needs definitely to be a more proacted
7 program to begin with. Otherwise, there will be
8 this incredible waste and frustration.
9 MR. BLACK: Precisely. Interestingly
10 enough, the code professional, the code enforcement
11 community in this country, the four model codes and
12 the Council of American Building Officials took one
13 of the leads in trying to accomplish exactly what
14 you are saying: That we wanted to give us language,
15 give us guidance. We're saying this to HUD, so that
16 we can adopt this into our codes and therefore give
17 it to our local people as a package and they can
18 take those proactive stands. My hearing of what the
19 HUD representatives said in response to that, and
20 this was in a meeting in Washington about a year and
21 a half ago, was that the Fair Housing Amendments Act
22 has no bearing on either the technical standards for
23 accessible design, nor the deliberations of the

1 Council of American Building Officials. That they
2 were two separate entities.
3 MS. NISHI: With what authority was that
4 stated?
5 MR. BLACK: That was apparently their
6 opinion.
7 MS. NISHI: Well, that was an opinion which
8 seems to me not to be pursued in terms of -- well,
9 it seems to me that the point you raised is
10 extremely important; that is, federal regulations
11 which do not work through the mechanisms of
12 enforcement are virtually, they're bound to failure
13 or certainly extreme frustration, that this would
14 certainly be something that I think ought to be more
15 officially addressed rather than just getting a
16 bureaucrat's opinion.
17 MR. BLACK: We continue in a dialogue
18 within the system, Secretary Mansfield from HUD who
19 used to work for us. So, we have got a good
20 relationship and are attempting to do that, but I
21 don't know where it goes from here.
22 MR. OI: May I ask a question of Ms.
23 Silverstein?

1 MS. SILVERSTEIN: Yes.

2 MR. OI: The case that you brought forward

3 was against the Rochester Housing Authority, which

4 is a public agency, but under the American

5 Disabilities Act, Title 3 extends the requirements

6 of equal access to places that are public in nature,

7 and does that list include housing?

8 MS. SILVERSTEIN: Well, my understanding

9 is --

10 MR. OI: It includes dentists' offices and

11 my tanning salon, doesn't it?

12 MS. SILVERSTEIN: My understanding is that

13 the ADA doesn't address housing because the Fair

14 Housing Amendments Act themselves extends to the

15 protection of the people with disabilities to

16 private landlords as well. Not only landlords,

17 which is my area of expertise, but all areas of

18 housing; rental, home purchase, mortgage financing

19 an so on. Previously to that the Rehabilitation Act

20 of 1973 had these protections just for federally

21 funded housing. Another reason why we targeted the

22 Housing Authority first since it came into law since

23 1973 that they couldn't do this. Of course I should

1 note that although the statute was passed in 1973,
2 the regulations took 15 years to come out by HUD.
3 The regulations weren't enacted until 1988. So, I
4 think that says a little bit about HUD's interest in
5 enforcing and monitoring these Fair Housing Laws.
6 And then I think the ADA sort of makes it a complete
7 package and extends the same types of protection
8 that are in the Fair Housing Amendments Act of
9 housing and to all public spheres in addition to
10 employment, public accommodations and so on.
11 MS. NISHI: I might note here that from the
12 testimony that our last speaker presented, there
13 seems not to be any resistance on the part of
14 building code developers and designers, which is a
15 rather refreshing kind of --
16 MR. OI: That there isn't what?
17 MS. NISHI: There seems not to be
18 resistance.
19 MR. OI: I think they are dragging their
20 feet quietly. They're dragging them very much is
21 the impression I get.
22 MR. NISHI: I'm sure, but at this point
23 they have presented no institutionalized resistance

1 and so, thus it would be extremely important to
2 develop the implementation of the requirements of
3 the law before there is this build-up of organized
4 resistance as has occurred in many other
5 institutionalized realms.
6 MR. CUNNINGHAM: May I ask a question?
7 MS. CIPRICH: Yes.
8 MR. CUNNINGHAM: Mr. Black, what is your
9 opinion of your organization of the proposed rules
10 that HUD has had under review? Where do you stand
11 on those?
12 MR. BLACK: Our official position is that
13 we support Option 1 with some modification. Option
14 1 being that proposed by HUD.
15 Again, our parent organization was the
16 primary author of Option 2 and we suggested to HUD
17 they adopt those parts of Option 2 which are there.
18 Am I making no sense? For instance, the doorways in
19 Option 1 cannot be used by many people. Virtually
20 all people in wheelchairs, if you have to pull the
21 doors towards you. Assistant Secretary Mansfield
22 who is in a wheelchair, he knows that, and yet this
23 option will not provide that, wheelchair access.

