CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HEALTH

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HELD AT: Committee Room, City Hall

B E F O R E: Lynn C. Schulman, Chairperson

COUNCIL MEMBERS:

Joann Ariola
Charles Barron
Crystal Hudson
Julie Menin
Mercedes Narcisse
Marjorie Velázquez

A P P E A R A N C E S (CONTINUED)

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SERGEANT AT ARMS: Hello everyone. Welcome to today's New York City Council hybrid hearing of the Committee on Health. Place all electronic devices to vibrate or silent mode. If you wish to submit testimony, you may send it to testimony@council.nyc.gov. Again that's testimony@council.nyc.gov. Chair, we're ready to begin. Thank you for your cooperation everyone.

[GAVEL]

Good morning. I am Councilmember Lynn Schulman, Chair of the Committee on Health. I want to thank all of you for joining us for today's oversight hearing. The purpose of today's hearing is to discuss and evaluate the city's efforts to improve and expand access to in-community health care, and to allow New Yorkers to make informed decisions about their health. There is longstanding deep inequity in access to health care in New York City. At the borough level, Manhattan has 1200 General Practitioners per 100,000 residents, while Queens is only 365 practitioners per 100,000 residents, and the Bronx has only 225. There is an insufficient number of primary care providers citywide with 52% of all primary care located in Manhattan and Brooklyn.

When people have to travel further for care, they are less likely to access that care because of having to miss work, obtain child care, or because a disability or chronic condition makes travel difficult. The lack of in-community care options, gaps in access to public transportation, and the lack of culturally and linguistically competent care at the community level excludes many New Yorkers from the healthcare system and denies them the ability to take control of their health.

More than 40% of adults in our state of chronic health conditions. rates of heart disease and hypertension in New York, are well above the national average. With the current crisis of healthcare staffing, and an aging population that is experiencing worsening health outcomes, we must do everything we can to educate our communities about managing their health, and we must take steps to reduce the burden on our strained healthcare system.

As Chair of this committee, I have continually emphasized the need for equity in healthcare, and that starts with equity in access to education, primary care, life-saving medicines, and medical

devices to help individuals monitor their health and manage chronic conditions.

Today, we are hearing a suite of bills designed to bring care closer to home. These bills seek to expand access to care, allow New Yorkers to make informed decisions about their health, and learn skills to help neighbors in need of emergency assistance. My bill, Intro 975, would require the Department of Health and Mental Hygiene to post information about free CPR courses available to the public in New York City, and to update this information regularly to ensure that New Yorkers know when and where these courses are offered.

According to the American Heart Association, CPR has been shown to increase the chance of survival in individuals who experience sudden cardiac arrest. The first few minutes after a person goes into cardiac arrest are the most critical. Bystanders who witness or encounter a person in cardiac arrest are the ones who can maintain blood flow to the vital organs, by performing chest compressions before trained medical professionals arrive, improving a person's chances of survival.

With my legislation, we will better connect people with free CPR courses in their communities, and empower them to take action and save lives. I've dedicated my personal and professional life to healthcare advocacy.

As someone who has had firsthand experience working in the healthcare field, I believe that education and easy access are critical tools in ensuring that New Yorkers have the information and resources they need to live healthy and happy lives.

We continue to be in desperate need of additional hospital capacity, and we must strive for more community-based primary care that is culturally and linguistically tailored to each community. Healthcare is a human right, and your status, financial circumstances, and zip code should not determine the quality of care you receive and how quickly you receive it.

I want to conclude by thanking the committee staff for their work on this hearing, committee counsel Sarah Sucher, and Chris Pepe, and Policy Analyst Mahnoor But, as well as my team chief of staff Jonathan Boucher, and Legislative Director Kevin McAleer.

I will now turn it over to Councilmember Narcisse for a statement on her legislation being considered today. Thank you.

COUNCILMEMBER NARCISSE: Good morning. As a nurse-- My name is Mercedes Narcisse, and I represent the 46th district, which covers the Canarsie area, Flatlands area, and those areas known to have-- I mean, to get the brunt of anything, and the pandemic hit us hard. It has been difficult.

So I'm here to address the inequities not only in the 46th district, but throughout New York City. As chair of the Hospitals Committee in New York City Council here, I'm looking forward to listen to see how the best way we can address the inequities.

My community, I have seen and worked in my community for many decades, tried to do the best I can on my own platform. But it's not enough. I believe New York City, like Chair Schulman said, is a right. Folks should have access to quality health care no matter what zip code you live in.

So as a nurse for three decades, I have worked in a hospital where the inequities was just in your face. You could not turn your back. Elmhurst Hospital. And I have a chance to do home care for

visiting nurse services, for Girling homecare, and I had worked in rehabilitation as well.

So what I'm here is to listen to you, and talk, and have a conversation, and have a plan and a strategy. All the bill that we're introducing today is a bill to address-- I mean, legislation to address the problem that we have in New York City. It should not be based on your zip code, like we said. All the bills from 0.25, 0096. Those are things that we should have done before. We should not be taking so long. We have to lead by example. New York City is a place that we say welcome for everyone. And we have to lead us such providing health care is a right. And I'm looking forward to listening to you, and to see how the best way we can address the inequities in our city. So thank you Chair Schulman.

CHAIRPERSON SCHULMAN: Thank you, Councilmember Narcisse. I also want to acknowledge that we've been joined by Councilmembers Crystal Hudson and Julie Menin. So I'm going to ask the Counsel to administer the oath.

COUNSEL: Good morning everyone. Please raise your right hand. Do you swear to tell the truth, the

whole truth, and nothing but the truth and to respond honestly to Councilmember questions?

ALL: I do.

COUNSEL: Okay. You may proceed with your testimony. Thank you.

ASSISTANT COMMISSIONER MARU: Good morning. And Amen to those words, Councilmembers Mercedes Narcisse, and Council Chairperson Lynne Schulman it's really an honor to be here today. My name is Dr. Duncan Maru. I am an internal medicine and pediatric doctor. I also practice and teach at H+H Elmhurst Hospital, and I serve as the Assistant Commissioner for the Bureau of Equitable Health Systems here at the New York City Health Department. I'm joined by my two wonderful and creative colleagues, Emily Ashton, who is the Assistant Commissioner for Family and Child Health Administration and Strategy, along with our Deputy Commissioner for Environmental Health, Corinne Schiff.

And this topic is very clearly quite personal for all of you, and all of us as we try to memorialize, and recover, and reimagine our communities and health of our communities at this moment.

The Health Department's mission is to protect and improve the health of all New Yorkers so that everyone can realize their full health potential, regardless of who they are, how old they are, where they are from, or where they live. Our work is broad ranging. You see us in the inspection grades at restaurants, the low-to-no-cost health clinics, neighborhoods, and birth certificates for your children. We are also behind the scenes investigating clusters of illnesses, studying the patterns, causes, and effects of health and disease conditions in New York city neighborhoods. We also work to address enduring gaps in health between white New Yorkers and communities of color, as you both just mentioned.

Structural racism is at the root of these health inequities, which is why we have made racial justice a foundation of all the work that we do.

A key pillar in our approach is providing targeted services in the most historically marginalized communities in our city, and which also experience the highest rates of illness and premature death.

We have established Neighborhood Health Action Centers in the Tremont neighborhood of the South Bronx, in East Harlem, and in Brownsville, Brooklyn. These Neighborhood Health Action Centers include co-located community-based organizations, and provide a one stop shop for critical services and supports that serve the needs of their neighborhoods. This includes primary mental health care, referral to networks of neighborhood resources, health and wellness classes, workshops, and activities.

In 2021, we also launched the Public Health Corps, which strengthens the city's public health infrastructure by partnering with community groups and community health workers. The initial work of the Public Health Corps is focused on outreach and education to eliminate COVID-19 inequities. However, the work goes beyond COVID-19, providing communities with education and connections to resources on other issues, such as chronic diseases. These are just a few ways in which the health department is focused on providing neighborhood-based programming that addresses the health of our communities.

I'll now turn to the bills under consideration today. Regarding Intro 975, the Health Department

supports the intent of Intro 975, which would provide information on free cardiopulmonary resuscitation courses to the public. When the cardiac arrest occurs outside of a hospital setting, the risk of mortality significantly increases. According to the American Heart Association, 9 in 10 people who experience out-of-hospital cardiac arrest have unfortunately fatal outcomes. Fortunately, as council member mentioned, administration of cardiopulmonary resuscitation can double or triple a person's chance of survival if performed within the first few minutes of cardiac arrest. Further, individuals from low-income, predominantly black and Hispanic neighborhoods are less likely to receive CPR from bystanders than people in higher income and majority white neighborhoods. Common barriers to bystander-administered CPR our fear of causing additional injury, or concerns about inadequate skills. We would like to highlight that the fire department, FDNY, offers free hands-on CPR classes to New Yorkers through their FDNY Free CPR Program, and FDNY Teens Take Heart CPR Program. And we certainly encourage New Yorkers to take advantage of this wonderful resource.

Regarding the pre considered Intro regarding hypertension, our health department very much supports the intent of providing people with hypertension the ability to monitor their blood pressure outside of clinical settings. Hypertension, or high blood pressure, is a major risk factor for cardiovascular disease and a leading cause of death in New York City. We are happy to share that we convened the city's first comprehensive population-wide initiative focusing on preventing and controlling High Blood Pressure called Take The Pressure Off New York City. The initiative is led by a coalition of faith and community-based organizations, employers, healthcare systems, pharmacies, organized labor, health insurance payers, government agencies and other stakeholders.

