NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Ashwin Vasan, MD, PhD
Commissioner

Testimony

of

Duncan Maru, M.D, PhD
Assistant Commissioner for the Bureau of Equitable Health Systems
and
Corinne Schiff, Deputy Commissioner for Environmental Health

New York City Department of Health and Mental Hygiene

Before the

New York City Council

Committee on Health

on

Improving Access to In-Community and At-Home Health Care

March 30th, 2023
New York, NY

Good morning, Chair Schulman and members of the Committee. I am Dr. Duncan Maru, Assistant Commissioner for Equitable Health Systems. I am joined today by my colleagues Corinne Schiff, Deputy Commissioner for Environmental Health and Emily Ashton Assistant Commissioner for Family and Child Health Administration & Strategy.

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 in your neighborhood and the birth certificates for your children. We are also behind the scenes investigating suspicious clusters of illness, studying the patterns, causes and effects of health and disease conditions in New York City neighborhoods and working to address enduring gaps in health between white New Yorkers and communities of color. 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 which also experiences the highest rates of illness and premature death. We have the established Neighborhood Health offices 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 organization and provide a one stop shop for critical services and supports that serve the needs of their neighborhoods. This includes primary and mental health care, referrals to a network of neighborhood resources, health and wellness classes, workshops, and activities. In 2021, we also launched the Public Health Corp, 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, like chronic diseases. This is just a couple of ways that the Health Department is focused on providing place-based programming to address the health of our communities.

I'd like to now turn to the bills under consideration today.

Intro 975

The Health Department supports the intent of Intro 975 which would provide information on free cardiopulmonary resuscitation courses to the public. When cardiac arrest occurs outside of a hospital setting, the risk of mortality significantly increases. According to the American Heart Association (AHA), 9 in 10 people who experience Out of Hospital Cardiac Arrest (OHCA) have fatal outcomes. Fortunately, administration of cardiopulmonary resuscitation (CPR) 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, Black, and Hispanic neighborhoods are less likely to receive CPR from bystanders than people in high-income, white neighborhoods. Common barriers to

bystander-administered CPR are fear of causing additional injury or concerns about inadequate skills. We would like to highlight that the FDNY offers free hands-only CPR classes to New Yorkers through their FDNY Free CPR Program and FDNY Teens Take Heart CPR Program. We encourage New Yorkers to take advantage of this resource.

Pre-considered Intro

The Health Department supports the intent of providing people with hypertension the ability to monitor their blood pressure outside of clinic 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 convene the city's first comprehensive, population-wide initiative focusing on preventing and controlling high blood pressure called Take the Pressure Off, NYC. The initiative is led by a coalition of faith and community-based organization, employers, health care 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 a major 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 Taskforce on Racial Inclusion and Equity neighborhoods to promote self-blood pressure monitoring. Expanding blood pressure kiosks is another model. However, not everyone is willing 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 also make use of these kiosks a barrier. Because of this the Health Department is working to better addressing barriers in obtaining at home blood pressure monitors as the best patient care. We are happy to continue discussions on this bill and the best way to address blood pressure monitoring for the public.

Intro 96

Regarding Intro 96, the Department recognizes the importance of ensuring visions testing for low-incoming New Yorkers. As part of last year's budget negotiation, the Department was asked to pilot a program that would create a mobile vision program that would provide 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 3 years. This pilot will be evaluated to determine if the project should be continued or expanded. Health + Hospitals also provides eye care for children, adolescent and adults through eye-care clinics located throughout New York City. H+H services include address conditions like cataracts, glaucoma, retinal disorders as well as eye glass prescriptions – which are often filled on-site – and contact lens prescriptions. We are happy to discuss with Council further the intent of this legislation given that low-cost eye care is available through H+H and while the pilot is underway.

Intro 325

Regarding Intro 325 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 provider 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. We are happy to discuss further.

Intro 814

Finally, regarding Intro 814, to issue a report on the quantities and locations of automated external defibrillators 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 EMS colleagues 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.

Thank you. Good morning. I am Corinne Schiff, Deputy Commissioner for Environment Health. The Health Department is charged with permitting and inspecting radiation-emitting equipment, such as x-ray machines and CT scans, in the health care 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 health care provider making a diagnosis or using 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 health care need. That is true no matter where you receive the x-ray, whether in a hospital, a stand-alone 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 mean 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 the protections that accompany it.

This Health Code rule mirrors the recommendation of the Conference of Radiation Control Program Directors—the industry standard-setting non-governmental organization—and other jurisdictions, including the U.S. Food and Drug Administration and Environmental Protection Agency, and states around the country.

Thank you for your time and consideration today. We are happy to take your questions.

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Testimony of the American Heart Association

Before the New York City Council Committee on Health

March 30, 2023

Greg Mihailovich, Community Advocacy Director
American Heart Association, New York City

Thank you, Chair Schulman, and the members of the New York City Council Committee on Health. On behalf of the volunteers of the American Heart Association, we are grateful for the opportunity to present testimony related to key educational initiatives that our organization believes will motivate healthy behaviors in young New Yorkers.

As the nation's oldest and largest voluntary organization dedicated to fighting heart disease and stroke, of which approximately 80% of diagnoses are preventable[i], the American Heart Association prioritizes many policies that promote better cardiovascular health and health equity. Unfortunately, heart diseases and stroke continue to be our city's leading causes of death and disability. With your continued help, however, we hope to change these statistics.

I. Int 0975-2023 - Information on free cardiopulmonary resuscitation courses available to the public.

Cardiac arrest – an electrical malfunction in the heart that causes an irregular heartbeat (arrhythmia) and disrupts the flow of blood to the brain, lungs, and other organs – is a leading cause of death. Each year, more than 350,000 EMS-assessed out-of-hospital cardiac arrests (OHCAs) occur in the United States, with 70% happing in homes. When a person has a cardiac arrest, survival depends on immediately receiving CPR from someone nearby. About 90 percent of people who suffer out-of-hospital cardiac arrests die. CPR, especially if performed immediately, can double, or triple a person's chance of survival. Unfortunately, bystanders only perform CPR 40% of the time.[ii]

Any initiative that increases the number CPR-trained people in the community will save lives, but there is often confusion in the community about the differences between CPR training and CPR certification. CPR training allows someone to practice compressions, learn situational awareness, and often – but not always – includes instruction on use of an automated external defibrillator (AED). CPR certification allows someone to practice using an AED and performing rescue breaths, in addition to chest compressions. The student is tested by an instructor and issued a certificate upon completion. Additionally, there are specialized classes on performing CPR on young children and infants. Including information about the differences between training and certification and any specializations will help people receive the instruction they are looking for.

II. Int 0814-2022 - Requiring an annual report indicating the quantities and locations of automated external defibrillators placed in public places.

More than 15% of assessed out-of-hospital cardiac arrests occur in a public location. However, the number of patients who have an automatic external defibrillator (AED) applied by a bystander remains low, occurring after only 10.2% of public arrests. Public access AEDs and community training have a large role to play in early defibrillation. Only 50% of people can locate an AED at work, and most do not know what public locations are required to have an AED. Different laws mandate AED placement in public places. Federal law requires AEDs in government buildings and airports. New York State law requires AEDs in public schools, health clubs, swimming facilities, and dental offices. New York City law requires AEDs in nursing homes, senior centers, and selected city-operated parks. Compiling a comprehensive list of what locations are required by law to have an AED would greatly help in educating the public on where to go if they encounter a cardiac emergency. A clear bullet point that all health clubs should have an AED on site will likely be more easily retained than a list of every YMCA location in the five boroughs.

However, a regularly updated public directory that includes the specific individual locations would help ensure compliance with the various AED laws, and could include when the AED was last checked or serviced and the exact location within the site – reception desk, security office, break room, etc.

It is also important to note that there are different AED recommendations for children. Children over age 8 can be treated with a standard AED. For children ages 1–8, however, it is recommended that pediatric attenuated pads are used, and not all AEDs come with these additional child-appropriate pads. Some models have special child settings that are activated by a switch or inserting a special key. In infants less than 1 year of age, a manual defibrillator or an AED with a dose attenuator is preferred. If an AED is placed at a location that is frequented by children – elementary schools, day care centers, parks with playgrounds, etc. – it would be useful to know if that AED is optimal for use on a child.

III. T2023-3165 - Requiring the placement of automated, self-administered blood pressure testing machines at certain public places.

High blood pressure, or hypertension, is a key risk factor for heart disease and stroke and often there are no obvious symptoms to indicate something is wrong. As of 2019, 2.5 million adults, or 31% of New Yorkers,[iii] report having high blood pressure.[iv] Only 47% of those diagnosed with high blood pressure are under control.[v] The NYC Department of Health and Mental Hygiene (DOHMH) has undertaken a significant effort to promote awareness, clinical guidelines and treatment adherence called *Take the Pressure Off, NYC*! The program's goal was to reduce the number of New Yorkers with raised blood pressure by 150,000 by 2022 and NYC placed 300 blood pressure kiosks around the city for public use. Neighborhoods with higher rates of hypertension were prioritized, but there were still many parts of the city that did not have easy access to one of the kiosks (see attached maps). The kiosks were supposed to be maintained by the business that received them, but it was common to see kiosks that needed to be cleaned or were out of order. Additionally, many of the locations have since closed and it is unclear what happened to those kiosks. The intent was admirable, but that initiative did not have the intended impact in helping people with hypertension.

The pandemic and our increased reliance on remote medical care underscores the importance of access to self-monitoring devices. Just like having a thermometer will help someone tell if they have a fever or are just feeling flushed, access to blood pressure cuffs helps someone determine whether need to seek in-person care if they are feeling unwell. This is especially important if that person struggles with accessing telehealth services.

Self-measured blood pressure (BP) monitoring, the measurement of BP by an individual outside of the office at home, is a validated approach for out-of-office BP measurement. Several national and international hypertension guidelines endorse self-measured BP monitoring, which has high potential for improving the diagnosis and management of hypertension in the United States. However, to adequately address barriers to the implementation of self-measured BP monitoring, financial investment is needed.[vi]

Take the Pressure Off, NYC! has started reengaging partners and it is encouraging that the NYC Council is looking to support self-monitoring of blood pressure. However, to have a larger impact on hypertension rates in NYC, we should pivot to self-measuring of blood pressure at home by investing in blood pressure cuffs to provide to community partners (FQHCs, Health Systems, other clinics, CBOs) for distribution to those who do not have access to them and cannot physically travel to a public kiosk.

Thank you for everything you have done and will do to protect the lives of the people of New York City. The American Heart Association is a reliable and trusted source of information based in credible science, and we will continue to be your partner in ensuring the health and well-being of all New Yorkers.

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[i] "Preventable Deaths from Heart Disease & Stroke." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 3 Sept. 2013, www.cdc.gov/vitalsigns/HeartDisease-Stroke/index.html.