1 We are suggesting a compromise in that regard on our
2 position.
3 MR. CUNNINGHAM: So, Option 2 is a more
4 generous, more accommodating set of standards than
5 Option 1?
6 MR. BLACK: My professional opinion is, all
7 bias aside, is that it provides a greater degree of
8 access for people with disabilities at substantially
9 less cost than the other option.
10 MR. OI: Do these standards -- I have not
11 read them, but do they have any provisions for the
12 visually or hearing impaired or any other
13 disability, or is it primarily for the wheelchair?
14 MR. BLACK: Exclusively for mobility
15 impaired people. There are no provisions either for
16 the hard of hearing, deaf or visually impaired
17 people.
18 MS. SILVERSTEIN: If I may address that.
19 One of the areas that that might fit under is the
20 Reasonable Accommodation Standard, where if somebody
21 with a hearing impairment say needed a light door
22 bell instead of a sound door bell, and that cost
23 would be fairly minimal, that that could be required

1 of a landlord to install.
2 One of the other things that a lot of
3 direction I think was asked for from HUD was what is
4 reasonable accommodation because the regulations
5 say, talk about financial feasibility and I think a
6 lot of landlords wouldn't know how to balance what
7 they are required to do.
8 MR. OI: But the reasonable accommodations
9 at the tenant's expense, not at the builder's
10 expense then, low income rents?
11 MS. SILVERSTEIN: Well, there is two
12 separate provisions and I don't have the regulations
13 in front of me, which is a lawyer, you know, I'm
14 always a little nervous about stating what the law
15 is based on right now, but one section of the
16 regulations of the law deals with what I call
17 adaptability and that relates to the landlord giving
18 the option to make adaptations at their own expense
19 and then putting the property back into its prior
20 condition.
21 MR. OI: Right.
22 MS. SILVERSTEIN: In addition, landlords --
23 again, I speak mostly from the rental side because

1 that's what I'm familiar with. Landlords are
2 required to provide reasonable accommodations in
3 their programs and policies where I believe minor
4 physical adaptations where it doesn't incur
5 managerial financial burdens. So there are some
6 things that the tenant can do out of their own
7 pocket and then there are some things that the
8 landlord or housing provider would have to do which
9 really wouldn't change the nature of their
10 services.
11 MS. CIPRICH: Anymore questions?
12 (No response.)
13 MS. CIPRICH: Okay. Well, I would like to
14 thank everybody for coming and speaking to us
15 today. Thank you.
16 MR. OI: Thank you very much.
17
18 (Hearing concluded.)
19
20
21
22
23

UNITED STATES
COMMISSION ON
CIVIL RIGHTS

Eastern Regional Division
1121 Vermont Avenue, N.W. Rm. 710
Washington, D.C. 20425

New York State Advisory Committee
Dr. Walter Y. Oi, Chairman
October 29, 1990

T.J. Dulski Federal Bldg.
Conference Room 31
111 West Huron Street
Buffalo, New York 14202

PROVISIONAL AGENDA

Approx. Time	Items
9:00	Meeting Convened, Status of the Commission
9:15	FORUM:

Long-term Shelter and Nursing Care For the Minority Elderly

Hon. **Arthur O. Eve**, Deputy Speaker and Chair
Legislative Subcommittee on Minority Aging
New York State Assembly

Arthur G. Cryns, Ph.D, Senior Research Professor
Multi-Disciplinary Center on Aging
State University of New York/Buffalo

Daniel R. Acker, Branch President
NAACP/Buffalo Branch

Deborah Richter, M.D., Member
Physicians for National Health Programs (and)
Citizens Action