In regard to monitoring blood pressure, our focus has been on addressing the gaps and identifying the barriers to accessing at-home blood pressure monitors. Cost is an enormous barrier for use of these machines, and there has been work to address this, including distribution of home blood pressure monitors to providers and residents located in marginalized neighborhoods, including those

designated by the task force on racial inclusion and equity, TRIE neighborhoods. These promote self blood pressure monitoring.

Expanding blood pressure kiosks is another model. However, not everyone is willing or able to check their blood pressure in public. And one might not always get an accurate reading in that setting, because the person must rest quietly for five minutes before using the kiosk.

Confirming the diagnosis and monitoring blood pressure also requires frequent checks, which can make use of these kiosks a barrier. Because of this, the Health Department is working to better address barriers in obtaining at-home blood pressure monitors as the best available care. We are happy to continue discussions on this bill and the best ways to address blood pressure monitoring for the public.

Now, regarding Intro 96. The department recognizes the importance of ensuring vision testing for low-income New Yorkers. As part of last budget's negotiation, the department was asked to pilot a program that would create a mobile vision program to enable free eye exams and glasses for low-income New Yorkers. The demonstration project will be released

shortly and the $1.4 million contract will last for three years.

This pilot will be evaluated to determine if the project should be continued or expanded.

Health + Hospitals also provides eye care for children, adolescents, and adults through eye care clinics located throughout New York City. H+H services include at include conditions like cataracts, glaucoma, retinal disorders, in addition to eyeglass prescription, and these are often filled on site.

We are happy to discuss with the Council further the intent of this legislation, given that low cost eyecare is available through H+H, and while the pilot is presently underway.

Regarding Intro 325: Intro 325 aims to maintain a list of pediatric emergency rooms, including information about their locations and available medical services. The Health Department recognizes the intent of this bill. However, we believe that a primary care doctor remains the best resource for families to receive information regarding pediatric care facilities. A primary care doctor should guide parents and guardians on where to go in the case of a

true emergency, such as where the provider has a hospital affiliation to ensure continuity of care.

Additionally, it would be difficult to accurately provide the list of services pediatric emergency rooms provide since services can change with hospital designations, available consults, and a variety of other operational reasons, and we're certainly happy to discuss this further.

Finally, regarding Intro 814: To issue a report on the quantities and locations of automated external defibrillators, or AEDs, placed in public places. We would like to discuss with Council the goals of this legislation and options on how to meet these goals. We would like to include our Emergency Medical Services colleagues, EMS, since these devices are used in emergency situations. As written the bill would require resources to identify and monitor the location of AEDs in public places. There are also training considerations for AEDs to ensure that they are used properly.

I will now turn it over to Deputy Commissioner Schiff to discuss regulations around the use of x-ray equipment.

DEPUTY COMMISSIONER SCHIFF: Thank you. Good morning. I'm Corinne Schiff, Deputy Commissioner for Environmental Health. The Health Department is charged with permitting and inspecting radiation emitting equipment such as x-ray machines and CT scans in the healthcare setting. Exposure to radiation is a cancer risk, and the risk accumulates over a lifetime. It is important then for all of us individually and in public health to reduce radiation exposure. The New York City Health Code sets out requirements that do just that, with protections for patients, workers and others who may be in or near the facility. Of course, the x-ray is also useful for a healthcare provider making a diagnosis or using it therapeutically, and so our goal is to balance the potentially significant risk of radiation exposure with the importance of this tool.

The principle that guides this balance is to achieve an exposure that is as low as reasonably achievable or ALARA. In other words, at every step, the goal is ALARA: A radiation exposure that is as low as possible to meet the healthcare need. That is true no matter where you receive the x-ray, whether

in the hospital, a standalone radiological facility, an urgent care, or a provider's office.

The New York City Board of Health updated the health code in 2019 to align its requirements with updated industry standards and following robust engagement with stakeholders, including the greater New York Hospital Association, the New York State Radiological Society, the Greater New York Chapter of the Health Physics Society, and the Radiological and Medical Physics Society of New York.

The final rule incorporated the feedback from these stakeholders.

The updated health code rule includes, as relevant to this hearing limits on the use of mobile x-ray equipment. Mobile x-ray equipment creates specific risk of radiation exposure because, for example, it may be used in a room not meeting the construction mandates that control exposure, and because it tends to produce a lower quality image that can result in the provider having to take multiple images, when otherwise fewer would be needed. Fewer images means less radiation exposure.

As dictated by ALARA the protective approach is to use mobile equipment only when needed for patient

health. That is to use equipment that can be brought to the patient only when the patient cannot reasonably be brought to the equipment. Accordingly, the health code limits use of mobile x-ray units to hospitals for emergency rooms, trauma centers, and in house patients who are not ambulatory, as well as for house calls and in long term health care facilities. Other locations must use fixed x-ray equipment with all of the protections that accompany it.

This health code rule mirrors the recommendation of the Conference of Radiation Control Program Directors, the industry standard setting nongovernmental organization, and other jurisdictions including the US Food and Drug Administration, and the Environmental Protection Agency, and states around the country. Thank you for your time and consideration today. We are happy to take your questions.

CHAIRPERSON SCHULMAN: Thank you very much for this comprehensive testimony. Before we get to questions, I'm going to ask Councilmember Krishnan to make a statement about his-- his bill that he's introducing.

COUNCILMEMBER KRISHNAN: Good morning, everyone. Thank you so much, Chair Schulman, for today's hearing, for giving me an opportunity to speak on my legislation. It's so good to see you all today from the Health Department too, and Assistant Commissioner Maru, it is very nice to see you as a constituent, and someone who does great work both in our neighborhood and around the city and the country for health care access. So thank you for your testimony. Very nice to see you.

I wanted to say a few words on my legislation, Intro 814, regarding having more data available, and sharing more information about the existence of automatic external defibrillators, or AEDs, across New York City.

One thing we know for sure, in the medical context, and we've seen over and over again, when it comes to public health. The two most effective ways to address-- address health crises and medical problems in our healthcare system is, one, of course prevention, and two is education: Making sure that patients and individuals know the availability of healthcare, healthcare resources and services to them as a tremendous benefit in both. If not, if we're

increasing preventative responses, but for responding in the situation as it's occurring.

When it comes to cardiac arrest, we know that this is a condition that affects so many Americans across the country. And it's one where every minute, every second of an abnormal heartbeat rhythm or cardiac arrest matters in chances of survival.

We don't need to look any further than just this past January when Buffalo Bills Safety Damar Hamlin, gave us all an incredible shock and scare around the country when he went into cardiac arrest on the football field. Thankfully, he's making an incredible recovery, and we need to make sure that every single New Yorker knows the resources available to them to assist in those situations.

Just yesterday, Majority Leader Chuck Schumer in the United States Senate unveiled legislation called the Access to AED act, with Safety Damar Hamlin, addressing on the federal level the way in which to expand access to AEDs for-- for schools.

Our bill on the citywide level would require the city of New York, in collaboration with you all, to compile information on the existence of AEDs currently across New York City. Whether that data is

shared through a new system created by our Health Department or whether it's done through putting it on the city's open data portal as well, the point of the legislation is to make sure that every New Yorker knows where the life saving equipment is, God forbid there should be any situation where anyone needs it and goes into cardiac arrest. Again, a situation where every second in response time matters. And it also can give us an ability to, one, make sure that every New Yorker knows in language accessible-- once we know the-- the existence and location of all the AEDs throughout our city, then we can ensure that every New Yorker is, through an extensive public education campaign, both that is culturally and linguistically accessible, knows where the resources are, knows how to access them in a time of emergency. And we can also identify places that are AED deserts, where we need to have AEDs that don't currently exist, and come up with an action plan to make sure that everyone has access to AEDs.

But the one thing that we do know, and that we've seen over and over again is expanding access, expanding education efforts can go an incredibly long

way in both preventing situations, or addressing them in times of crisis.

According to the US Centers for Disease Control, and preventative Division for Heart Disease and Stroke Prevention, placing AEDs at public locations where cardiac arrest is likely to occur have been found to increase out-of-hospital cardiac arrest survival, improved neurological outcomes for patients and increased rates of return of spontaneous circulation or the resumption of sustained heart rhythms. We know these solutions work, and this legislation will help us tremendously in making sure that everyone has both the knowledge of where AEDs are currently located, and we can improve and expand upon access for every New Yorker. So no New Yorker has to suffer a cardiac arrest or abnormal heart rhythm without knowing whether there is resources on the other side available to them.

I would like to thank in particular, Jackson Heights resident-constituent, Sumana Harihariswara, who has brought this issue to our attention from her own personal experience, knowing that it could have also saved her father's life as well. It's something that both is personally very impactful to me, and is

a reason why we wanted to push forward this legislation as well.

So thank you all. Thank you Chair Schulman. I'm looking forward to continued conversation to make sure we get the legislation enacted and implemented.

CHAIRPERSON SCHULMAN: Thank you. Before I begin, I want to acknowledge we've been joined by Councilmembers Barron and Ariola, and earlier this morning, Councilmember Velázquez.

So I just want to ask some general questions about Urgent Care Centers and in-community care. The New York City Health Department clinics offer patients sexual health, immunization, and tuberculosis services regardless of immigration status by operating a number of sexual health clinics, immunization clinics, and TB chest centers across New York City. Can you elaborate on what services each clinic provides, and what are their limitations in terms of services?