[ii] Heart Disease and Stroke Statistics—2023 Update: A Report From the American Heart Association
Connie W. Tsao, MD, MPH, FAHA, Chair, Aaron W. Aday, MD, MSc, FAHA, Zaid I. Almarzooq, MBBCh, MPH, Cheryl A.M. Anderson, PhD, MPH, FAHA, Pankaj Arora, MD, FAHA, Christy L. Avery, PhD, MPH, FAHA, Carissa M. Baker-Smith, MD, MPH, FAHA, Andrea Z. Beaton, MD, MS, FAHA, Amelia K. Boehme, PhD, MSPH, Alfred E. Buxton, MD, Yvonne Commodore-Mensah, PhD, MHS, RN, FAHA, Mitchell S.V. Elkind, MD, MS, FAHA, Kelly R. Evenson, PhD, MS, FAHA, Chete Eze-Nliam, MD, MPH, Setri Fugar, MD, Giuliano Generoso, MD, PhD, Debra G. Heard, PhD, Swapnil Hiremath, MD, MPH, FAHA, Jennifer E. Ho, MD, FAHA, Rizwan Kalani, MD, Dhruv S. Kazi, MD, MSc, MS, FAHA, Darae Ko, MD, MSc, Deborah A. Levine, MD, MPH, Junxiu Liu, PhD, Jun Ma, MD, PhD, FAHA, Jared W. Magnani, MD, MS, FAHA, Erin D. Michos, MD, MHS, FAHA, Michael E. Mussolino, PhD, FAHA, Sankar D. Navaneethan, MD, MS, MPH, Nisha I. Parikh, MD, MPH, Remy Poudel, MS, MPH, CPH, Mary Rezk-Hanna, PhD, FAHA, Gregory A. Roth, MD, MPH, FAHA, Nilay S. Shah, MD, MPH, Marie-Pierre St-Onge, PhD, FAHA, Evan L. Thacker, PhD, Salim S. Virani, MD, PhD, FAHA, Jenifer H. Voeks, PhD, FAHA, Nae-Yuh Wang, PhD, MS, FAHA, Nathan D. Wong, PhD, MPH, FAHA, Sally S. Wong, PhD, RD, CDN, FAHA, Kristine Yaffe, MD, Seth S. Martin, MD, MHS, FAHA, Vice Chair, on behalf of the American Heart Association Council on Epidemiology and Prevention Statistics Committee and Stroke Statistics Subcommittee

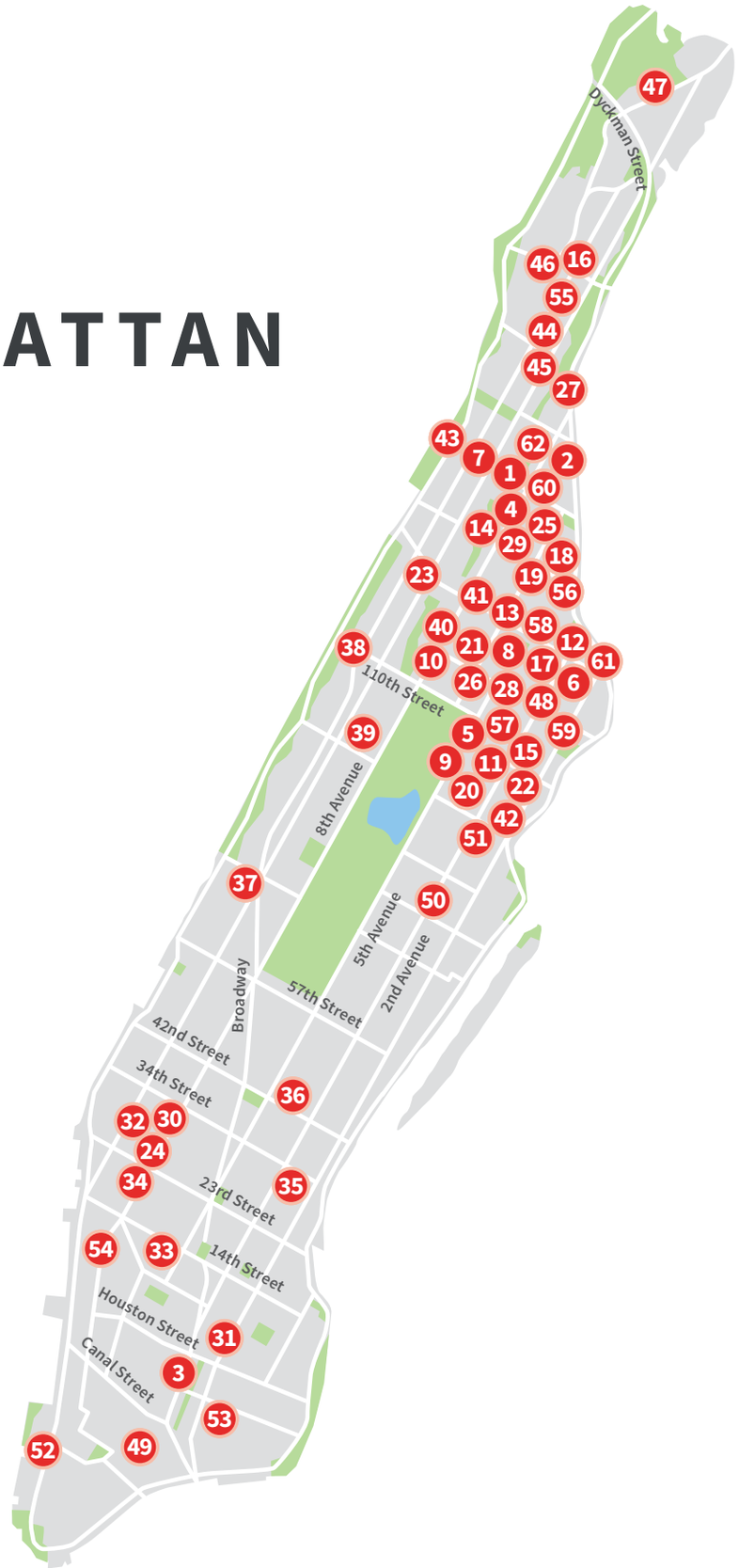
[iii] City of New York. (2017, February 2). 2020 population. Retrieved October 2020,
from https://data.cityofnewyork.us/City Government/2020 population/t8c6 3i7b

[iv] New York City Department of Health and Mental Hygiene. (2017, November). Epi Data Brief, No.
95. Retrieved October 2020, from https://www1.nyc.gov/assets/doh/downloads/pdf/epi/databrief95.pdf

[v] Angell, S. Y., Garg, R. K., Gwynn, R. C., Bash, L., Thorpe, L. E., & Frieden, T. R. (2008, September). Prevalence,
Awareness, Treatment, and Predictors of Control of Hypertension in New York City. Circulation:
Cardiovascular Quality and Outcomes, 1 (1), 46 53.

[vi] Shimbo D, Artinian NT, Basile JN, Krakoff LR, Margolis KL, Rakotz MK, Wozniak G; on behalf of the American Heart Association and the American Medical Association. Self-measured blood pressure monitoring at home: a joint policy statement from the American Heart Association and American Medical Association. Circulation. 2020;141: e•••–e••• doi: 10.1161/CIR.0000000000000803.

MANHATTAN



Check for Free Today!

It's important to check your blood pressure regularly. Ask your health care provider how often you should check it.

Check your blood pressure for free at a pharmacy on this map. Visit **nyc.gov/health/map** or call **311** to find other participating pharmacies.

This map is available in other languages.