Lucy Velez, Senior Services Director
Hispanics United of Buffalo

[**Louise Kamikawa**, Executive Director
National Pacific/Asian Resource Center on Aging
STATEMENT BEING SUBMITTED FOR RECORD]

10:45 **Michael R. Carter**, Investigations Division Chief
Office for Civil Rights (Region II)
U.S. Department of Health and Human Services

Tai S. Kang, Ph.D; **Marie Baker**, D.S.W.; Members
Statewide Committee on Minority Participation
New York State Office for the Aging

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Washington, D.C. 20425

FOR MORE INFORMATION, CALL:

Dr. Walter Y. Oi, Chairman
New York State Advisory Committee
(716/275-4991, 275-5252)
Tino Calabia, Eastern Reg. Div.
New York State Advisory Committee
(202/523-5264, 244-4679)

FOR IMMEDIATE RELEASE

Federal Civil Rights Panel Holds Two Forums on: Long-term Shelter and Nursing Care for Minority Elderly; Implementing the 1988 Fair Housing Amendments Act

BUFFALO--Organized by Greater Buffalo residents, attorney Paula M. Ciprich and SUNY professor Richard H. Cox, two forums will be held by the New York State Advisory Committee to the U.S. Commission on Civil Rights during its October 29, 1990 meeting in Conference Room 31 of the Dulski Federal Building, 111 West Huron Street, Buffalo. Starting at 9:15 a.m., the morning forum will involve 9 panelists speaking on **Long-term Shelter and Nursing Care for the Minority Elderly**, and the 1:30 p.m. forum will hear from 11 panelists on **Implementing the 1988 Fair Housing Amendments Act.**

About 9:15, deputy speaker of the New York State Assembly **Arthur O. Eve**, who chairs the Legislative Subcommittee on Minority Aging, will open the day's activities, followed by: Dr. **Arthur G. Cryns**, an educator and research author at the Multi-Disciplinary Center on Aging of the State University of New York (SUNY)/Buffalo; **Daniel R. Acker**, NAACP Buffalo Branch president; **Lucy Velez**, Senior Services director of Hispanics United of Buffalo; executive director **Louise Kamikawa** of the National Pacific/Asian Resource Center on Aging; **Michael R. Carter**, Investigations Division chief of the Region II Office for Civil Rights of the U.S. Department of Health and Human Services; **Livingston S. Francis**, who chairs the Statewide Committee on Minority Participation of the New York State Office for the Aging; director **William B. Carmello** of the Bureau of Health

Facilities Coordination of the New York State Department of Health; and commissioner **Robert A. Mendez** of Erie County's Department of Senior-Aging Services.

At 1:30, the forum on housing discrimination will be opened by **Olga I. Diaz**, Region II Director of Fair Housing Enforcement in the U.S. Department of Housing and Urban Development, followed by: **Richard E. Clark**, regional director of the New York State Division of Human Rights; **Daniel Symoniak**, executive vice president, Greater Buffalo Association of Realtors; assistant director **Daniel Quider** of the Buffalo Municipal Housing Authority; attorney **Susan A. Silverstein**, Monroe County Legal Assistance Corp.; attorney **Michael Hanley**, Greater Upstate Law Project/Rochester; attorney **Dennis McGrath**, Neighborhood Legal Services/Buffalo; executive director **Scott W. Gehl** of Housing Opportunities Made Equal (HOME); Mr. **Acker** of the NAACP; housing director **Kurt Lauer** of Hispanics United of Buffalo; and housing advocate **Maggie Lee** of the Western New York Independent Living Center.

In addition to local members Ms. **Ciprich (716/857-7548)** and Professor **Cox (716/636-2251, 838-2025)**, the Committee includes chairman **Walter Y. Oi** of Rochester, Dr. **William Gangi**, Dr. **John A. Murley**, Dr. **Setsuko M. Nishi**, and **James I. Nixon.** The Committee has four vacancies.

The national Commission is chaired by Arthur A. Fletcher with Charles Pei Wang, vice chairman. The other commissioners include William B. Allen, Carl A. Anderson, Mary Frances Berry, Esther G. Buckley, Blandina C. Ramirez, and Russell G. Redenbaugh. Wilfredo J. Gonzalez is the staff director, and John I. Binkley is the director of the Eastern Regional Division.

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