ASSISTANT COMMISSIONER MARU: Thank you for that question, Chair Schulman. Our sexual health clinics provide STI services, HIV services, contraception services, medication, abortion, EMPOC services, and urgent care follow up for some patients. Our

immunization clinics offer all scheduled vaccines for Children ages four to eighteen, and vaccines for adults. We are happy to get you a full list of vaccines offered separately.

The TB chest centers offer TB testing, chest x-rays, medical evaluations for TB treatment, social service referrals, HIV counseling and testing and other services, and for a complete list of services we do provide those online.

CHAIRPERSON SCHULMAN: So what are the what are the limitations in terms of services? By the way, I also would like for you to mention the new rapid testing that you-- you're going to have for STIs if you want to elaborate on that?

ASSISTANT COMMISSIONER MARU: Yes. So in terms of our limitations, we are proud to offer an array of services that we provide our clinics. The, you know, we do have-- there is a very particular role of public health clinics that meet certain needs with respect to-- that complement and meet gaps that are not filled by the healthcare delivery system, including the extensive public services that we're very fortunate to have through H+H. And with respect to the-- your other question regarding rapid testing

for STIs. I actually don't-- I think we'll have to have to get back to you on that.

CHAIRPERSON SCHULMAN: Okay, that's-- that's fair. How many sexual health clinics are located throughout New York City?

ASSISTANT COMMISSIONER MARU: There's five of the sexual health-- eight sexual health clinics are currently operational. These are Chelsea, Fort Greene, Morrisania, Jamaica, and Corona. The closed clinics are Crown Heights, Central Harlem, and Riverside.

CHAIRPERSON SCHULMAN: Are there any plans to open more sexual health clinics?

ASSISTANT COMMISSIONER MARU: Not-- Not at this time.

CHAIRPERSON SCHULMAN: Okay. How-- How many immunization clinics are there?

ASSISTANT COMMISSIONER MARU: Currently, we have the Fort Greene Health Center, which offers immunization at no cost regardless of immigration status for all people, ages four years and older.

CHAIRPERSON SCHULMAN: And the number of TB chest centers.

ASSISTANT COMMISSIONER MARU: There are four chest centers at Morrisania, Fort Greene, Washington Heights, and Corona.

CHAIRPERSON SCHULMAN: Now going back to the sexual health clinics. There's been-- or it's been reported to us, there's a little bit-- or there seems to be a little bit of a rise in HIV and AIDS, STIs, especially post COVID. Because you have a limit-- you have a limited amount of Central Health Clinics, do you cross over and do work with H+H around that? Or how do we-- how do we expand services for people that need to be tested and get treatment?

ASSISTANT COMMISSIONER MARU: That's a wonderful question. You know, we certainly have many forms in which we tried to align our services with H+H, again, recognizing our role as a public health department vis-a-vis New York City Health+Hospitals as a healthcare delivery system. And we're certainly happy to have followup conversations about how to better align those and identify the gaps you're-- you're talking about.

CHAIRPERSON SCHULMAN: Besides DOHMH run clinics, what are the benefits associated with having

community health centers in multiple locations across New York City?

ASSISTANT COMMISSIONER MARU: Another wonderful question. The-- It's vital, especially at this moment in our city and nation's history to have a physical presence of public health in neighborhoods. And so it's vital both for providing services and for our staff to have eyes and ears on the ground, listening to community members, and being able to amplify their voices and help us do our job better.

CHAIRPERSON SCHULMAN: How do community health centers differ from urgent care centers, such as CityMD in terms of types of services offered? And I just want to express that what's upsetting to me is that in my community, we have a-- we have a number of urgent care centers like CityMD, which, when I go around, and I talk to people in the community, they tell me that that's what they use as their primary care, as opposed to having a community health center. So that's why I'm asking that question.

ASSISTANT COMMISSIONER MARU: Absolutely. And thank you for elevating this issue. The urgent care center ecosystem, if you will, is rapidly expanding

in New York City. And I certainly think it's a it's a very important healthcare delivery question.

They-- The idea of urgent care, is that they provide some immediate services outside of a-- an an emergency department, to-- that enables more timely care, and helps to decrease the burden on our emergency departments. And especially given the, as you already-- you have mentioned, the-- the real inequities and lack of primary care centers in New York City, urgent cares do fill a certain gap for providing a number of urgent services outside of that-- that our primary care system is not-- is not currently providing.

And-- And I think just to your point about cost and affordability, I certainly, again, I mean, this is largely a-- New York state regulates this, but it is a-- it's an enormous equity issue, both for safety net primary care providers who are trying to care for and provide medical homes, and-- and are in a sense getting-- are competing with these urgent care centers. And, and also for the fact that many urgent care centers do not accept certain forms of insurance.

CHAIRPERSON SCHULMAN: So how can access -- again, sort of wrapping this line of questioning -- How can access to in-community healthcare in any form be improved throughout New York City, especially in high-need areas such as health deserts? Hard questions.

ASSISTANT COMMISSIONER MARU: Yeah. I'd love to, you know, we'd love to talk with this much more extensively offline with you all.

CHAIRPERSON SCHULMAN: Okay.

ASSISTANT COMMISSIONER MARU: I mean, I think just the one line here is: How do we all work together to make a more robust primary care system where every New Yorker has a medical home where-- that you know, your providers, your providers know you, and you have-- you can access those services in a convenient way, in a person-centered way, and at minimal cost to you as a user of those services. And as you well know, we have a very far way to go.

CHAIRPERSON SCHULMAN: Yeah. So I have in my district, and I have one of the highest number of older adults in the city and older adult population is get increasing. So how do you reach out to them? What kind of services? Do you work with DFTA around

this issue? Because a lot of them don't have access, and these are the people that I'm talking to in my community that are going to city MD and-- and places like that. So they need to have, especially with chronic disease, especially there, there are issues in terms of when one's getting older and everything else so...

ASSISTANT COMMISSIONER MARU: Yeah. Another really important question. The-- We are-- We certainly have-- We have a number-- a group-- a health aging unit at our health department, and we are collaborating with DFTA on a number of initiatives, and we're taking part in the cabinet for-- New York City's Cabinet for Older Adults, and certainly our Mayor and Deputy Mayor are prioritizing how do we-- different agencies, work together on these-- these very intersectional issues related to health and well-being, and social safety. And we're very keen to continue-- to continue that dialogue with you all and with our partners at DFTA.

CHAIRPERSON SCHULMAN: Yeah. One of the things I would like to do during my time in the Council and as Health Chair, is to try and pull all this together so that our seniors and everybody else, and including

what my-- what Chair Narcisse had said about zip code, that we have to make sure that healthcare is accessible and affordable. So I'll be-- I'm hoping to work with you guys moving forward on that. I-- I will now turn it over to Councilmember Barron, to ask some questions.

COUNCILMEMBER BARRON: Thank you very much. Do you all go to Commissioner School on how to answer our questions. Because you always say, "Thank you for that question. What a wonderful question." All the commissioners say that. Do you really think all of our questions are wonderful? Or is it Commissioner School that you go to, when you address the Council? Make sure you thank them for that question. [LAUGHTER]

ASSISTANT COMMISSIONER MARU: Thank you for that question. [LAUGHTER]

COUNCILMEMBER BARRON: When I hear our commissioners say, "I agree with the intent of a bill." That's a red flag for me. These bills to me are no-brainers. Even if you're doing equitable services, we're not doing enough. So whether we're about defibrillators, or whether it's about vision care. I don't understand the just out-and-out

support of the bill -- not just the intent, because that really means nothing; it doesn't tell whether you are supporting the bill. You all usually say, "I support the intent of the bill, but we need to have more discussions." This-- These bills are so-- so no-brainers to me that at least say you support the bill. And we'll talk about ways that we can implement these bills with some concerns we have. But at least say you support the bill. And that's number one. Good question?

Number two, how impacting is the mayor's cuts? Did you did get cuts to your agency, I think 3% across the board? Correct?

ASSISTANT COMMISSIONER MARU: I would have to defer to our OMB colleagues on that one.

COUNCILMEMBER BARRON: You don't know whether your agency's budget was cut?

DEPUTY COMMISSIONER SCHIFF: This panel doesn't have the budget information.

COUNCILMEMBER BARRON: Excuse me?

DEPUTY COMMISSIONER SCHIFF: This panel here doesn't have the budget information. I know we were here last week at our budget hearing.

COUNCILMEMBER BARRON: You're assistant commissioners, right? So you don't know what your agency budget is, and whether it was cut by the mayor or not? Come on now. Stop it. You were. And my concern is that we have the rhetoric in place, but the reality is that the dollars are not committed there. Even when you say we have a center in Brownsville to deal with the racism, and one in the Bronx and-- You know, woefully inadequate, what's happening in our communities. That's lip service, and a pittance, you know, in terms of what you're putting in our communities.

Most of our primary care doctors is the emergency room for our communities. That's the primary care. The emergency room. These are deeply, deeply rooted racist problems that we have in our-- in our districts. And I just think that there has to be more meat, have to be more in-depth commitment to resources. We do have a urgent care. You know, Brookdale hospital is in my area. And I know that's not under you. But Brookdale, that's a voluntary hospital. It has an urgent care. We have a family care and all of that. And we have a Betty Shabazz Medical Center that my wife and I, Inez Barron, when

she was a councilmember, we had come in. But it still does not come near meeting the needs.

So I would like to see in my beloved East New York a greater commitment to primary care, a greater commitment to the resources that are needed to deal with the deeply rooted racism in the healthcare delivery system and New York and all throughout black communities in America.

[BRIEF SILENCE]

Now's the time to say something. Now you can say, "I really like that."