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Blood Pressure Kiosk Map

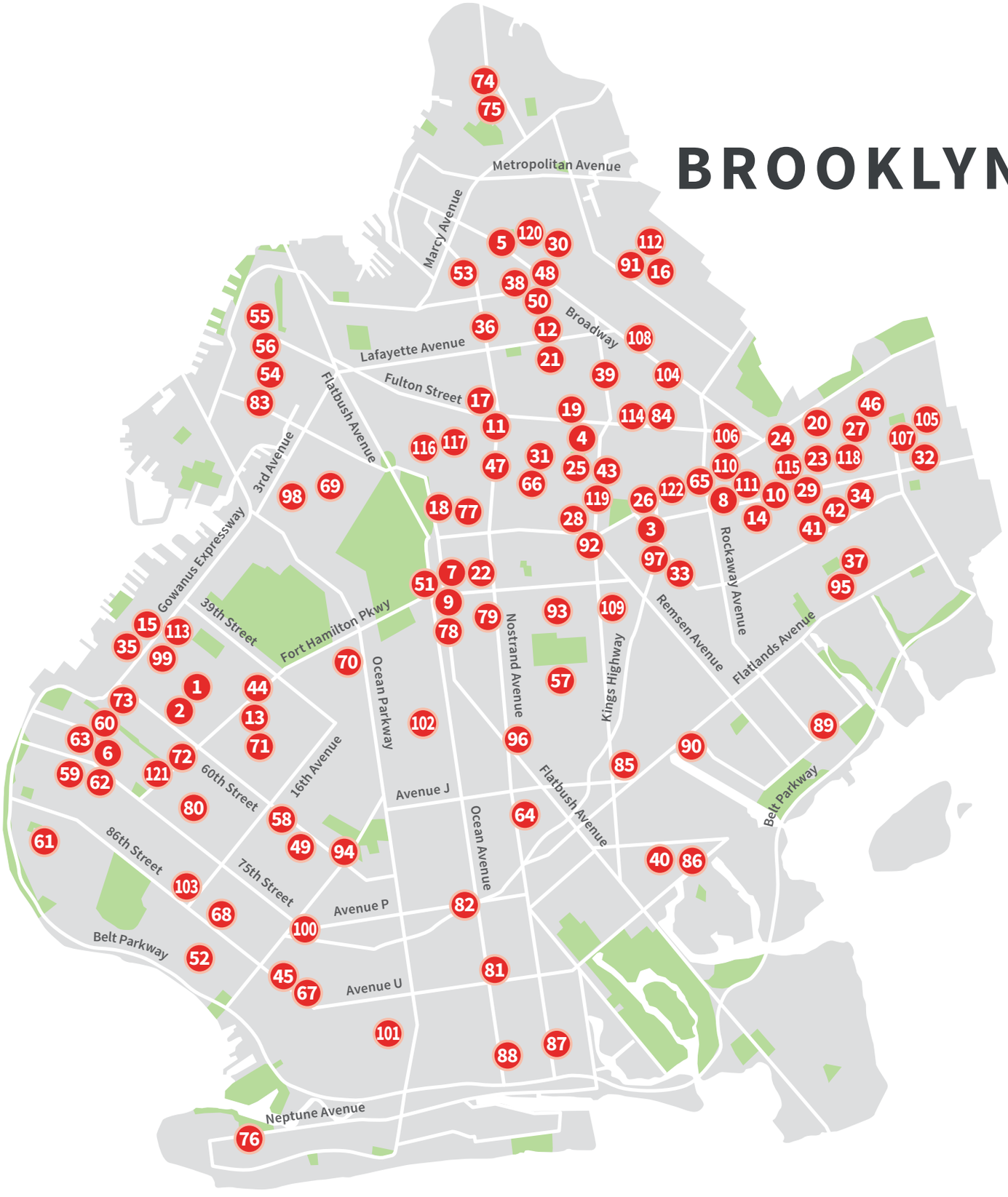
MANHATTAN

NYC Health

Blood Pressure Kiosk Map

MANHATTAN

1. **145th Street Pharmacy**
   300 W. 145th St.
   New York, NY 10039
2. **8th Avenue Pharmacy**
   2830 Frederick Douglass Blvd.
   New York, NY 10039
3. **A.M. Pharmacy II**
   219 Grand St.
   New York, NY 10013
4. **Ajanta Pharmacy**
   2718 Frederick Douglass Blvd.
   New York, NY 10030
5. **Bliss Pharmacy**
   1590 Madison Ave.
   New York, NY 10029
6. **Buena Vista Pharmacy**
   2022 Third Ave.
   New York, NY 10029
7. **Center Pharmacy**
   1290 Amsterdam Ave.
   New York, NY 10027
8. **Comfort Care Pharmacy**
   1990 Lexington Ave.
   New York, NY 10035
9. **Drug Loft Pharmacy**
   1412 Madison Ave.
   New York, NY 10029
10. **Drug Shoppe**
    2074 Frederick Douglass Blvd.
    New York, NY 10026
11. **Ecogreen Pharmacy**
    1600 Madison Ave.
    New York, NY 10029
12. **Gotham Pharmacy**
    2258 Third Ave.
    New York, NY 10035
13. **Harlem Pharmacy**
    17 W. 125th St.
    New York, NY 10027
14. **Heritage Pharmacy & Surgical Supplies**
    2258 Adam Clayton Powell Jr. Blvd.
    New York, NY 10027
15. **Isla Drug Stores**
    1994 Third Ave.
    New York, NY 10029
16. **La Fe Pharmacy**
    4220 Broadway
    New York, NY 10033
17. **LDC Pharmacy Corporation**
    1901 Madison Ave.
    New York, NY 10035
18. **Lenox Terrace Pharmacy**
    20 W. 135th St.
    New York, NY 10037
19. **Life Pharmacy**
    471 Malcolm X Blvd.
    New York, NY 10037
20. **Madison Avenue Pharmacy**
    1407 Madison Ave.
    New York, NY 10029
21. **Malcolm Pharmacy**
    160 Malcolm X Blvd.
    New York, NY 10026
22. **Maxwell Pharmacy**
    234 E. 106th St.
    New York, NY 10029
23. **Mishkin's Drug Store**
    1714 Amsterdam Ave.
    New York, NY 10031
24. **New London Pharmacy**
    246 Eighth Ave.
    New York, NY 10011
25. **Palace Pharmacy**
    543 Malcolm X Blvd.
    New York, NY 10037
26. **Preferred Pharmacy**
    3 E. 115th St.
    New York, NY 10029
27. **Rangel Pharmacy**
    159-12 Harlem River Dr.
    New York, NY 10039
28. **Raysol Pharmacy**
    1870 Lexington Ave.
    New York, NY 10029
29. **Reliance Pharmacy**
    480 Malcolm X Blvd.
    New York, NY 10037
30. **Rite Aid Pharmacy**
    282 Eighth Ave.
    New York, NY 10001
31. **Rite Aid Pharmacy**
    81 First Ave.
    New York, NY 10003
32. **Rite Aid Pharmacy**
    188 Ninth Ave.
    New York, NY 10011
33. **Rite Aid Pharmacy**
    501 Sixth Ave.
    New York, NY 10011
34. **Rite Aid Pharmacy**
    195 Eighth Ave.
    New York, NY 10011
35. **Rite Aid Pharmacy**
    550 Second Ave.
    New York, NY 10016
36. **Rite Aid Pharmacy**
    Grand Central Terminal
    New York, NY 10017
37. **Rite Aid Pharmacy**
    210 Amsterdam Ave.
    New York, NY 10023
38. **Rite Aid Pharmacy**
    2833 Broadway
    New York, NY 10025
39. **Rite Aid Pharmacy**
    741 Columbus Ave.
    New York, NY 10025
40. **Rite Aid Pharmacy**
    2170 Frederick Douglass Blvd.
    New York, NY 10026
41. **Rite Aid Pharmacy**
    35-45 W. 125th St.
    New York, NY 10027
42. **Rite Aid Pharmacy**
    1951 First Ave.
    New York, NY 10029
43. **Rite Aid Pharmacy**
    3539 Broadway
    New York, NY 10031
44. **Rite Aid Pharmacy**
    4046 Broadway
    New York, NY 10032
45. **Rite Aid Pharmacy**
    1033 St Nicholas Ave.
    New York, NY 10032
46. **Rite Aid Pharmacy**
    4188 Broadway
    New York, NY 10033
47. **Rite Aid Pharmacy**
    4910 Broadway
    New York, NY 10034
48. **Rite Aid Pharmacy**
    2155 Third Ave.
    New York, NY 10035
49. **Rite Aid Pharmacy**
    7 Madison St.
    New York, NY 10038
50. **Rite Aid Pharmacy**
    1535 Second Ave.
    New York, NY 10075
51. **Rite Aid Pharmacy**
    1849 Second Ave.
    New York, NY 10128
52. **Rite Aid Pharmacy**
    225 Liberty St.
    New York, NY 10281
53. **Rite Aid Pharmacy**
    408 Grand St.
    New York, NY 10002
54. **Rite Aid Pharmacy**
    534 Hudson St.
    New York, NY 10014
55. **Rite Aid Pharmacy**
    1510 St Nicholas Ave.
    New York, NY 10033
56. **Riverton Pharmacy**
    2085 Lexington Ave.
    New York, NY 10035
57. **Royal Care Pharmacy**
    127 E. 110th St.
    New York, NY 10029
58. **S B Pharmacy**
    27 E. 124th St.
    New York, NY 10035
59. **Second Avenue Pharmacy**
    249 E. 115th St.
    New York, NY 10029
60. **Seventh Avenue Pharmacy**
    2454 Adam Clayton Powell Jr Blvd.
    New York, NY 10030
61. **Taino Pharmacy**
    2403 Second Ave.
    New York, NY 10035
62. **The Pharmacy**
    2541 Seventh Ave.
    New York, NY 10039



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12/18

Blood Pressure Kiosk Map

BROOKLYN

NYC Health

Blood Pressure Kiosk Map

BROOKLYN

1. **8th Avenue Pharmacy**
5504 Eighth Ave.
Brooklyn, NY 11220

2. **A.M. Pharmacy**
5702 Eighth Ave.
Brooklyn, NY 11220

3. **Abigail's Pharmacy**
9717 Kings Hwy.
Brooklyn, NY 11212

4. **Atlantic Pharmacies**
1706 Atlantic Ave.
Brooklyn, NY 11213

5. **Avon Pharmacy**
82 Graham Ave.
Brooklyn, NY 11206

6. **Bay Ridge Rx**
7119 Fifth Ave.
Brooklyn, 11209

7. **Bedford Medical Supply**
2036 Bedford Ave.
Brooklyn, NY 11226

8. **Belmont Pharmacy**
102a Belmont Ave.
Brooklyn, NY 11212

9. **Brookedale Pharmacy**
25 Linden Blvd.
Brooklyn, NY 11208

10. **Brooklyn Pharmacy**
589 Sutter Ave.
Brooklyn, NY 11207

11. **County Pharmacy**
580 Nostrand Ave.
Brooklyn, NY 11216

12. **Dekalb Drugs**
173 Marcus Garvey Blvd.
Brooklyn, NY 11221

13. **Drug Mart Pharmacy**
4914 New Utrecht Ave.
Brooklyn, NY 11219

14. **Dumont Pharmacy**
364 Junius St.
Brooklyn, NY 11212

15. **Expressway Pharmacy**
4620 Third Ave.
Brooklyn, NY 11220

16. **Fine Care Pharmacy**
380 Knickerbocker Ave.
Brooklyn, NY 11237

17. **Five Star Pharmacy**
1200 Fulton St.
Brooklyn, NY 11216

18. **Franklin & Carroll Drugs**
886 Franklin Ave.
Brooklyn, NY 11225

19. **Fulton Drugs**
1548 Fulton St.
Brooklyn, NY 11216

20. **Fulton Pharmacy**
2818 Fulton St.
Brooklyn, NY 11207

21. **Gates & Garvey Pharmacy**
276 Marcus Garvey Blvd.
Brooklyn, NY 11221

22. **Greenway Pharmacy**
644 Rogers Ave.
Brooklyn, NY 11226

23. **Health Mart Pitkin Pharmacy**
2232 Pitkin Ave.
Brooklyn, NY 11207

24. **Health One Pharmacy**
119 Pennsylvania Ave.
Brooklyn, NY 11207

25. **HealthPro Pharmacy**
217 Schenectady Ave.
Brooklyn, NY 11213

26. **Hina Drugs**
4 Sutter Ave.
Brooklyn, NY 11212

27. **Hoyt Pharmacy**
3024 Atlantic Ave.
Brooklyn, NY 11208

28. **Jacoff Pharmacy**
839 Empire Blvd.
Brooklyn, NY 11213

29. **Joyma Enterprise**
291 Pennsylvania Ave.
Brooklyn, NY 11207

30. **Katz Drugs**
76 Graham Ave.
Brooklyn, NY 11206

31. **Kingston Pharmacy**
1106 St Johns Pl.
Brooklyn, NY 11213

32. **Kruticks Pharmacy**
589 Crescent St.
Brooklyn, NY 11208

33. **La Ruche Pharmacy**
494 Rockaway Pkwy.
Brooklyn, NY 11212

34. **Lawrence Pharmacy**
740 New Lots Ave.
Brooklyn, NY 11207

35. **Lutheran Pharmacy**
5407 Second Ave.
Brooklyn, NY 11220

36. **Manipal Drugs**
280 Nostrand Ave.
Brooklyn, NY 11205

37. **Marben Pharmacy**
679 Stanley Ave.
Brooklyn, NY 11207

38. **Marcy Pharmacy**
170 Throop Ave.
Brooklyn, NY 11206

39. **Med Pharmacy**
264 Malcolm X Blvd.
Brooklyn, NY 11233

40. **Mill Basin Pharmacy**
5829 Avenue T
Brooklyn, NY 11234

41. **New Lots Pharmacy**
475 New Lots Ave.
Brooklyn, NY 11207

42. **New Lots Pharmacy**
739 New Lots Ave.
Brooklyn, NY 11207

43. **New Ronson Pharmacy**
237 Utica Ave.
Brooklyn, NY 11213

44. **New Utrecht Pharmacy**
4624 New Utrecht Ave.
Brooklyn, NY 11219

45. **Nextgen Pharmacy**
2483 86th St.
Brooklyn, NY 11214

46. **Norwood Pharmacy**
3138 Fulton St.
Brooklyn, NY 11208

47. **Phamco Drugs**
802 Nostrand Ave.
Brooklyn, NY 11216

48. **Pharmacia Popular**
17 Marcus Garvey Blvd.
Brooklyn, NY 11206

49. **Pyramids Pharmacy**
6403 20th Ave.
Brooklyn, NY 11204

50. **Qasim Pharmacy**
934 Myrtle Ave.
Brooklyn, NY 11206

51. **Raaees Pharmacy**
750 Flatbush Ave.
Brooklyn, NY 11226

52. **Regal Remedies**
1853 Cropsey Ave.
Brooklyn, NY 11214

53. **Remedies Pharmacy**
711 Bedford Ave.
Brooklyn, NY 11206

54. **Rite Aid Pharmacy**
182 Smith St.
Brooklyn, NY 11201

55. **Rite Aid Pharmacy**
101 Clinton St.
Brooklyn, NY 11201

56. **Rite Aid Pharmacy**
120 Court St.
Brooklyn, NY 11201

57. **Rite Aid Pharmacy**
4123 Avenue D
Brooklyn, NY 11203

58. **Rite Aid Pharmacy**
6101 18th Ave.
Brooklyn, NY 11204

59. **Rite Aid Pharmacy**
7821 Third Ave.
Brooklyn, NY 11209

60. **Rite Aid Pharmacy**
6900 Fourth Ave.
Brooklyn, NY 11209

61. **Rite Aid Pharmacy**
9302 Third Ave.
Brooklyn, NY 11209

62. **Rite Aid Pharmacy**
7501 Fifth Ave.
Brooklyn, 11209

63. **Rite Aid Pharmacy**
7118 Third Ave.
Brooklyn, NY 11209

64. **Rite Aid Pharmacy**
2577 Nostrand Ave.
Brooklyn, NY 11210

65. **Rite Aid Pharmacy**
1631 Pitkin Ave.
Brooklyn, NY 11212

66. **Rite Aid Pharmacy**
1040 Saint Johns Pl.
Brooklyn, NY 11213

67. **Rite Aid Pharmacy**
2532 86th St.
Brooklyn, NY 11214

68. **Rite Aid Pharmacy**
8222 18th Ave.
Brooklyn, NY 11214

69. **Rite Aid Pharmacy**
249 Seventh Ave.
Brooklyn, NY 11215

70. **Rite Aid Pharmacy**
302 Church Ave.
Brooklyn, NY 11218

71. **Rite Aid Pharmacy**
5102 13th Ave.
Brooklyn, NY 11219

72. **Rite Aid Pharmacy**
6423 Fort Hamilton Pkwy.
Brooklyn, NY 11219

73. **Rite Aid Pharmacy**
6201 Fourth Ave.
Brooklyn, NY 11220

74. **Rite Aid Pharmacy**
783 Manhattan Ave.
Brooklyn, NY 11222

75. **Rite Aid Pharmacy**
723 Manhattan Ave.
Brooklyn, NY 11222

76. **Rite Aid Pharmacy**
3001 Mermaid Ave.
Brooklyn, NY 11224

77. **Rite Aid Pharmacy**
1679 Bedford Ave.
Brooklyn, NY 11225

78. **Rite Aid Pharmacy**
892 Flatbush Ave.
Brooklyn, NY 11226

79. **Rite Aid Pharmacy**
2819 Church Ave.
Brooklyn, NY 11226

80. **Rite Aid Pharmacy**
7009 13th Ave.
Brooklyn, NY 11228

81. **Rite Aid Pharmacy**
2002 Avenue U
Brooklyn, NY 11229

82. **Rite Aid Pharmacy**
1720 Kings Hwy.
Brooklyn, NY 11229

83. **Rite Aid Pharmacy**
320 Smith St.
Brooklyn, NY 11231

84. **Rite Aid Pharmacy**
1950 Fulton St.
Brooklyn, NY 11233

85. **Rite Aid Pharmacy**
1791 Utica Ave.
Brooklyn, NY 11234

86. **Rite Aid Pharmacy**
2064 Mill Ave.
Brooklyn, NY 11234

87. **Rite Aid Pharmacy**
3823 Nostrand Ave.
Brooklyn, NY 11235

88. **Rite Aid Pharmacy**
2981 Ocean Ave.
Brooklyn, NY 11235

89. **Rite Aid Pharmacy**
9738 Seaview Ave.
Brooklyn, NY 11236

90. **Rite Aid Pharmacy**
7812 Flatlands Ave.
Brooklyn, NY 11236

91. **Rite Aid Pharmacy**
355 Knickerbocker Ave.
Brooklyn, NY 11237

92. **Rite Aid Pharmacy**
506 Utica Ave.
Brooklyn, NY 11203

93. **Rite Aid Pharmacy**
4102 Church Ave.
Brooklyn, NY 11203

94. **Rite Aid Pharmacy**
5901 Bay Pkwy.
Brooklyn, NY 11204

95. **Rite Aid Pharmacy**
1111 Pennsylvania Ave.
Brooklyn, NY 11207

96. **Rite Aid Pharmacy**
1559 Flatbush Ave.
Brooklyn, NY 11210

97. **Rite Aid Pharmacy**
1154 Clarkson Ave.
Brooklyn, NY 11212

98. **Rite Aid Pharmacy**
462 Fifth Ave.
Brooklyn, NY 11215

99. **Rite Aid Pharmacy**
5224 Fifth Ave.
Brooklyn, NY 11220

100. **Rite Aid Pharmacy**
185 Kings Hwy.
Brooklyn, NY 11223

101. **Rite Aid Pharmacy**
344 Avenue X
Brooklyn, NY 11223

102. **Rite Aid Pharmacy**
1419 Newkirk Ave.
Brooklyn, NY 11226

103. **Rite Aid Pharmacy**
1532 86th St.
Brooklyn, NY 11228

104. **Rite Aid Pharmacy**
960 Halsey St.
Brooklyn, NY 11233

105. **Rose Pharmacy**
1074 Liberty Ave.
Brooklyn, NY 11208

106. **Rossi Pharmacy**
1891 Eastern Pkwy.
Brooklyn, NY 11233

107. **Salaam Pharmacy**
155 Crystal St.
Brooklyn, NY 11208

108. **Sams Drugs**
1367 Broadway
Brooklyn, NY 11221

109. **Silver Rod Pharmacy**
5105 Church Ave.
Brooklyn, NY 11203

110. **Sims Pharmacy**
1711 Pitkin Ave.
Brooklyn, NY 11212

111. **Square Deal Pharmacy**
437 Mother Gaston Blvd.
Brooklyn, NY 11212

112. **St. Jude Pharmacy**
121 St Nicholas Ave.
Brooklyn, NY 11237

113. **Sunset Park Pharmacy**
4510 Fifth Ave.
Brooklyn, NY 11220

114. **Sure Drugs**
312 Ralph Ave.
Brooklyn, NY 11233

115. **Sut Penn Pharmacy**
629 Sutter Ave.
Brooklyn, NY 11207

116. **Thriftcare Pharmacy**
759 Washington Ave.
Brooklyn, NY 11238

117. **Thriftway Pharmacy**
720 Classon Ave.
Brooklyn, NY 11238

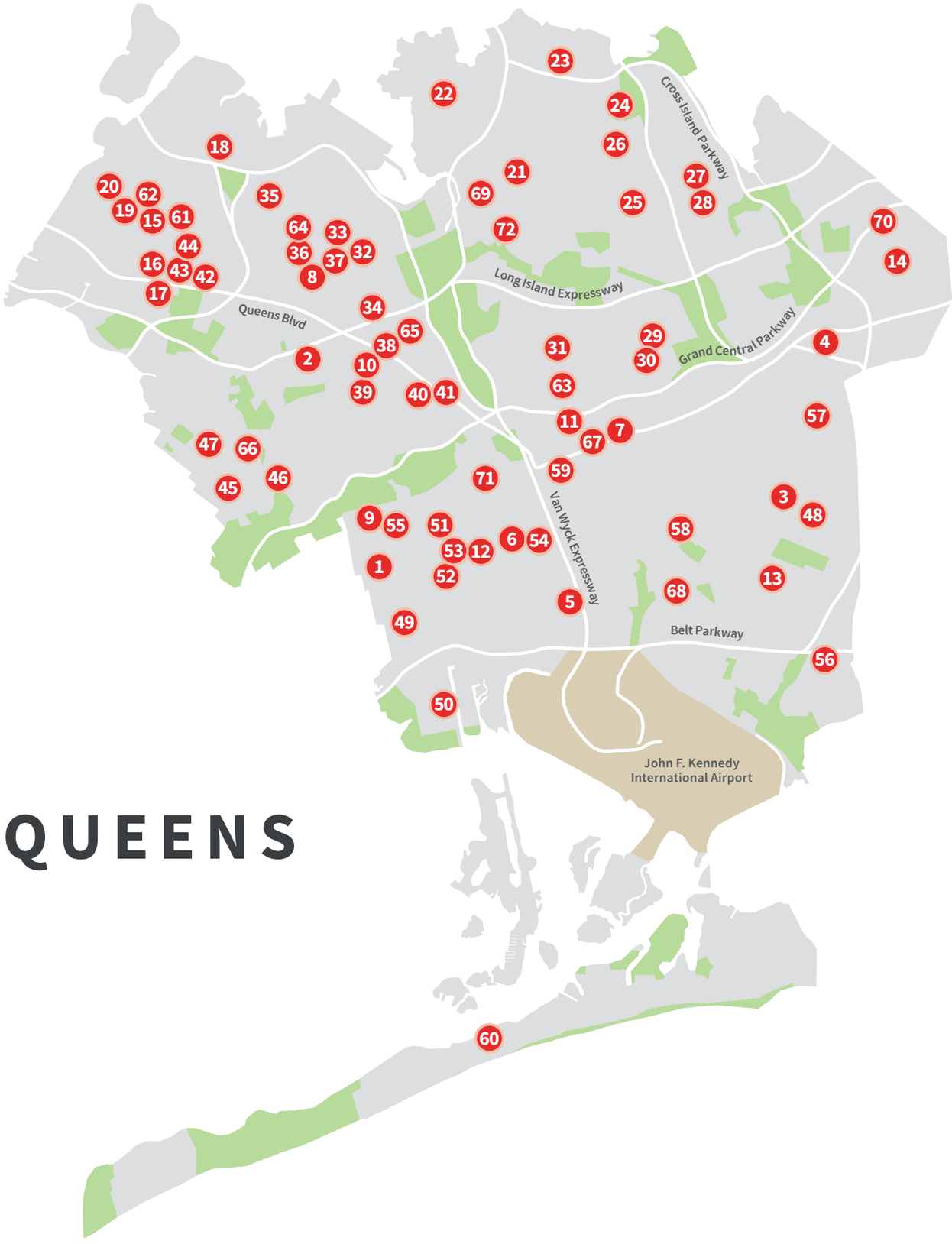
118. **Umamah Pitkin Pharmacy**
2232 Pitkin Ave.
Brooklyn, NY 11207

119. **Utica Pharmacy**
285 Utica Ave.
Brooklyn, NY 11213

120. **V & A Pharmacy**
72 Manhattan Ave.
Brooklyn, NY 11206

121. **V.L.S. Alleon Drugs**
6823 Fort Hamilton Pkwy.
Brooklyn, NY 11221

122. **Zoya Pharmacy**
1527 Pitkin Ave.
Brooklyn, NY 11212



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This map is available in other languages.