ASSISTANT COMMISSIONER MARU: Well, thank you for that. And-- And I think you know, we'd certainly agree with much of your assessment, and I think it resonates with our-- the Board of Health Resolution relating to structural racism as a public health crisis.

I think one of the challenges we have is-- is really the-- much of the regulatory authority with-- with respect to health care delivery lies at the New York State. And-- And so it really continues-- eager to continue this conversation about-- about what we together can do.

COUNCILMEMBER BARRON: Well that just means things that you can do within the confines of your authority, not reaching out to New York State. But there's some things that you can do in the confines of your authority, because I don't want you to throw us to the State and then State throws us back to you. And then we don't go anywhere.

So just in the context of your resources, your authority, your ideas, you know, we are woefully, inadequately addressing the needs of particularly black and brown low-income communities, and that needs to change radically.

CHAIRPERSON SCHULMAN: Thank you, Councilmember. I'm now going to turn it over to Councilmember Narcisse for her questions.

COUNCILMEMBER NARCISSE: Good morning, and thank you again, chair. I believe in preventive care, because preventive care can help us right? Hypertension affects an estimated 1.8 million adults in New York City, and is a leading risk factor for heart disease and stroke. We must provide New Yorkers -- wouldn't you say that we must provide New Yorkers? -- with every available resources that we

can give them to keep folks alive and maintaining their lives? Yes.

Blood-- For the blood pressure being a homecare using them, we call them sphygmomanometer, right? Based on your knowledge and expertise. What can you tell us about the use of blood pressure monitors in our homes or in public places? Are they useful, and/or sufficiently accurate? You, I mean, are familiar with the different type of personal blood pressure machines or sphygmomanometers.

ASSISTANT COMMISSIONER MARU: Thank you so much, Councilmember Narcisse. And again, it's wonderful to have a Councilmember who is a nurse and healthcare provider and advocate.

So first on the-- the use and utility of self-monitored blood pressure or home blood pressure monitors. Certainly, as you mentioned, evidence shows that measuring out of blood pressure-- out of office blood pressure, outside of a primary care clinic is a very useful way, an important way to identify certain important types of hypertension, including white coat hypertension and masked hypertension. And we believe that using expanding

home self-monitored blood pressure is-- is certainly a public health priority.

We continue to work to address gaps and identify barriers to accessing blood pressure monitors in areas with the highest prevalence of hypertension, such as your own constituents. Limited funds do constrain our ability to expand access to home blood pressure monitors. And-- and then your final question about the types of blood pressure monitors.

COUNCILMEMBER NARCISSE: Are they useful? That is what I want to hear.

ASSISTANT COMMISSIONER MARU: Oh. Yeah. They are-- We agree that they're useful and they're-- they're a definitely an evidence based component of comprehensive management of blood pressure by people who are living with-- with high blood pressure.

COUNCILMEMBER NARCISSE: But as a nurse, what we do, the doctors usually send a note for us to document the blood pressure throughout. Or sometimes, like if you're not seeing the client on a regular basis, they will have a home blood pressure kit. So when you're not there for them to take their own blood pressure because if the doctor has to make a decision in changing medication, they need to know

what is the blood pressure, the average per each day, but since the nurses not that every day, so they will have a monitor. So I find that they were useful. You find them useful.

ASSISTANT COMMISSIONER MARU: I completely agree.

COUNCILMEMBER NARCISSE: So which type of blood pressure machine that you recommend for them to use at home?

ASSISTANT COMMISSIONER MARU: I-- You know, we would defer that-- the question about which specific type of blood pressure monitor, we would defer that to discussions between, you know, individual care seekers and their care providers or nurse clinicians, their doctors.

COUNCILMEMBER NARCISSE: So you're not familiar with them? With a blood pressure machine, a sphygmomanometer.

ASSISTANT COMMISSIONER MARU: Well, as a clinician, certainly I am familiar with them. I'm just saying that I don't-- I don't think that we as a health department are not recommending any particular brand or make of a home blood pressure machine.

COUNCILMEMBER NARCISSE: Okay. What is the average cost of a blood pressure monitor? Would you know?

ASSISTANT COMMISSIONER MARU: I mean, they're highly variable in terms of the end cost to the user because it depends upon the, again, the brand and type, and then various electronic sort of bells and whistles, but anywhere between $10 and $500. I mean, in terms of the cost to the user.

COUNCILMEMBER NARCISSE: It's not that, $10 to $5-- But anyway, we can do more research on that, to see the average, because lately I've not been in the market buying them, but I know they pretty decent, reasonable price, that you can get a blood pressure machine.

How often must blood pressure monitors be replaced? Do you know?

ASSISTANT COMMISSIONER MARU: That depends on their use and the type of blood pressure monitor.

COUNCILMEMBER NARCISSE: Averaging? Can you take a shot of it? No? No.

Okay, can you elaborate on the tools available through DOHMH Hypertensive Action Kit?

ASSISTANT COMMISSIONER MARU: So thank you for that for that question. The-- our Health Department's Hypertension Action Kit provides resources for providers including guides on hypertension, management, coaching, self-measured blood pressure monitoring as we were talking about, and other references to support person-centered hypertension care. The kit also includes clinical tools for providers to educate and empower their patients, such as a planner, medication adherence assessment, blood pressure tracking card, and educational information regarding sodium intake. Finally, the kit includes patient education materials, including educational palm cards on salt, blood pressure, and posters on how to take one's blood pressure. All these resources are intended to support providers and help educate on blood pressure management, and they're available online.

COUNCILMEMBER NARCISSE: You see the tracking you mentioned, the cards, those are all the things that the people can use so, as well-- that people at home.

ASSISTANT COMMISSIONER MARU: That's correct.

COUNCILMEMBER NARCISSE: Folks at home. Is there any information in the kit that relate to self-measured blood pressure monitoring?

ASSISTANT COMMISSIONER MARU: That's correct.

COUNCILMEMBER NARCISSE: Okay, if so, what information is specifically provided to the public?

ASSISTANT COMMISSIONER MARU: Specifically, how one can take the blood pressure at home using a blood pressure monitor, and safely and accurately interpret that.

COUNCILMEMBER NARCISSE: Is there guidance on how to take your blood pressure?

ASSISTANT COMMISSIONER MARU: Yes.

COUNCILMEMBER NARCISSE: According to the DOHMH website, local data suggests that the rate of controlling blood pressure among patients diagnosed with hypertension is lowest among black adults at 59%, compared to whites 73%, Asian 73%, and Latino adults 69%. How is DOHMH working to address the rate of control blood pressure among patients, particularly black New Yorkers diagnosed with hypertension?

ASSISTANT COMMISSIONER MARU: Thank you again for elevating this vital public health and racial justice

issue. The two areas that we are in particular working on: One is as I mentioned through Take The Pressure Off New York, which is a multistakeholder coalition to address comprehensively hypertension, screening prevention, and treatment. And the second is that we work with our network of small primary care, and primary care clinic, and federally qualified health center partners in supporting their use of tools such as a hypertension action kit, and other tools to improve the quality of-- of hyper hypertension management that they provide.

COUNCILMEMBER NARCISSE: Thank you. Does DOHMH have access to the locations of all public blood pressure monitors in New York City right now?

ASSISTANT COMMISSIONER MARU: We do not.

COUNCILMEMBER NARCISSE: Hmm?

ASSISTANT COMMISSIONER MARU: We do not.

COUNCILMEMBER NARCISSE: Many patients suffering from hypertension have a difficult time finding a blood pressure machine monitor with a cuff that fits their arms. I always had that problem as a homecare nurse. I always have to have a different one, right? Do you know what cuff sizes available to the public and how they can access them?

ASSISTANT COMMISSIONER MARU: Well, I can definitely-- I definitely share your the challenge there, both when I care for kids and for adults on this issue. There's-- there's sort of four main categories: One, the pediatric cuff, the adult cough, the large adult cuff, and the thigh cuff. And then a number of special specialized ones that are used in different circumstances, particularly in a hospital setting. And again, the the proper sizing of those cuffs, we recommend to be in consultation with nurses and clinicians.

COUNCILMEMBER NARCISSE: Consultation with the nurses. We're the one that actually takes the blood pressure all the time, right? The doctors rarely do that. They only do it when the nurse is not around.

Studies have shown that older adults are more likely to get inaccurate measurements from their at-home blood pressure monitors. Is DOHMH working with the New York City aging population to ensure that they are properly educated on how to use the BPMs and how to read the measurements?

ASSISTANT COMMISSIONER MARU: At this time, we don't have specific programming around that.

COUNCILMEMBER NARCISSE: So. So now I hope that you can join me in what I'm asking for. Because when you don't know, you don't-- I mean, individually, it's so hard, because people have different size of arms. But if you know that person, you give them that cuff, that measurement for themselves, you can automatically know how to measure.

One of the thing for my experience-- one of my-- one of the experiences that I have, when you go to take the blood pressure and they are borrowing from somebody else, it cannot fit, you cannot get a proper reading. You know that, right? If the cuff is not fitting, right?, you get-- the reading is going to be inaccurate. So I'm hoping that you can join me, whatever, that we can have the discussion to make sure that we address it properly. But it will save lives. That what at the end of the day, all right? In helping keeping those folks that are at risk, because we know predisposition for all the disease, especially during COVID. When COVID hit most of the folks that end up dying are the one that suffer either heart problem, hypertension, diabetes. So therefore hypertension, if we can address hypertension, you have more people right now walking

around with hypertension that have no knowledge, no clue, every day, because it's a silent killer. That's what we call it. So I'm hoping that you can join me in addressing that. And that would be a start for us to keep New Yorkers healthy, healthy as well. Thank you, Chair.