12/18

Blood Pressure Kiosk Map

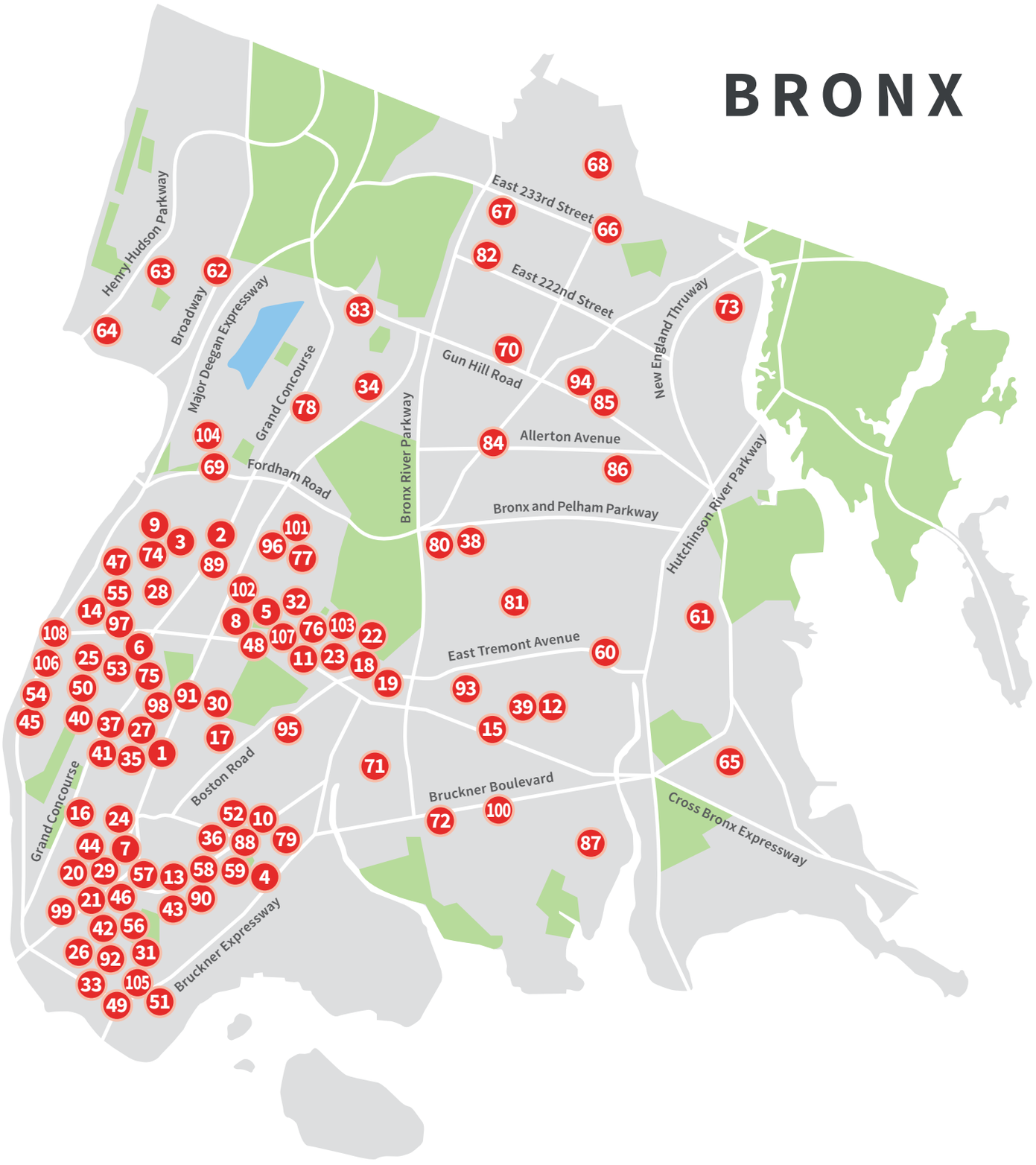
QUEENS

NYC Health

Blood Pressure Kiosk Map

QUEENS

1. **Al-Haqq Pharmacy**
   7507 101st Ave.
   Queens, NY 11417
2. **Artis Drugs**
   8002 Eliot Ave.
   Queens, NY 11379
3. **Bakers Drugs**
   205-43 Linden Blvd.
   Queens, NY 11412
4. **Braddock Pharmacy**
   236-01a Braddock Ave.
   Queens, NY 11426
5. **CPW Drugs**
   13107 Rockaway Blvd.
   Queens, NY 11420
6. **CPW Pharmacy**
   12116 Liberty Ave.
   Queens, NY 11419
7. **Estates Pharmacy**
   169-01 Hillside Ave.
   Queens, NY 11432
8. **Grace Pharmacy**
   91-01 43rd Ave.
   Queens, NY 11373
9. **Healthmax Pharmacy**
   80-07 Jamaica Ave.
   Queens, NY 11421
10. **K.S. Pharmacy**
    93-05 63rd Dr.
    Queens, NY 11374
11. **Medscript Rx Pharmacy**
    83-42 Parsons Blvd.
    Queens, NY 11432
12. **Meeraj Pharmacy**
    115-17 Liberty Ave.
    Queens, NY 11419
13. **Quick Fill Pharmacy**
    216-17 Merrick Blvd.
    Queens, NY 11413
14. **Rite Aid Pharmacy**
    255-01 Union Tpke.
    Queens, NY 11004
15. **Rite Aid Pharmacy**
    32-87 Steinway St.
    Queens, NY 11103
16. **Rite Aid Pharmacy**
    45-02 43rd Ave.
    Queens, NY 11104
17. **Rite Aid Pharmacy**
    46-12 Greenpoint Ave.
    Queens, NY 11104
18. **Rite Aid Pharmacy**
    43-02 Ditmars Blvd.
    Queens, NY 11105
19. **Rite Aid Pharmacy**
    32-14 31st St.
    Queens, NY 11106
20. **Rite Aid Pharmacy**
    21-25 Broadway
    Queens, NY 11106
21. **Rite Aid Pharmacy**
    144-29 Northern Blvd.
    Queens, NY 11354
22. **Rite Aid Pharmacy**
    15-08 College Point Blvd.
    Queens, NY 11356
23. **Rite Aid Pharmacy**
    153-65 Cross Island Pkwy.
    Queens, NY 11357
24. **Rite Aid Pharmacy**
    19-23 Utopia Pkwy.
    Queens, NY 11357
25. **Rite Aid Pharmacy**
    193-01 Northern Blvd.
    Queens, NY 11358
26. **Rite Aid Pharmacy**
    27-07 Francis Lewis Blvd.
    Queens, NY 11358
27. **Rite Aid Pharmacy**
    39-20 Bell Blvd.
    Queens, NY 11361
28. **Rite Aid Pharmacy**
    43-20 Bell Blvd.
    Queens, NY 11361
29. **Rite Aid Pharmacy**
    69-62 188th St.
    Queens, NY 11365
30. **Rite Aid Pharmacy**
    186-16 Union Tpke.
    Queens, NY 11366
31. **Rite Aid Pharmacy**
    71-18 Kissena Blvd.
    Queens, NY 11367
32. **Rite Aid Pharmacy**
    40-16 National St.
    Queens, NY 11368
33. **Rite Aid Pharmacy**
    3700-06 Junction Blvd.
    Queens, NY 11368
34. **Rite Aid Pharmacy**
    57-16 99th St.
    Queens, NY 11368
35. **Rite Aid Pharmacy**
    75-75 31st Ave.
    Queens, NY 11370
36. **Rite Aid Pharmacy**
    82-13 37th Ave.
    Queens, NY 11372
37. **Rite Aid Pharmacy**
    9108 Roosevelt Ave.
    Queens, NY 11372
38. **Rite Aid Pharmacy**
    95-14 63rd Dr.
    Queens, NY 11374
39. **Rite Aid Pharmacy**
    65-35 Woodhaven Blvd.
    Queens, NY 11374
40. **Rite Aid Pharmacy**
    71-14 Austin St.
    Queens, NY 11375
41. **Rite Aid Pharmacy**
    110-88 Queens Blvd.
    Queens, NY 11375
42. **Rite Aid Pharmacy**
    58-01 Queens Blvd.
    Queens, NY 11377
43. **Rite Aid Pharmacy**
    50-15 Roosevelt Ave.
    Queens, NY 11377
44. **Rite Aid Pharmacy**
    60-26 Woodside Ave.
    Queens, NY 11377
45. **Rite Aid Pharmacy**
    55-60 Myrtle Ave.
    Queens, NY 11385
46. **Rite Aid Pharmacy**
    6036 Myrtle Ave.
    Queens, NY 11385
47. **Rite Aid Pharmacy**
    583 Grandview Ave.
    Queens, NY 11385
48. **Rite Aid Pharmacy**
    222-14 Linden Blvd.
    Queens, NY 11411
49. **Rite Aid Pharmacy**
    78-14 Linden Blvd.
    Queens, NY 11414
50. **Rite Aid Pharmacy**
    160-40 Cross Bay Blvd.
    Queens, NY 11414
51. **Rite Aid Pharmacy**
    102-30 Atlantic Ave.
    Queens, NY 11416
52. **Rite Aid Pharmacy**
    96-02 Rockaway Blvd.
    Queens, NY 11417
53. **Rite Aid Pharmacy**
    109-07 101 Ave.
    Queens, NY 11419
54. **Rite Aid Pharmacy**
    122-02 Liberty Ave.
    Queens, NY 11419
55. **Rite Aid Pharmacy**
    89-10 Jamaica Ave.
    Queens, NY 11421
56. **Rite Aid Pharmacy**
    245-14 Francis Lewis Blvd.
    Queens, NY 11422
57. **Rite Aid Pharmacy**
    218-35 Hempstead Ave.
    Queens, NY 11429
58. **Rite Aid Pharmacy**
    115-10 Merrick Blvd.
    Queens, NY 11434
59. **Rite Aid Pharmacy**
    90-01 Sutphin Blvd.
    Queens, NY 11435
60. **Rite Aid Pharmacy**
    10640 Rockaway Beach Blvd.
    Queens, NY 11694
61. **Rite Aid Pharmacy**
    47-07 Broadway
    Queens, NY 11103
62. **Rite Aid Pharmacy**
    33-01 30th Ave.
    Queens, NY 11103
63. **Rite Aid Pharmacy**
    158-02 Union Tpke.
    Queens, NY 11366
64. **Rite Aid Pharmacy**
    85-10 Northern Blvd.
    Queens, NY 11372
65. **Rite Aid Pharmacy**
    63-37 108th St.
    Queens, NY 11375
66. **Rite Aid Pharmacy**
    66-54 Fresh Pond Rd.
    Queens, NY 11385
67. **Rite Aid Pharmacy**
    162-19 Hillside Ave.
    Queens, NY 11432
68. **Rite Aid Pharmacy**
    165-02 Baisley Blvd.
    Queens, NY 11434
69. **Roosevelt Pharmacy**
    133-55 Roosevelt Ave.
    Queens, NY 11354
70. **Tower Drugs**
    272-68 Grand Central Pkwy.
    Queens, NY 11005
71. **Triangle Pharmacy**
    119-01 Jamaica Ave.
    Queens, NY 11418
72. **Well Care Pharmacy**
    4283 Main St.
    Queens, NY 11355



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12/18

Blood Pressure Kiosk Map

BRONX

NYC Health

Blood Pressure Kiosk Map

BRONX

1. **167th Street Pharmacy**
1150 Webster Ave.
Bronx, NY 10456
2. **Akshar Pharmacy**
2200 Grand Concourse
Bronx, NY 10457
3. **Alico Pharmacy**
2027 Jerome Ave.
Bronx, NY 10453
4. **Barretto Pharmacy**
1009 Longwood Ave.
Bronx, NY 10459
5. **Best Aid Pharmacy**
563 E. Tremont Ave.
Bronx, NY 10457
6. **Bronx Eden Pharmacy**
1575 Grand Concourse
Bronx, NY 10452
7. **Bronx Pharmacy**
690a Melrose Ave.
Bronx, NY 10455
8. **Bronx Pharmacy**
511 E. Tremont Ave.
Bronx, NY 10457
9. **Burnside Pharmacy**
75 W. Burnside Ave.
Bronx, NY 10453
10. **Care Pharmacy**
979 Westchester Ave.
Bronx, NY 10459
11. **Care Well Rx**
826 E. Tremont Ave.
Bronx, NY 10460
12. **Castle Topp Pharmacy**
1370a Castle Hill Ave.
Bronx, NY 10462
13. **Cauldwell Pharmacy**
609 Westchester Ave.
Bronx, NY 10455
14. **Choice One Pharma**
1550 University Ave.
Bronx, NY 10452
15. **Circle Pharmacy**
116 Hugh J Grant Cir.
Bronx, NY 10472
16. **Concourse Pharmacy**
767 Concourse Village W.
Bronx, NY 10451
17. **Drug Depot**
619 E. 169th St.
Bronx, NY 10456
18. **East Tremont Pharmacy**
2026 Boston Rd.
Bronx, NY 10460
19. **East Tremont Pharmacy**
1065 E. Tremont Ave.
Bronx, NY 10460
20. **Express Pharmacy**
273 E. 149 St.
Bronx, NY 10451
21. **Family Pharmacy**
2754 Third Ave.
Bronx, NY 10455
22. **Farmacia Honeywell**
882 E. 180th St.
Bronx, NY 10460
23. **First Aid Pharmacy**
921 E. Tremont Ave.
Bronx, NY 10460
24. **Goodman Pharmacy**
779 Melrose Ave.
Bronx, NY 10451
25. **Grant Pharmacy**
1340 Edward L Grant Hwy.
Bronx, NY 10452
26. **Hispaniola Pharmacy**
411 E. 138th St.
Bronx, NY 10454
27. **J & N Pharmacy**
1220 Morris Ave.
Bronx, NY 10456
28. **Jerome Drugs**
1788 Jerome Ave.
Bronx, NY 10453
29. **Kings Care Pharmacy & Store**
306 E. 149th St.
Bronx, NY 10451
30. **Kings Pharmacy**
545 St Pauls Pl.
Bronx, NY 10456
31. **Kramer Pharmacy**
309 St Ann's Ave.
Bronx, NY 10454
32. **La Farmacia**
709 E. Tremont Ave.
Bronx, NY 10457
33. **Lacross Drugs**
530 E. 138th St.
Bronx, NY 10454
34. **Leroy Pharmacy**
314 E. 204th St.
Bronx, NY 10467
35. **Lincoln Care Drugs**
270 E. 165th St.
Bronx, NY 10456
36. **Longwood Pharmacy & Surgical**
839 Prospect Ave.
Bronx, NY 10459
37. **Lumit Pharmacy**
200 E. 167th St.
Bronx, NY 10456
38. **Lydig Pharmacy**
742 Lydig Ave.
Bronx, NY 10462
39. **McGraw Pharmacy**
2048 McGraw Ave.
Bronx, NY 10462
40. **Medicine Center Rx**
92 E. 167th St.
Bronx, NY 10452
41. **Morris Pharmacy**
255 E. 165th St.
Bronx, NY 10459
42. **Mott Haven Pharmacy & Surgical Supply**
400 E. 141st St.
Bronx, NY 10454
43. **Nayosha Pharmacy**
755 E. 149th St.
Bronx, NY 10455
44. **Nisar Pharmacy**
229 E. 149th St.
Bronx, NY 10451
45. **Ogden Pharmacy**
1071 Ogden Ave.
Bronx, NY 10452
46. **Oz Pharmacy**
322 E. 149th St.
Bronx, NY 10451
47. **Park Plaza Pharmacy**
1773 University Ave.
Bronx, NY 10453
48. **Perla Pharmacy**
822 E. Tremont Ave.
Bronx, NY 10460
49. **Pharmacia Lacross**
543 E. 137th St.
Bronx, NY 10454
50. **Pinebrook Pharmacy**
1183 Jerome Ave.
Bronx, NY 10452
51. **Port Morris Pharmacy**
800 E. 138th St.
Bronx, NY 10454
52. **Prospect Avenue Pharmacy**
993 Prospect Ave.
Bronx, NY 10459
53. **Rite Aid Pharmacy**
32 E. 170th St.
Bronx, NY 10452
54. **Rite Aid Pharmacy**
1091 Ogden Ave.
Bronx, NY 10452
55. **Rite Aid Pharmacy**
88 Featherbed Ln.
Bronx, NY 10452
56. **Rite Aid Pharmacy**
537 E. 138th St.
Bronx, NY 10454
57. **Rite Aid Pharmacy**
3012 Third Ave.
Bronx, NY 10455
58. **Rite Aid Pharmacy**
642 Westchester Ave.
Bronx, NY 10455
59. **Rite Aid Pharmacy**
840 Westchester Ave.
Bronx, NY 10459
60. **Rite Aid Pharmacy**
2748 E. Tremont Ave.
Bronx, NY 10461
61. **Rite Aid Pharmacy**
1710 Crosby Ave.
Bronx, 10461
62. **Rite Aid Pharmacy**
5825 Broadway
Bronx, NY 10463
63. **Rite Aid Pharmacy**
541 W. 235th St.
Bronx, NY 10463
64. **Rite Aid Pharmacy**
21b Knolls Crescent
Bronx, NY 10463
65. **Rite Aid Pharmacy**
3590 E. Tremont Ave.
Bronx, NY 10465
66. **Rite Aid Pharmacy**
1179 E. 233rd St.
Bronx, NY 10466
67. **Rite Aid Pharmacy**
4159 White Plains Rd.
Bronx, NY 10466
68. **Rite Aid Pharmacy**
4232 Baychester Ave.
Bronx, NY 10466
69. **Rite Aid Pharmacy**
49 W. Fordham Rd.
Bronx, NY 10468
70. **Rite Aid Pharmacy**
901 E. Gun Hill Rd.
Bronx, NY 10469
71. **Rite Aid Pharmacy**
1516 Westchester Ave.
Bronx, NY 10472
72. **Rite Aid Pharmacy**
925 Sound View Ave.
Bronx, NY 10473
73. **Rite Aid Pharmacy**
691 Co Op City Blvd.
Bronx, NY 10475
74. **Rite Aid Pharmacy**
57 E. Burnside Ave.
Bronx, NY 10453
75. **Rite Aid Pharmacy**
1540 Grand Concourse
Bronx, NY 10457
76. **Rite Aid Pharmacy**
650 E. Tremont Ave.
Bronx, NY 10457
77. **Rite Aid Pharmacy**
592 E. 183rd St.
Bronx, NY 10458
78. **Rite Aid Pharmacy**
239 E. 198th St.
Bronx, NY 10458
79. **Rite Aid Pharmacy**
950 Southern Blvd.
Bronx, NY 10459
80. **Rite Aid Pharmacy**
2158 White Plains Rd.
Bronx, NY 10462
81. **Rite Aid Pharmacy**
911 Morris Park Ave.
Bronx, NY 10462
82. **Rite Aid Pharmacy**
3901 White Plains Rd.
Bronx, NY 10466
83. **Rite Aid Pharmacy**
3480 Jerome Ave.
Bronx, NY 10467
84. **Rite Aid Pharmacy**
2750 Boston Rd.
Bronx, NY 10469
85. **Rite Aid Pharmacy**
3040 Eastchester Rd.
Bronx, NY 10469
86. **Rite Aid Pharmacy**
2426 Eastchester Rd.
Bronx, NY 10469
87. **Rite Aid Pharmacy**
650 Castle Hill Ave.
Bronx, NY 10473
88. **Rite Care Pharmacy**
898 E. 163rd St.
Bronx, NY 10459
89. **Rose Drug Store**
262 E. Burnside Ave.
Bronx, NY 10457
90. **RV Pharmacy**
754 E. 151st St.
Bronx, NY 10455
91. **Rx Masters Pharmacy**
1437 Webster Ave.
Bronx, NY 10456
92. **Safeway Pharmacy**
493 E. 138th St.
Bronx, NY 10454
93. **SAS Pharmacy**
1481 Leland Ave.
Bronx, NY 10460
94. **Scheer Drugs**
1343 E. Gun Hill Rd.
Bronx, NY 10469
95. **Sol's Pharmacy**
1515 Southern Blvd.
Bronx, NY 10460
96. **Specialty Care Pharmacy**
4463 Third Ave.
Bronx, NY 10457
97. **Starhill Pharmacy**
115 Featherbed Ln.
Bronx, NY 10452
98. **Stat Rx Pharmacy**
235 E. 167th St.
Bronx, NY 10456
99. **Third Ave Pharmacy**
2702 Third Ave.
Bronx, NY 10454
100. **Top Grade Pharmacy**
1903 Story Ave.
Bronx, NY 10473
101. **Total Care Pharmacy**
4531 Third Ave.
Bronx, NY 10457
102. **Tremont Drugs**
489 E. Tremont Ave.
Bronx, NY 10457
103. **Twin Parks Pharmacy**
817 E. 180th St.
Bronx, NY 10460
104. **University Avenue Pharmacy**
2465 University Ave.
Bronx, NY 10468
105. **Upgrade Pharmacy**
679 E. 138th St.
Bronx, NY 10454
106. **V & K Pharmacy**
1227 Ogden Ave.
Bronx, NY 10452
107. **Webster Drugs**
753 E. Tremont Ave.
Bronx, NY 10457
108. **Your Family Pharmacy**
1392 Ogden Ave.
Bronx, NY 10452

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12/18

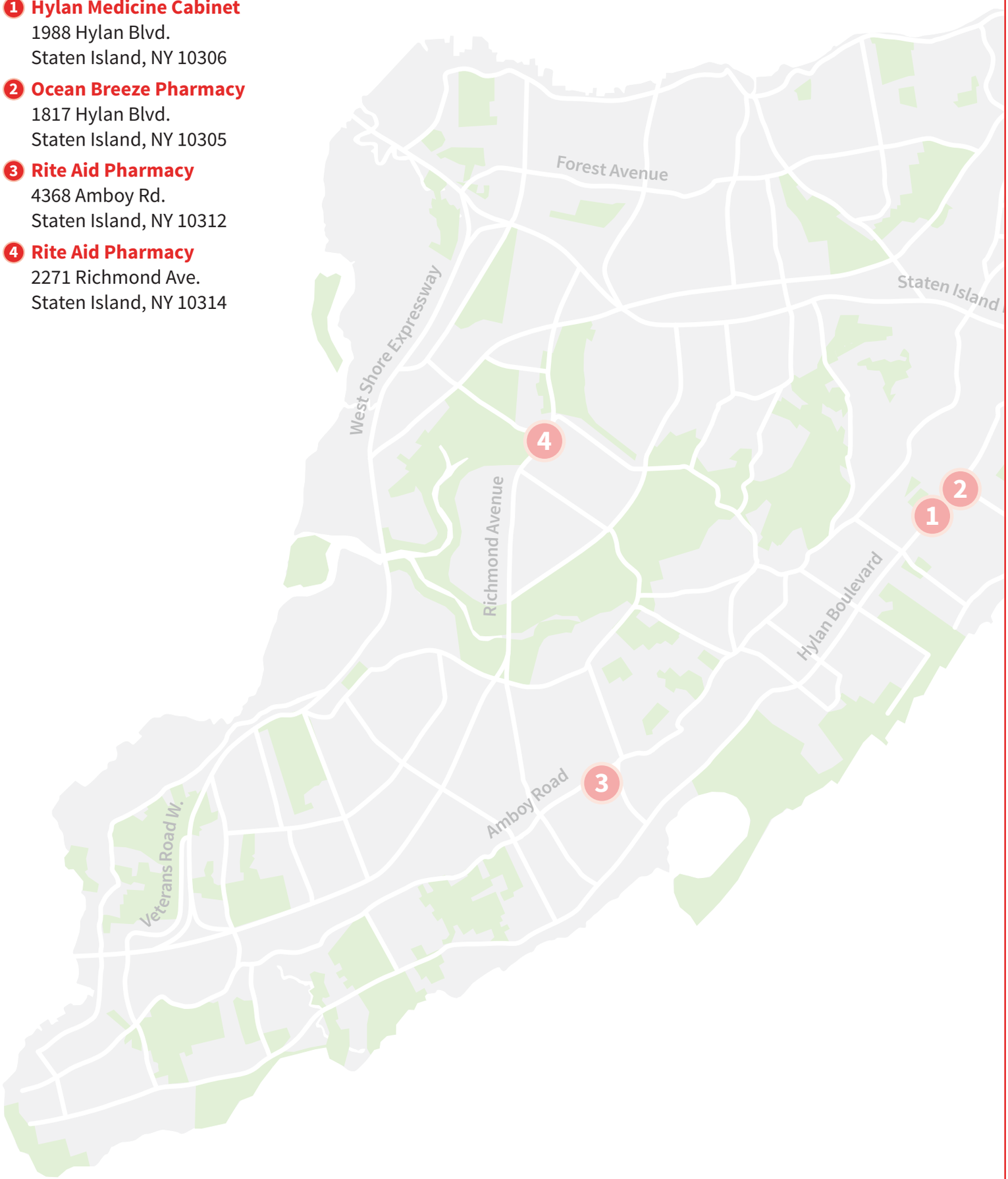
Blood Pressure Kiosk Map

STATEN ISLAND

NYC Health

Blood Pressure Kiosk Map
STATEN ISLAND

1. **Hylan Medicine Cabinet**
   1988 Hylan Blvd.
   Staten Island, NY 10306
2. **Ocean Breeze Pharmacy**
   1817 Hylan Blvd.
   Staten Island, NY 10305
3. **Rite Aid Pharmacy**
   4368 Amboy Rd.
   Staten Island, NY 10312
4. **Rite Aid Pharmacy**
   2271 Richmond Ave.
   Staten Island, NY 10314



March 30, 2023

TESTIMONY OF JOHN FLANAGAN, SR. VICE PRESIDENT-NORTHWELL HEALTH

Good Morning, my name is John Flanagan and I serve as the Senior Vice President for Government Affairs at Northwell Health. I am appearing today on behalf of Northwell Health- GoHealth Urgent Care and do so with Dr. Neal Shipley, Medical Director and Radiation Safety Officer, who oversees all of our GoHealth facilities in New York City. We are deeply grateful to Chairwoman Shulman, as well as all the members of the Health Committee, for holding this important hearing. The subject matter is pivotal to the work and mission that we engage in every day. We are also acutely mindful of the pressures on your time, especially during the Budget process.

Dr. Shipley will offer testimony as to the details of our operations at our GoHealth facilities and outline what we believe are beneficial options in delivering critical care in an urgent care setting. His scope of knowledge and his years of experience make him particularly well suited to speak to the practical aspects of how we deliver urgent care services. Bringing care to the patient that includes operational flexibility and minimizing any inconvenience to them while maintaining the highest standards of care for our patients and our employees is central to our mission of providing access, equity and excellence.

Northwell Health is fully committed, under the leadership of Michael Dowling, to providing the highest quality of care to all our patients - and doing so in the most appropriate and cost efficient setting. With health care evolving virtually every day we are always looking for means to facilitate patient care, and urgent care is essential to achieving those goals. Keeping patients out of emergency departments when they can be treated properly at a lower cost and in a timelier manner is integral to the work of GoHealth. We strive to achieve the highest quality level of care while protecting everyone who visits or works in our facilities and we do so by adhering to all applicable rules and regulations as well as independent monitoring of our operations.