CHAIRPERSON SCHULMAN: You're welcome. I'm going to ask-- First I want to acknowledge we've been joined by Councilmember Gale Brewer, and she has some questions to ask.

COUNCILMEMBER BREWER: Thank you. I'm sorry I was late. Um, the issue that I'm concerned about with Councilmember Brannon is pediatrics emergency room. And the reason this came up was: I have two friends, a colleague and a friend. They have three year olds, five year olds. In one case, EMS came very quickly, the child passed out with many, many ailments. Panicked parents. Ambulance comes. And where do you want to go? Which hospital? Which is-- I know I've been in an ambulance. They ask that question sometimes. And the parents didn't know. So they picked the hospital where the child had been born. They get to the hospital. And it's not a pediatric emergency. I know they're supposed to take

care of everyone. But the mother felt, in two cases, that it wasn't the appropriate place for a child, even in the ER. What the mothers would have liked would be a list of the pediatric emergencies where they could have gone, where they felt they would have gotten better support. Sometimes the hospitals are right near each other. This particular ER told them to go to the pediatric elsewhere.

So we need that list. It doesn't exist. So my interns are fabulous. And they made a list of what they think the pediatric emergency rooms are, but there's no such list. So I'm just wondering, is that something that-- would this kind of information, sharing it with 311, whether you think that would be a good idea. Like I said: Then it would be circulated to the schools, and mom emails, and so on and so forth. And I didn't know if you think it's a good idea.

And then I think we do need to understand the difference between a pediatric ER and emergency rooms. I must admit, my kids are older, I didn't know that there was a difference, I thought it would all be the same. That is not how parents feel. And

actually, that's not how doctors feel, interestingly enough. So I'd like to get your input.

ASSISTANT COMMISSIONER MARU: Thank you, thank you, again, for your passion for this issue. I'll share it, just as a, you know, fairly-- fairly recently, as a pediatrician at Elmhurst, again, I-- I had a situation that also highlights the need for-- the importance of pediatric emergency rooms and what their role is. You know, I, for many years, prior to coming to New York City, I was I was complex care pediatrician, which cares for kids with various developmental and other complex medical needs. And those kids, as we were talking about, regarding primary care, really need a very comprehensive medical team, clinical team, that interdisciplinary team that cares for all of their needs. And so we admitted a child who had these sorts of complex care needs. And we're talking with a father who happened to be Spanish speaking. And he, he said, you know-- you know, I have this issue of my G tube, the gastrostomy tube, because my child doesn't eat, so we have-- he has a G tube. And I have this issue. And whenever-- I can't bring him into the hospital, so I have to call EMS. And so then I call EMS and they

say, you know, because you live in the catchment area of Elmhurst Hospital, you have to go to Elmhurst Hospital, which we do have a pediatric emergency room, we do have a pediatric inpatient room, but his-- his care providers are actually a Cohen's, you know, out towards outer Queens, towards Long Island, which has-- they have all the-- all of his primary care providers. And so, you know, I actually, I said, "Look, you know--" His dad was just like, "I want to talk to my GI doc. I want you guys to be able to coordinate care. So we can you transfer me to Cohen's?" I said, "Absolutely," and we arranged for that. And I wrote him a letter that said: Doctor's orders, when EMS comes, hand this to EMS and say, take me to Cohen's.

So I-- You know, I think that this issue is-- has many different layers to it. And I, again, I applaud you for, for elevating it. I think-- And, you know, there really is a vital role of pediatric emergency rooms. And I'm not just saying that as a pediatrician. I really do-- As a parent as well, I do think it's vital.

In terms of-- of, you know, how do we get the word out about this? You know, one-- one is that,

you know, really what we recommend to parents is that you call 911, and EMS direct, as appropriate, because in an emergency, they have to take you to, to really the nearest emergency room, and they can transfer you as-- You know, and I think the other piece is, you know, that-- that there are there are, you know, New York State, which regulates clinical care, they do maintain a website of pediatric facilities. And so, you know, I think what we want to just ensure is that, whatever, you know, that this is timely, up to date, accurate information, that-- that's not conflicting with, with other sources.

COUNCILMEMBER BREWER: Well, I mean, these are very sophisticated parents. They know nothing about the state list. So I mean, I think the city should have the same list. And then you should-- there should be a law that says you publicize it, because it's one thing to have a list on the website, but if nobody knows about it-- This ambulance driver, and they're all great, said, "Where do you want to go?" I've had that too, with my kids. "Where do you want to go?" So, I mean, I don't know.

I think people should know that there are choices when you have a, you know, a baby, basically. And

it's, you know, to transfer is-- is heart wrenching also, because time is of the essence. These parents-- these parents were totally panicked.

So I just think you should-- we should have a much more robust information than what we have now, because nobody has told me. This is my negligence, but certainly these parents are, you know, Type A's, as we call them. And they didn't know a thing about the state list, that there is such a thing. You know, I have a list on the interns. Elmhurst is on it, obviously. But, you know, no addresses. Nobody-- Nobody knows what you know.

And so the question is: What can Department of Health-- Is that something that you think you would do in terms of publicizing, working with DOE, et cetera, and keeping it up to date on both state and city? Is that something that you would consider? That's my question.

ASSISTANT COMMISSIONER MARU: Yes, thank you for that. And I'm certainly happy to discuss further sort of the intent and how we how we get there.

COUNCILMEMBER BREWER: Thank you, Madam Chair. I'm very concerned about this issue.

CHAIRPERSON SCHULMAN: No, absolutely. I'm going to-- I have some more questions, but I'm going to turn it over to Councilmember Krishnan to ask his questions.

COUNCILMEMBER KRISHNAN: Thank you so much Chair. Just a few questions on Intro 814, on AED access. So as we know, the bill would require DOHMH to issue a report on the number and location of AEDs in public places. Does DOHMH currently have a framework or a list of the location of all AEDs in New York City?

ASSISTANT COMMISSIONER MARU: We do not.

COUNCILMEMBER KRISHNAN: You do not, right?

ASSISTANT COMMISSIONER MARU: That's correct.

COUNCILMEMBER KRISHNAN: Does DOHMH distribute free or low cost AEDs to public institutions and spaces like schools, houses of worship, nursing homes, not-for-profit organizations, or parks?

ASSISTANT COMMISSIONER MARU: We do not.

COUNCILMEMBER KRISNHAN: Is there an existing system that keeps track of the number of AEDs that have been issued and to whom?

ASSISTANT COMMISSIONER MARU: There is not.

COUNCILMEMBER KRISHNAN: Is there an exact number or estimate on how many AEDs are currently available in public places in New York City?

ASSISTANT COMMISSIONER MARU: There is not.

COUNCILMEMBER KRISHNAN: Is there a maintenance system in place to regularly check on the condition of AEDs?

ASSISTANT COMMISSIONER MARU: There is not.

COUNCILMEMBER KRISHNAN: Do we-- So I would assume that we don't know then how many AEDs are in good working condition and ready for use in the event of an emergency?

ASSISTANT COMMISSIONER MARU: We do not.

COUNCILMEMBER KRISHNAN: What maintenance is typically required for AEDs to make sure they're kept up to code and ready for use?

ASSISTANT COMMISSIONER MARU: That's a-- That's a great question. I-- We don't-- You know, we don't have our-- we don't have guidance on that, and we don't-- because we don't monitor or collect information on AEDs. I'm certainly happy to discuss more with you and with fire department and emergency medical services on that topic.

COUNCILMEMBER KRISHNAN: Sure. Thank you, Assistant Commissioner. Those are my questions. I just want to end by saying, given all of that, I think the urgency and the need for this legislation to be implemented is-- is very high. I do agree with Councilmember Barron, that these bills are all bills that we should be moving forward expeditiously. We don't want, God forbid, another emergency crisis in the city where resources could have been available, life-saving devices, but we as a city don't have any clue as to whether-- how many are maintained, whether they're in good working order, where they're maintained.

So I do appreciate your testimony. But it's my priority to make sure that this legislation both moves quickly, and as implemented quickly. So I know there are things that we want to talk about and discuss as well. But I don't want to slow down the process. Because as we know, this is-- these are life-saving devices. And we as a city have got to do a much, much better job of tracking them, making sure they're in good working order, and finding a place where we actually do need them or they don't currently exist.

And so given that we don't have any of those systems right now, it's clear that this legislation fills a glaring void in our healthcare access, for such a crucial life saving instrument. But I know that you all on, under Commissioner Vasan, and Assistant Commissioner Maru, I know you all are very committed to this and that the healthcare access is a top priority for you all, and finding any way to-- the data is especially important to you all too. So I look forward to us working together to make sure that we can implement this as quickly as possible.

ASSISTANT COMMISSIONER MARU: Thank you.

COUNCILMEMBER KRISHNAN: Thank you.

CHAIRPERSON SCHULMAN: Thank you, Councilmember. And I want to echo what Councilmember Krishnan said about the AEDs. I used to work in a past life at the emergency medical-- with the emergency medical service. So they do they do look at them, now that it's part of FDNY. They look at the AEDs. One is that, I will tell you that I know from experience that a lot of them are not checked regularly. So we're going to have to-- we're going to have to deal with that. And we also-- It is important to have a list of where they are and so that people can help to

maybe save-- save a life here and there. So I think that that's very important.

I will also say that having I worked at Woodhull Hospital, so at H+H, and to Councilmember Brewer's point about pediatric Eds. We had a pediatric ED there, and it does make a difference. The instruments are different. The care is different. Not that it's different-- that you get better care one way or the other, but it's-- it's a specialty area, so that if you have a child with some acute issue, it's not always picked up in the regular ED. So to that point, I want to echo what-- what that Councilmember said.

And then going lastly to the blood pressure cuff-- blood pressure issue. I-- I'm technically an older adult, and when I-- I will tell you that my when my blood pressure is checked by machine, it's 20 points higher always than when it's done manually. And so I think that people really need to be educated. And I'm pretty educated. And I've been working in healthcare for a very long time about how that works, whether we should be alarmed or not alarmed, because I can take it one place, and it's perfectly normal. And in another place, it's high.

So I don't know how that's calibrated on the machines. I don't know how that's-- how we get word out to folks, especially older adults. So I'm asking the question.

ASSISTANT COMMISSIONER MARU: Yeah, thank you for that. Can you just-- so you're-- Just, can you clarify your specific question?

CHAIRPERSON SCHULMAN: My question is: How do we educate people on-- when they get their blood pressure taken, or if they get a screening, whether that's an accurate reading or not? And how can they determine if it is? Like I said, the machines sometimes not calibrated right, depending on what you get, what you don't get. If you buy one, some of them are better than others, some of them have a very vast error rate. So that's the issue.

And then why is-- I'm just curious as to why there's a difference between taking the blood pressure manually and doing it with a machine because the tendency is, and I'm told the machines are calibrated higher

ASSISTANT COMMISSIONER MARU: Yeah, absolutely. Yeah. I mean, I think this, I very much acknowledge and appreciate your experience here with respect to

the discrepancies between different forms of manually and also different forms of automatic blood pressure cuff measurements. And I think it really does, it again highlights the importance of education, as you mentioned, and working with improving Primary Care access, because really having consistency blood pressure monitoring and-- and management is really, for many of us, is a lifelong endeavor, whether we have diagnosed hypertension or not. And so having consistency and regularity with a-- within the primary care system is vital. I'm certainly happy to discuss more how we can work on some of this specific issue of the accuracy and reliability of these different machines with both TPO-- Take The Pressure Off Program and the NYC REACH program.

CHAIRPERSON SCHULMAN: No. I-- and I also think it's important for doctors and nurses, everybody that takes blood pressure to sort of be educated about how to do it. Because if you-- when I'm reading stuff, I read that you supposed to be quiet and sit still and your arm is supposed to be elevated and all this other stuff. And that never happens in a doctor's office. Never ever, ever. So I think there needs to be an education. I know that the State does that

with, you know-- has responsibility for that with physicians, but I'd like for DOHMH to work with the state on really clarifying and educating the public, and that -- my colleague is smiling -- about what, what is involved here, and so that we can really have people be healthy and be-- be confident in that when they're getting a reading, that it's a certain way. That you know, because I will tell you that a lot of the medications that there are for blood pressure are not the greatest either. And there are side effects to it. So it's a question of, what is it that we have to do? And are we getting-- are we getting good readings from-- just in general? Like what, what the what the practice is, what the standard should be, and everything else? There's a lot of confusion out there.

ASSISTANT COMMISSIONER MARU: Absolutely. Thank you.

COUNCILMEMBER NARCISSE: I need to spend time with my colleagues on that one.

CHAIRPERSON SCHULMAN: Okay, thank you. I don't have any further questions. Does anybody else...? Thank you very much for coming to testify today. We really appreciate it and we'll follow up.

COUNSEL: Okay, that concludes testimony from the administration. We are now going to move to public testimony. So what we will do is we will start with public testimony from folks who are in the room, and then we will move to virtual testimony.

Just a reminder that if you are submitting written testimony, you have up to 72 hours after this hearing to do that. You can do that at testimony@council.nyc.gov is the email address. And-- and also just Yeah, so why don't we get started then?

We will start with the first panel. We're going to be hearing from John Flanagan and Dr. Neal Shipley.

And then, just a reminder to speak clearly into the microphone, and you'll press the red-- press the button, wait for the red light before you begin your testimony.

MR. FLANAGAN: All set.

COUNSEL: You may begin.

MR. FLANAGAN: Alright, good morning. Thank you very much. Very nice to be here. Quite educational to be able to listen to the preceding testimony, and it drew my attention to a lot of issues. But my name

is John Flanagan. I'm a-- I serve as Senior Vice President for Government Affairs at Northwell Health. And I'm going joined today by Dr. Neal Shipley. Dr. Shipley oversees our GoHealth Urgent Care facilities. And Dr. Shipley is our Medical Director and our Radiation Safety Officer for all of our GoHealth Urgent Care facilities.

And I just want to give a shout out to Councilmember Krishnan in particular on AEDs. In a former iteration of my life, I got a chance to work on very extensive legislation that came out of constituent work. A family, the Akanpour's, lost their son many years ago to a tragic lacrosse accident. And they were the genesis for changing the state law. And a lot has happened since then. So that's one thing I very keenly understand.

That said, we're delighted to be here. I want to thank all the members, the chair in particular, but all the members of the committee for affording us the opportunity to speak on the issues that are before the committee today for their consideration. And I'm wholly mindful that you're in the middle of the budget process. So the fact that we would be able to be here is equally helpful.

I'm going to speak very briefly and then hand it over to Dr. Shipley, just in terms of community care and urgent care in particular, and how we run our operations and the things that we focus on.

Our CEO Michael Dowling is heralded as a national healthcare leader. He was voted as the number one healthcare leader in the country. And having worked very closely with him, it's about mission, it's about access, about equity, and about excellence.

And I know that factually, because I talk to him all the time, work on issues with him in our hospital-based settings, in particular of course, but outside of that, if you would ask about Northwell as a system, there's a lot more that happens outside the hospitals than happens inside the hospitals, and about 55% of our-- our revenue comes from outside the hospital.

The point we want to talk about today relates to urgent care. For efficient operation, flexibility, how we serve people in their time of need, how we try and avoid people coming to the emergency department unnecessarily, and with it's all with an eye towards getting out into the communities and providing the best care possible. We're very confident that Dr.

Shipley can articulate it extremely well. He's got decades of experience and it's our frontline personnel on issues involving urgent care. Dr. Shipley. And thank you again.

DR. SHIPLEY: Good morning. My name is Dr. Neal Shipley. I'm been in New York City resident for about 35 years. I'm board certified in emergency medicine and I've been practicing in emergency medicine in urgent care since 1993.

In 2021, I had the honor and privilege of being sworn in as a New York City honorary police surgeon for our work with the police department in support of the COVID pandemic.

For the past seven years, I've been the medical director for a large health system, Northwell Health System affiliated Urgent Care Network. We have 20 sites located in New York City.

As we know, urgent care centers play a very important role in the New York City Health Care System by improving access and equity of care for thousands of New Yorkers. Eds in New York City are generally overcrowded, long wait times, access to PCPs can be challenging and the cost of an urgent care visit is something like four or five times less

than the cost of a visit in the emergency department for the same-- for the same condition.

Prior to the urgent care model, really the only place New Yorkers could access immediate unscheduled care was-- was the ED.

Another example of the role that urgent cares can, and hope-- we hope to play in avoiding unnecessary ED visits is the upcoming launch of our partnership with CMS and FDNY in a program called ET3. ET3 stands for Emergency Triage, Treat, and Transport. It is a federally sponsored demonstration project that will go live in 2023. And it will allow FDNY EMS crews to bring patients to alternative destinations. Lower acuity patients can be brought directly to the emergency department-- sorry, to the urgent care center instead of the emergency department for diagnosis, evaluation, and treatment. We are very closely aligned with CMS and FDNY on the importance and impact of this demonstration project for New Yorkers.

This specific regulation we're discussing today regarding the use of mobile x-rays in the urgent care center is very problematic for us as a business -- [BELL RINGS] Is it okay to continue? Thank you. --

-- and for our ability to serve this purpose for the New York City community. Our centers were designed to be small, to penetrate retail spaces and be close to public transportation hubs to give patients best access. The cost of the facility modifications alone to convert our sites to fixed x-ray rooms would be a big economic hardship for the business.

But more importantly, in having to do so, we would have to eliminate at least one probably two of the existing exam rooms in all of our centers. That would dramatically reduce our capacity and throughput and the ability to see patients and provide them with alternative destinations to the emergency department.

I'd like to spend the rest of the time here talking about our quality and safety program for the mobile x-rays.

We've been performing them in our centers since we first opened in 2014. Our priority has and always will be patient and staff safety. Since 2014, in our New York City based locations, we have performed over 72,000 mobile x-rays. We have a rigorous quality control program that is comparable to the ones in place in hospital EDs and inpatient unit that also

use mobile x-ray. I'm going to just highlight two of those programs.

Since 2014, no staff member radiology technician has ever received a radiation exposure that reaches or exceeds the maximum occupational dose for either quarterly or annual exposure limits. The folks before us from the Department of Health talked about the ALARA principle, As Low As Reasonably Acceptable. We have never exceeded that once since 2014. Zero.

The other thing that was spoken about is the-- what's called the R-R Analysis, or Repeat Reject Analysis. Repeat imaging due to improper technique is a leading contributor to unnecessary radiation exposure. The standard for this is less than 5%. We do R-R Analysis quarterly on all of our units and all of our sites. Our performance is well below that. We are consistently at or below 2.0% of images that have to be repeated or rejected due to quality. That is comparable to the R-R rate that is observed in Northwell inpatient and hospital based units.