I thank the Chair and her Committee and the Members for providing this opportunity to offer testimony and I will turn it over to my colleague Dr. Neal Shipley. We will be happy to answer any questions as well. Thank you

Northwell Health | GoHealth URGENT CARE

Neal Shipley MD MBA FACEP

Medical Director

Northwell GoHealth Urgent Care

NY City Council Health Committee

March 30, 2023

Good morning, my name is Dr. Neal Shipley and I've been a NYC resident for the past 35 years. I am Board Certified in Emergency Medicine and have been practicing Emergency Medicine and urgent care since 1993. I appreciate being given the opportunity to appear before this body today.

For the past 7 years, as Medical Director, I oversee a large health system affiliated urgent care (UC) network with 20 NYC sites in Queens, Brooklyn, Staten Island and NYC; our network cared for approximately 320,000 NYC residents in 2022.

In 2021, I had the honor and privilege of being sworn in as an NYC Honorary Police Surgeon for our support of and work with the NYC Police Department during the COVID-19 pandemic.

Urgent care centers play an important role in the NYC healthcare system by improving access to care for thousands of New Yorkers across the NY-Metro region. NYC Emergency Departments (EDs) are generally overcrowded, with long wait times and need to focus their resources on those who have high acuity conditions. ED are also the costliest way for patients to access acute care. On average, an ED visit costs 4-5 times that of an urgent care visit for a similar condition. At the other end of the spectrum, access to Primary Care Providers (PCPs) in NYC is equally challenging, with available appointment times often weeks away from when the patient needs care. As good stewards of health care resources, urgent care centers play a vital role in providing the residents of NYC accessible and affordable alternatives to their local Emergency Department. Prior to the urgent care model, the local ED was the only place NY'ers could access immediate unscheduled healthcare in NYC.

Nowhere was this more evident than in 2021 and 2022 when we treated in total over 2 million patients across the entire network and performed over 1.4 million COVID tests; of those 500,000 COVID tests were performed in the NYC boroughs and in NYC, we diagnosed and treated ~70,000 COVID cases thus playing a critical role to help to "flatten the curve" and keep NYC patients out of the hospital and freeing up capacity in the EDs.

Another example of the role that UC's can play in helping to avoid unnecessary ED visits is the upcoming launch of our ET3 partnership with CMS (Centers for Medicare and Medicaid Services) and the FDNY (Fire Department New York) . ET3 stands for Emergency Triage, Treat, and Transport; this federally sponsored demonstration project, expected to "Go-Live" in 2023, will allow the FDNY EMS (Emergency Medical Services) 911 system to transport lower acuity patients directly to the UC center instead of the ED for evaluation, diagnosis, and treatment. We are closely aligned with CMS and FDNY on the importance of this demonstration project and its potential positive impact on health care access and costs for NY'ers.

The regulation we are discussing today is very problematic for us as a business and for our ability to serve the NYC community. Our centers were designed with small ~ 2,000 sq. ft. footprints so they can fit into retail spaces, near public transportation hubs that are convenient for patient access. The cost of facility modifications to convert our sites to fixed x-ray rooms alone would be an economic hardship for us as a business, but in doing so, we would have to eliminate at least one, but more likely two of the existing exam rooms at each site. This would dramatically reduce our throughput and overall capacity to see patients and provide them with alternatives to the ED.

The capability to perform mobile x-ray in our centers plays an important role in our ability to support the communities and take on innovative care models such as ET3. Our use case for imaging in the urgent care setting is exclusively for patients with acute musculoskeletal injuries or acute chest complaints such as COVID -19, chest pain, difficulty breathing, or cough with fever. This capacity allows us to make prompt diagnosis of serious medical conditions such as fractures, dislocations, or pneumonia, to initiate proper care such as immobilization/splinting or antibiotics, to determine if a higher level of care is required, and to make appropriate referrals to specialists such as Orthopedics.

From a clinical, truly patient centric perspective, we believe that it's better to 'bring the x-ray to the patient' then ask a patient, who may have an unstable fracture or dislocation to move around our centers. Once the patient is in the room, use of mobile x-ray minimizes the possibility of further musculoskeletal injury and reduces pain, by allowing us to bring the mobile unit into the patient's room.

We have been performing mobile x-rays in our centers since we first opened in 2014 and our priority has and will always be patient and staff safety. Since 2014, in our NYC locations, we have performed over 72,000 mobile x-rays – almost 34,000 Chest -X-rays and 38,000 Musculoskeletal films. We have a rigorous Quality Control (QC) process that is comparable to ones in place in hospital emergency departments and inpatient units that also use mobile imaging. I would like to take a few minutes to highlight some of those programs and outcomes for the committee.

- Our Radiology Technicians (RTs) complete a comprehensive training program and competency is reviewed annually.

- Since 2014, no staff member or radiology technician has received an occupational radiation exposure dose reaching the maximum occupational dose for either quarterly or annual exposure limits.
- Repeat/Reject analysis (R/R Rate) – Repeat images due to improper technique are a leading contributor of unnecessary radiation exposure. In diagnostic radiology, delivering quality images with minimum exposure to staff and patients is of primary importance. Repeat/Reject (R/R) imaging is associated with unnecessary radiation exposure of both patients and staff as well as an increase in operational costs.
- We perform R/R analysis quarterly on all units and at all sites, and our performance is well below the < 5 % R/R acceptable threshold; we are consistently under 2.0 %., which is comparable to the R/R rate observed in our inpatient and hospital-based partners.

In summary, we believe that mobile x-ray is a safe, cost-effective, and critical component of how urgent care networks provide care to NYC residents and the communities they live in. Mobile imaging services assist us in providing high quality patient care at a lower cost than the ED and in giving patients, and soon, the FDNY EMS 911 system, an alternative to the ED for lower acuity conditions. Let me be clear –I respect and appreciate the regulatory intent behind Article 125-patient and staff safety are our highest priority. But we believe there is a way to preserve that regulatory intent by allowing urgent care centers to continue to perform mobile x-rays, while adhering to the same quality and safety standards as hospital EDs. We have a long track record of excellent patient and staff safety, have a robust quality control program in place that meets or exceeds all recognized standards, and without our ability to obtain mobile imaging, a significant portion of these ~ 72,000 patients would either have ended up in an overburdened ED or potentially deferred receiving care entirely, leading to worse clinical outcomes and higher costs of care.

Thank you for the opportunity to speak to the committee today on this important issue to all NY'ers.

Primary Care Development Corporation

Primary Care Development Corporation Testimony
New York City Council Committee on Health
Oversight – Improving Access to In-Community and At-Home Health Care
March 30, 2023

Thank you to Chair Schulman, and to the committee for the opportunity to provide testimony today. My name is Joe Telano, and I am a Senior Policy Manager with the Primary Care Development Corporation (PCDC). Primary Care Development Corporation (PCDC) is a nonprofit organization and U.S. Treasury-certified community development financial institution located in New York City.

PCDC's mission is to create healthier and more equitable communities by building, expanding, and strengthening access to quality primary care through capital investment and practice transformation, as well as policy and advocacy. Since our founding in New York City in 1993, PCDC has leveraged more than $1.4 billion to finance over 218 primary care projects. Across the country, these strategic community investments have built the capacity to provide 4.6 million medical visits annually, created or preserved more than 19,362 jobs in low-income communities, and transformed 2.5 million square feet of space into fully functioning primary care and integrated behavioral health practices. In New York State specifically, we have worked with health care organizations, systems, and providers across the state on over 3,200 financing and technical assistance projects to build, strengthen, and expand primary care operations and services.

PCDC understands that primary care saves lives, leads to better individual and community health, and is central to health equity, and urges the Council to center primary care in its efforts to increase access to "in-community" health care.

I. The Importance of Primary Care

Access to primary care is a key social determinant of health recognized by the World Health Organization (W.H.O.) and the U.S. Healthy People initiative framework.[i] Regular access to primary care is associated with positive health outcomes, especially when addressing heart disease, the leading cause of death in New York State, and other common chronic conditions such as diabetes and asthma.[ii] In addition, primary care reduces overall health care costs and is the only part of the health system that has been proven to lengthen lives and reduce population level health disparities.[iii]

However, primary care remains overburdened and underinvested. The lack of focus on primary care in the American health system has been called a "medical emergency."[iv] That emergency was undoubtedly heighted by the COVID-19 pandemic, which further highlighted existing

disparities, as communities with less access to primary care before the pandemic experienced more COVID infections, severe illness, and deaths than communities with better access to primary care.[v]

There is an urgent need to re-orient New York's health care system towards primary care, investing in the care that will address long-standing health disparities, improve the health status of underserved communities across New York State and New York City, make New York's health system more effective now and help keep all New Yorkers protected in the future.

PCDC encourages the Council to review each health proposal within the budget to ensure that primary care providers, patients, and the primary care workforce in general are included and prioritized.

II. PCDC's Report on Primary Care Access in NYC Council Districts

With much appreciated support from this Council in 2020-2021, PCDC undertook research to identify the relationship between access to primary care and the impact of COVID-19. Unfortunately but unsurprisingly, **our research revealed that communities with less access to primary care before the pandemic experienced more COVID infections and COVID-related illness and deaths than communities with better access to primary care.**[vi] Our report on this research, *Primary Care Access and Equity in New York's City Council Districts*, was initially released in July 2021, is available on our website here and will be shared with any council member or the public by request.

As a result of the pandemic, we have also seen the deferral of necessary health care, which is leading to a crisis of its own and can subsequently put an increased burden on our hospitals. People are now coming back to primary care with more severe preventable diseases, including more advanced cancers, and a drop in childhood vaccinations that could impact children and communities for decades to come.[vii] These lapses might have been prevented if primary care had been included in the initial COVID-19 response.

We encourage members of the Council to reach out at any time for more information about primary care in New York City and in their districts.

III. The Role of Primary Care in Pandemic Planning and Preparedness

As we continue to navigate the COVID-19 pandemic, New York 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 the disparities that have been so starkly illuminated. Primary care not only keeps people healthy and protected against severe disease and reduces health disparities,[viii] but "the primary care sector has an essential role in public health emergency preparedness" [ix] as well.

Primary care's role in preparing for and mitigating public health emergencies is not a new phenomenon. Yet despite expert research and previous experience, the primary care sector was largely left out of early COVID-19 planning, service delivery, and mitigation efforts. Eventually, Federally Qualified Health Centers (FQHC) were included in the federal vaccine distribution plan, and PCDC was grateful to provide pass through funding to FQHCs to support vaccine outreach and distribution in New York City.