So let me let me sum up here. We do appreciate the regulatory intent behind this article. Patient and staff safety is our highest priority. But we believe there's a way to preserve that intent by

granting waivers to urgent care centers to continue to perform mobile x-rays if they adhere to the similar quality and safety standards that you can find in the hospital setting. We have a very long track record of excellent patient and staff safety. We have a robust quality control program that meets or exceeds all recognized standards, and without our ability to do mobile x-ray, a significant portion of the 72,000 patients would have ended up in an overburdened emergency department or potentially deferred care, leading potentially to worse outcomes or higher costs of care.

So giving this ability will help us support this mission of increased access and equity to care for all New Yorkers. So thank you for the opportunity to speak to you on this important issue today. And we're obviously open to answer any questions.

CHAIRPERSON SCHULMAN: Before-- I have a couple of questions, but before I do that, I want to recognize my colleague, Councilmember Ariola, who wants to ask some questions.

COUNCILMEMBER ARIOLA: Hi, thanks so much for coming to testify today. So just-- I have one question. Do you have any recommendations for the

best way to expand care in communities outside of the hospital setting?

DR. SHIPLEY: The best way to expand care in any communities? Look, we are not in competition with primary care offices. We complement them, you know, we're open when they're not, on the weekends and evening hours. I think a comprehensive focus on, you know, access to primary care is-- is critical for communities. I think access to urgent care, to unscheduled walk in care should be part of that sort of overall picture. So I think it's a kind of a triad, you need to have a great public health system, public health departments, you need to have a robust emergency department, and you need something-- and you need Primary Care.

Urgent Care fits into that space between primary care in the emergency department: Lower cost, easy to access, you don't need to make an appointment. Most of our patients walk in on the same day, the visits lasts 45 minutes to an hour, they cost a fourth or a fifth of the emergency department.

So I don't think there's a one size fits all solution. I think it's a combination that has to be multifactorial.

COUNCILMEMBER ARIOLA: Thank you very much.

MR. FLANAGAN: I'll just add to what the doctor said. You know, we're asking for specific relief in the overall view of healthcare. And I think what we're looking for-- If you-- you can perform these services in somebody's home or in a long term health care facility, you can perform the services in urgent care facilities outside of the city of New York, you can perform them in hospitals all throughout our region.

We have zero issue with the notion of standards, Strong oversight, regulatory review, and we adhere to that, and as Dr. Shipley said, we have 100% compliance. We've never had an incident. Our specific ask in terms of the global stuff, as well, is to say, relief here would be very important to our patients. And I would reiterate, we-- we hold our employees to the same standards that we do our patients, meaning that it will we want to do every single thing possible to protect them. This relief, delivers better patient care. Thank you.

CHAIRPERSON SCHULMAN: Yeah, I just-- I just want to say, thank you. And, you know, we'll-- we'll take this in, and we have-- If you-- Doctor, I don't know

if you summarized your testimony, but you can submit the whole thing because it does get looked at by the committee, and everybody else, and the central staff. I do want to say that I have-- In my district, I have Northwell Forest Hills, and I work closely with them. And the CEO there is great. And so we're trying to do what we can. And I've used the urgent care as well, I just want to be on the record, Northwell Urgent Care. And so-- And gotten, and received good treatment there.

But I do want to say-- One of the things I do want to suggest is to talk to the Department of Health and Mental Hygiene, I'm sure that you've gone to them already. But I think that they would be willing to work with you and try to come to some kind of compromise.

But you know, so that's-- that's just a suggestion I want to make. But I do want to thank you for coming here and giving the testimony. [TO COUNCILMEMBER NARCISSE: You do?] Okay, I'm going to turn it over to my colleague, Councilmember Narcisse. She has a question.

COUNCILMEMBER NARCISSE: Um, I'm trying to understand. Do you have urgent-- how many you have?

Do you have urgent healthcare right now that you are--?

DR. SHIPLEY: There are 20 in the New York City boroughs. If you expand the entire size of the footprint which includes Westchester, Nassau, and Suffolk, we have 57 urgent care centers, but 20 are located in the New York City boroughs.

COUNCILMEMBER NARCISSE: Okay. How many clients do you see per year? Last year?

DR. SHIPLEY: In New York City boroughs, about 320,000. Across the entire network about 950,000. Again in 2021, slightly over 1 million patients. During the pandemic, we did about 500,000 COVID tests in the New York City boroughs. We diagnosed about 70,000 patients with COVID, treating them and keeping them out of the hospital emergency department flattening the curve. So I don't know if that is answering the question.

COUNCILMEMBER NARCISSE: No, that answers the question. Where are you most-- I mean, what my question is, just I want to see how you strategically placed them? Were they throughout Brooklyn, different zip codes, different places in Queens, how you plan to put them?

DR. SHIPLEY: We have we have a list which we can submit to show--

COUNCILMEMBER NARCISSE: How did you decide-- My question should be: How you decided where to place the urgent care.

DR. SHIPLEY: Yeah. So I'm the Medical Director. I'm responsible for clinical quality and safety. I don't make the real estate decisions. I know that we are in, you know, in the New York City boroughs and Westchester, and Staten Island, and-- and Manhattan and Queens, and Brooklyn. But again, I don't play a role in deciding the locations of the centers. My job is to stay focused on clinical quality and patient safety.

COUNCILMEMBER NARCISSE: Because I know a lot of people use urgent care. So thank you for your time.

MR. FLANAGAN: Councilmember, I'll take a stab at that if it helps. We are-- Our GoHealth operations, the urgent care centers, are a joint venture with Northwell. And I think it's viewed in the context of a couple of different things. Where's our footprint? Where are we growing? And unlike a lot of other healthcare systems, we are continuing to expand. So we have close to 900 facilities outside of the

traditional hospital setting. And that's ever-evolving, because of the evolution in healthcare generally, insurance reimbursement issues, and things like that. And some of it is a health-- a healthcare compliant, in terms of where are we providing services? Where do we see healthcare deserts, so to speak, and what are we trying to do about that? So it's a healthcare perspective, combined with a business review.

And we can absolutely send you a list of the facilities that we have. And you can let us know what you think.

COUNCILMEMBER NARCISSE: Thank you. Thank you chair.

DR. SHIPLEY: May I say one other thing? The previous folks who were sitting at this table had some comments about insurance, and I just want to be clear, we accept every insurance that the health system does including Medicaid, Medicare. So again, we believe our centers do improve access and equity to care. And again, reflecting on our strong track record of patient safety and quality, we think that this relief would help us continue to preserve that mission for New Yorkers.

COUNCILMEMBER NARCISSE: Thank you.

CHAIRPERSON SCHULMAN: Thank you. I have no other questions. Unless... what? Gale, do you?

COUNCILMEMBER BREWER: Dr. Shipley is my neighbor. I have no questions. Thank you.

CHAIRPERSON SCHULMAN: That's a good thing, doctor.

MR. FLANAGAN: What happens on the Upper West Side stays on the Upper West Side, yes Gale?

CHAIRPERSON SCHULMAN: All right. Thank you very much for-- for your testimony. We appreciate it. And you know, we can-- we'll certainly work with you to see what we can do to make sure that everybody has access to healthcare, and the healthcare they need. Thank you.

COUNSEL: Thank you very much for this panel. Next, we'll be hearing from Greg Mihailovich, please.

Just whenever we're ready.

MR. MIHAILOVICH: Okay. Hi. Thank you for the opportunity to be here. My name is Greg Mihailovich, I'm the Community Advocacy Director for the American Heart Association here in New York City. I'm very excited for the topics of today's hearing. AHA is the nation's oldest and largest voluntary

organization dedicated to fighting cardiovascular disease and stroke. And we talked a lot about CPR and AEDs, and we're very excited for the topic, because CPR saves lives, AED saves lives.

And I just wanted to comment, a couple of things. I won't go into the stats, because everyone covered that, and I want to use my two minutes, you know, efficiently.

Within Intro 975, with the CPR classes. Yay. We love it. Just a little clarity about training-versus-certification, because we get that kind of question, where training is practicing compressions and situational awareness, where certification is actually like rescue breaths. And also specifying where child and infant CPR classes are, because those-- those are different. And a lot of times they're included in parenting classes, but not always.

Intro 814, with the AED reporting. Again, there's some clarity-- clarity there. I'm happy to see that Councilmember Krishnan was talking about, like, upkeep and how often they're doing it. But to your point, Chair Schulman, for children, you know, over the age of eight, you can use a standard AED,

but one to eight, you have to use pediatric pads, or AEDs that might have a kid switch that reduces the-- the voltage, and children you know, under one have to use, you know, a manual defibrillator. So clarity on on what's available there.

And then for the BP kiosks: Were a big fan of Take The Pressure Off NYC. We're on the steering committee. So we're very excited to see this kind of renewed focus. But the kiosks, I think, are kind of a old school way of doing things. I mean, we talked about how self monitoring blood pressure at home is a validated approach to managing your blood pressure. And the kiosks that were placed.

It's funny you ask where they were. I actually printed the city's maps, where they were placed. And I'm happy to share it with the Council. I just didn't want to share it before there. The placement was a little uneven. So there were four on Staten Island, none on the North Shore, which is, you know, lower income black and brown communities. I think there was only one in your district Councilmember Ariola. I think there was only one-- there was only one north of 181st street. So kiosks may not be the best way.

So we would definitely support ways that we can get BP cuffs into the communities, with community partners, local health clinics for distribution so people can monitor their blood pressure safely at home. And I can leave this if people actually want to see the maps. It's just city-- they put it directly-- Oh, and most of these places have closed by the way, the Rite Aids and everything is closed.

CHAIRPERSON SCHULMAN: We'll take it, and we'll make sure that we document it.

MR. MIHAILOVICH: Yeah. So thank you for your attention all this. Any way we can be a useful partner, we're happy to assist in any way we can. Thank you for the time here today.

COUNCILMEMBER NARCISSE: So you encourage the blood pressure-- to have the machine at home.

MR. MIHAILOVICH: Yeah. Yeah, I mean-- the kiosk-- we--

COUNCILMEMBER NARCISSE: The kiosk is the only one--

MR. MIHAILOVICH: Yeah. We think-- I mean, in the DOH-- to the document the DOH was talking about, like the white coat syndrome where people are tense, and the idea that-- I mean, you know, you're a nurse.

I feel like I shouldn't be saying this to you. The idea that when more relaxed, they can do this.

I mean for personally, we're also seeing this, like greater reliance on remote care because of the pandemic. People are having their Zoom meetings with a doctor. Just like we always said that people should have thermometers at home, or the O2 monitors, the idea that having your blood pressure cuff at home really helps you manage your numbers a little better.

So they-- you know, they talk about like it's covered by insurance. Not everyone has insurance. Not everyone's insurance covers it. So the idea of figuring out a way that we can get the cuffs into the hands of people who need it, who maybe aren't going to take a bus and travel for an hour to the nearest pharmacy that has a kiosk, we think is, is meeting people where they are and it really helps people have that kind of health equity issue, and we will happy to talk with you more about this.

COUNCILMEMBER NARCISSE: Okay. Thanks.

CHAIRPERSON SCHULMAN: Thank you, Councilmember. Councilmember Ariola, do you have any questions? Okay. Thank you.

COUNSEL: Thank you very much to this panel. We're not going to call up Richard Flores please.

You can proceed when you're ready.

Hi, are you ready?

MR. FLORES: Yeah. I read on the website that they were covering, providing vision testing and eyeglasses to low income individuals, for residents whose annual gross income is within 250% of the federal poverty level. Is that correct?

COUNSEL: That's correct.

MR. FLORES: I wanted to testify simply, on behalf of a personal reason that I think that the healthcare system is-- is failing.

Regarding the urgent care centers, I have to be honest with you, I've never ever gone to the urgent care centers. I've always thought that the better route, despite the budget reasons that you discussed, was simply to go to the hospital to get care, and not have a nurse or someone else see me and then refer me to a hospital. I currently have Empire Blue Cross Blue Shield as my insurance and I have Medicare and Medicaid. So have Part A, Part B, Part C, and Part D.

I went to the Eye and Ear Infirmary last Monday, simply to get a test for my vision. I'd like to be really blunt here, and hopefully you can use this data for what it will be used for later.

Councilmember Barron may have a few remarks about discrimination and racism in the system and how that's impacting upon the system. The ophthalmologist I saw was-- was this gentleman, Dr. Aaron C. Brown, at the Eye and Ear Infirmary, and he conducted the examination. What I'd like to say for the record here was that he did a very, very poor job of examining my eyes in the room. He didn't tell the truth about any preexisting conditions that I have.

CHAIRPERSON SCHULMAN: Sir, if you want to make a statement just about in general about the health care, but if you're talking about a specific doctor, individual, we can entertain that here.

MR. FLORES: Right. Well, I thought it would work in conjunction with making the testimony. What I-- What I've seen what my personal experience has been is that there seems to be an endemic corruption in the healthcare system and I'm sure I'm not the only person that's experiencing it. That's even with

the COVID-19 health crisis and other pre-existing conditions that people have.

And I think that what that's doing is that's making the system work harder and spend more money and more individuals are sick and more people are ill, as everyone knows, as a result of the fact that the system seems to be not working correctly.

The budget proposals that you people make and the policy decisions that you make, understandably, I don't know it's full complexity. You know, a lot more than I do. But I thought simply using my experience, you can use that for your data and all the other individuals that are impacted. And I just wanted to use that example of that.

I find it just really kind of strange to be honest with you, as a, as a civilian as a-- as a citizen of the city, that the Committee understands and has knowledge that this kind of thing is occurring. And my question to you -- I'll stop here -- is, what are you prepared to do about it? If you if you can do something?

CHAIRPERSON SCHULMAN: This is-- this is a-- this is a hearing for you to just give your thoughts on not to-- we have a process here in the City Council.

You should contact your local councilmember, whoever that is, to talk to them specifically about going through that with them.

And we appreciate you bringing us the testimony just about the particular place that you were at, and so we'll take that in. We just can't be talking about individual doctors, or individuals-- individuals, in general, is not appropriate for this forum.

But we'll take in what you said and we encourage you-- I encourage you to talk to your local councilmember who can go through the process with you. Okay, thank you.

MR. FLORES: Thank you.

COUNSEL: Thank you to this panel. At this time, if there is anyone left in the room who would like to testify, but has not done so yet. Please fill out an appearance card and give it to the Sergeant at Arms.

And seeing none. We are now going to move to virtual testimony. We have I believe one registered panelist. So we're going to hear from Dr. Joseph Talano, please.

SERGEANT AT ARMS: You may begin.

MR. TALANO: Can you hear me? Yes. Great, thank you. And also I want to thank you for promoting me to doctor. I am not a doctor but I appreciate that nonetheless. Lofty goals for one day maybe.

But thank you to Chair Schulman and to the Committee for the opportunity to provide testimony today. My name is Joe Tolano. I'm a Senior Policy Manager with the Primary Care Development Corporation, or PCDC. We're a nonprofit organization, US Treasury certified, CDFI, founded located here in New York City.

Our mission is to create healthier and more equitable communities by building, expanding, and strengthening access to quality primary care.

Since our founding in 1993, PCDC has leveraged more than $1.4 billion to finance over 218 primary care projects, helping to provide 4.6 million medical visits annually, and creating or preserving more than 19,000 jobs in low income communities.

Regular access to primary care is internationally recognized as a key social determinant of health, and is associated with positive health outcomes, especially when addressing common chronic conditions

like heart disease, the leading cause of death in New York.

Primary Care reduces overall health healthcare costs and is the only part of the healthcare system that has been proven to lengthen lives and reduce health disparities. PCDC urges the council to center primary care in its efforts to increase access to in-community health care. PCDC also encourages the council to ensure that each health proposal within the budget prioritizes and includes primary care providers, patients, and the workforce.

More details are included in my written testimony, but we also urge the council to increase investment overall in primary care and to advocate for related state policies, including restoring the city's Article Six reimbursement rate to 36%.

As we continue to navigate the COVID 19 pandemic, the city must think critically about the role of primary care in its resiliency efforts planning for future public health crises and accelerating efforts to address health disparities that had been exposed.

Relating specifically to primary care access in the city, PCDC's own research has indicated the critical role of FQHCs in improving and protecting

Community Health. In 2021 PCDC conducted research on the role of FQHCs on COVID outcomes and--

SERGEANT AT ARMS: Your time has expired.

CHAIRPERSON SCHULMAN: : No. Keep going. Go ahead.

MR. TOLANO: Great. Thank you so much. I appreciate that, Chair.

In 2021 PCDC conducted research on the role of FQHCs on COVID outcomes and concluded that FQHCs helped reduce community level COVID-19 mortality. We encourage the Council to conduct a study of existing FQFC locations to identify whether some areas would benefit from additional facilities.

Much is already known about primary care provider's role in the pandemic response. More than a decade ago during the H1N1 crisis, PCDC worked with _____, DOHMH, and City Emergency Management to develop the Primary Care Emergency Preparedness Network in New York City, and various studies suggest that a similar network would have supported a better pandemic response this time around as well.

Despite this primary care sector was largely left out of the early COVID-19 planning, service delivery, and mitigation efforts. Eventually FQHCs were

included in federal vaccine distribution plan, and PCDC was grateful to play a role by providing pass-through federal funding to FQHC support vaccine outcome, outreach, and distribution.

With the much-appreciated support from this Council, PCDC also undertook research regarding access to primary care and the impact of COVID-19, and determined that communities with less access to primary care before the pandemic experienced more COVID-related illness and deaths than communities with better access.

My written testimony includes more details and links to the City Council Primary Care Access dashboard, and we're happy to provide additional information.

We encourage the Council to support a thorough review of primary care providers experience throughout this pandemic.

We are also urge policymakers to ensure that spending of primary care and preventive services meets the demands of their communities so that people can lead healthier lives.

We welcome the opportunity to work with Health Committee and the Council to expand access to primary

care for all New Yorkers, particularly in those in disinvested underserved communities.

We thank you for your consideration of our recommendations and are happy to answer any questions.

CHAIRPERSON SCHULMAN: Thank you. I don't I don't have any questions. But we appreciate the testimony.

MR. TOLANO: Thank you. And I appreciate the extra time.

COUNSEL: All right, thank you very much. At this time, if there's anyone else who would like to testify virtually, but has not had their name called please indicate that you would like to testify using the Zoom raise hand function.

Seeing no hands, turning it back to the chair for closing remarks.

CHAIRPERSON SCHULMAN: So I want to-- I want to thank everyone today. You know, as I said earlier, healthcare is a human right, but we have to get some of the basics down so we're going to be making sure that DOHMH and other agencies within the city come together so that we can have a cohesive health system that takes care of people regardless of their status,

regardless of their finances, and regardless of their zip code. And with that I am adjourning today's hearing of the Health Committee. Thank you.

[GAVEL]

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date 04/10/2023