Much is already known about primary care providers' role in a pandemic. More than a decade ago, during the height of the H1N1 pandemic, PCDC and the Community Health Care Association of New York State (CHCANYS), working with DOHMH and New York City Emergency Management, developed the Primary Care Emergency Preparedness Network (PCEPN) in New York City. PCEPN's mission was to improve the ability of New York City's primary care sector to prepare for, respond to, and recover from health care crises, as well as to bring primary care representation to city government's emergency planning process.[x] In 2015, a study in the *American Journal of Public Health* evaluated the impact of PCEPN and found that:

> The primary care sector has an essential role in public health emergency preparedness. Facilities providing primary care can directly augment and support crises medical surges because they routinely deliver clinical care for a large segment of the population across a broad spectrum of medical services. Primary care facilities and practitioners can also provide adequate medical evaluation and care during large-scale events that exceed the limits of the typical emergency medical infrastructure in an affected community.[xi]

The study concluded that primary care providers who participated in the program, which included training and coordination with city officials and emergency planners, were more prepared to respond during a pandemic or other health crisis. The study also concluded that while "[p]artnership between public health and primary care is essential for effectively responding to and recovering from public health threats. . . [p]rimary care faces many challenges in preparing for emergencies including lack of resources and lack of communication with external stakeholders, such as public health agencies."[xii]

Unfortunately, the lessons learned from this program and report were not implemented or even recognized as policymakers confronted the COVID-19 pandemic. A 2020 report from the Council on Foreign Relations aptly described the role of primary care in a pandemic and the responsibility of policymakers to understand and support it, echoing the 2015 *American Journal of Public Health* findings, including that primary care systems:

> provide a ready infrastructure for disease surveillance, [] promote healthier populations by preventing and managing chronic illnesses that often worsen health outcomes from emerging infections. They nurture trust, cultivated in strong patient-provider relationships, which reduces the harm of medical misinformation and disinformation campaigns. Finally, they can bolster surge capacity during pandemics, particularly when patient volume spikes in emergency care settings. These multiple benefits suggest that greater investments in primary care should be a central element of any effort to strengthen the pandemic response capacity of the U.S. health-care system.[xiii]

Yet, policymakers failed to support or utilize primary care providers as key actors when the COVID-19 pandemic began. The Council on Foreign Relations noted that early on, "patients seeking medical attention for COVID-19 overwhelmed emergency rooms and urgent clinics," which should have resulted in additional support and funding directed to helping patients see primary care providers whenever possible to keep emergency rooms for those who were in critical condition. Instead, "funding and logistical support for family medicine, trauma surgery, pediatrics, and obstetrics and gynecology has remained stagnant,"[xiv] and for those providers dependent on "fee-for-service" visits, the deep decline in in-person visits made it nearly impossible for many primary care providers to maintain their services, especially before the relaxing of the telehealth regulatory framework.[xv]

The American Academy of Family Physicians (AAFP) has reached similar conclusions, noting to Congress in a June 2020 letter that "the most significant barrier to health system resilience is the lack of a long-term, objective and consistent support necessary for public health and primary care . . . any effort to prepare for future pandemic must include a clearly defined primary care strategy."[xvi] Moreover, AAFP noted that COVID-19, like many other respiratory illnesses, is most likely to be diagnosed by a primary care provider – data from 2018 indicate that while 260,000 patients are hospitalized with respiratory infections each year, 19.5 million patients with respiratory conditions are seen annually by primary care providers.[xvii]

PCDC encourages the Council to support a thorough review of primary care providers' experience in this pandemic, including not just health centers but also independent primary care practices and hospital-associated primary and ambulatory care facilities. This research could focus on the guidance primary care givers were provided with, if any, as well as access to PPE, emergency funds, testing materials, and finally, vaccines, so that we can learn from this pandemic, plan more effectively, and include all types of primary care providers from the beginning in the next pandemic or emergency.

IV. Supporting Restoring Article 6 Reimbursement and Primary Care Investment on the City and State level

A. Article 6

Article 6 is a critical source of state funding for city public health activities, potentially include pandemic preparedness in primary care, which is operationalized through a state partial reimbursement for city tax levy funding. However, several years ago, New York State cut New York City's reimbursement rate from 36% to 20%, the only jurisdiction targeted for this type of cut. This results in approximately $60 to 90 million less in State public funding for New York City annually. Those funds had been used for a range of public health programs. PCDC urges New York City to make up the funds for those programs, but also to continue to work with lawmakers in New York State to restore New York City's Article 6 reimbursement rate to 36%.

B. Primary Care Investment

A recent landmark report from the National Academies of Science, Engineering, and Medicine (NASEM) entitled *Rebuilding the Foundations of Health Care*, concluded that "[w]ithout access to high-quality primary care, minor health problems can spiral into chronic disease, chronic disease management becomes difficult and uncoordinated, visits to emergency departments increase, preventive care lags, and health care spending soars to unsustainable levels."[xviii] Despite its proven impact, primary care continues to be underfunded and undervalued. In the United States, primary care accounts for approximately 35% of all health care visits each year – yet only about 5 to 7% of all health care expenditures are for primary care services.[xix] In contrast, other similarly situated countries spend as much as 12-14% on primary care as a proportion of their total health care spending,[xx] at the same time as spending more on social services and social determinants of health.[xxi] Experts including the World Health Organization and the authors of the NASEM report have called on governments to "increas[e] the overall portion of health care spending in their state going to primary care."[xxii]

New York's per-person health care costs are higher than the national average, yet consistently ranks below many states in key health indicators such as low birth weight, preventable hospitalizations, and childhood immunizations, all of which can be improved with better access to primary care.[xxiii] Many parts of New York State lack an adequate number of primary care providers, leaving residents in those areas without a resource for prevention, early diagnosis and treatment of common health issues such as diabetes, hypertension and depression.[xxiv] The lack of sufficient funding for primary care impacts both patients and providers, leading to inadequate access, low-quality care, worse outcomes, and a burdened and burnt-out workforce that loses experienced professionals and has trouble attracting new ones.[xxv]

Almost 6.5 million New Yorkers live in HRSA-designated primary care Health Professional Shortage Areas, including many in the five boroughs.[xxvi] Projection analysis predicts a shortage of physicians of any specialty by 2030 in New York State, and the COVID-19 pandemic has only exacerbated health care worker burnout, including in primary care.[xxvii] Fewer medical graduates choose primary care in comparison to other specialties, in part because of disparate levels of anticipated income.[xxviii]

Investing more resources into primary care is a critical way to achieve the kind of robust health care system our communities deserve, including by expanding the number and diversity of providers who enter primary care and who accept new patients, including those with Medicaid coverage. This kind of investment can be through reimbursement and incentive payments but can also be in the form of capital.

One important step that New York City could take towards expanding access to care in New York City would be to conduct a study of existing FQHC locations, to identify whether there are areas in the City that would benefit from additional FQHC facilities. FQHCs are an essential source of care for low-income and uninsured New Yorkers and have a demonstrated impact on improving individual and community health. In 2021, PCDC conducted research on the role of FQHCs on COVID outcomes and concluded that "Federally-Qualified Health Centers help[ed] reduce community-level COVID-19 mortality."[xxix] **Given FQHCs direct role in helping keep communities healthy, identifying New York City neighborhoods that lack this critical source of care could help support efforts to draw capital investment to increase access, including potential City capital.**

PCDC urges the City Council to support policies that increase investment in primary care and to undertake research to truly understand where the need is greatest in order to help direct resources where they would do the most good.

V. Conclusion

In the last few years, PCDC has published research showing that: (1) the impact of COVID-19 fell hardest in New York City on communities that lacked access to primary care before the pandemic;[xxx] (2) that delays in accessing health care were associated with worse COVID-19 outcomes across the state; and (3) that communities in New York with more FQHCs had reduced COVID-19 mortality.[xxxi] Our research further drives home the point that without primary care access, communities will have worse health outcomes, both from COVID and other preventable diseases – in contrast, *with* access to quality primary care, communities are better protected both from COVID and many other health issues.

We welcome the opportunity to work with the Health Committee and the New York City Council to expand access to primary care for all New Yorkers, particularly for those in disinvested, underserved communities. Please contact Jordan Goldberg, Director of Policy, at jgoldberg@pcdc.org with any questions or to request additional information.

Thank you for your consideration of PCDC's recommendations.

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[vi] *See, e.g.* Primary Care Development Corporation, *Primary Care Access and Equity in New York's City Council Districts*, July 2021, *available for download at* https://www.pcdc.org/resources/nyc-council-district-primary-care-access-and-equity-report/.

[vii] Dave A. Chokshi & Mitchell H. Katz, *Emerging Lessons From COVID-19 Response in New York City*, JAMA Forum, April 20, 2020, *available at* https://jamanetwork.com/journals/jama-health-forum/fullarticle/2764817.

[viii] Barbara Starfield, *Primary Care And Equity In Health: The Importance To Effectiveness And Equity Of Responsiveness To Peoples' Needs*, 33 Humanity & Society 56 (2009), *available at* https://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-primary-care-policy-center/Publications_PDFs/A243.pdf; James Macinko, Barbara Starfield & Leiyu Shi, *supra note* 54; Leiyu Shi, Barbara Starfield, Robert Politzer et al., *supra note* 5; Lynn A Blewett, et al., *When a usual source of care and usual provider matter: adult prevention and screening*, 23 J. Gen. Intern. Med. 1354 (2008), *available at* https://pubmed.ncbi.nlm.nih.gov/18506542/.

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[xiv] *Id.*
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Erik Moeller
SE Malden St.
Portland, OR 97206

Subject: Make public access defibrillator data freely available via an improved Int. 0814-2022.

To whom it may concern:

I am writing in support of making precise location information for public access defibrillator data freely available. **Public access defibrillators save lives.** Open access to this data is essential so that anyone is empowered to build locator applications for diverse needs and audiences.

Spefific recommendations:

- Ensure that the data includes exact location information
- Ensure that the data is made available and routinely updated on an open data portal, such as https://opendata.cityofnewyork.us/data/
- Ensure a free and open license for the data, such as CC-0: https://creativecommons.org/publicdomain/zero/1.0/

Int. 0814-2022 provides a good foundation which can be further amended to ensure data about public access defibrillator is complete, up-to-date, and freely available.

Sincerely,

Erik Moeller

To the Committee on Health,

To begin, I would like to thank the Committee for taking proposed Int 501-A into consideration, as this is another positive step in the right direction for enabling safe and equitable transportation options for everyone. New York City has made tremendous strides over the last several years to improve its micromobility infrastructure; however, as you are aware, there are still ongoing issues that require such initiatives to be considered.

I am strongly in favor of this initiative for many reasons, as current services like 311 are not designed to deal with real-time issues, such as idling cars in the bike lane, which are often ephemeral yet still pose a high risk to cyclists. Based on NYC OpenData, from January 1st of this year to time of writing this testimony (March 24th) there have been **5,883** reports of illegal parking in the bike lane, which would gross an estimated **$1,029,525** in revenue at $175/violation. I can personally attest that many of the reports I file often contain multiple vehicles in a single report.

Although, I do agree some revisions need to be made, such as removing the bounty so there is no malicious intent in filing these reports, there are proposed changes that raise concern that we will only be creating loopholes for the current problem to persist without punishment, even if citizens are able to report them directly.

The primary example being the "**revised bill requires that the car be "unoccupied" when a report is filed, a change that is aimed at avoiding conflict."** Occupied or unoccupied, a cyclist would still be required to merge into motor vehicle traffic that is moving at varying speeds with vehicles that are at least **150x the weight of an average bicycle**. Based on many studies, "the speed and volume of motor traffic, width of a street, number of lanes, or presence of parked cars have a negative effect on cyclists' perceived safety" and unsafe cycling conditions are often cited as one of the primary deterrents for why people choose not to cycle.

In a study by Portland State University, "bike lanes typically have a neutral or positive impact on nearby businesses" as "walk-able or bike-able neighborhoods and commercial areas tend to attract a lot more foot traffic" and "pedestrians and cyclists tend to patronize business more frequently than drivers." This would not only potentially reduce the safety risks for cyclists but would also benefit our local economy in a positive way.

Please take the above data and research into consideration for the proposed revisions to Int 501-A and help make bike lanes safe for everyone.

Thank you,

John Goldgar

As a citizen trained in first aid and emergency response I would be willing and able to help someone having a heart attack if I knew where an AED was located, but as of right now if I see someone dying in the street because of one I can’t do anything except call 911, by the time paramedics get there it will likely be too late.

During the hearing, a DOHMH assistant commissioner mentioned concerns that AED users need training to use AEDs effectively. But bystanders (even untrained ones) who use AEDs on victims can save lives; "Application of an AED in communities is associated with nearly a doubling of survival after out-of-hospital cardiac arrest." Share that and similar research.

In the hearing, DOHMH said they don't have this data; they do have access to it via NYC REMSCO.

rod.esp.m.g@gmail.com

April 1, 2023

Honored members of the city council:

Thank you for considering this important issue. As an emergency medical technician in King County, I have seen firsthand the benefits of having AED data accessible by the general public. King County offers a queryable registry of AED locations, matching the location of patients who need them to the location of the nearest AEDs. This is part of a program to broaden the availability of AEDs to the general public and reduce the access time, saving lives. This program has been a wild success, and we have world-class save rates from cardiac arrest and related conditions, which you can read about here: https://kingcounty.gov/legacy/depts/health/emergency-medical-services/community/aed.aspx I would be delighted to see New York take similar proactive measures to protect its citizens and empower emergency responders and the general public alike to save lives effectively and efficiently during those crucial moments.

Very truly yours,
Raven Alder

Testimony in support of Int. 814-2022

New York City Council, Committee on Health

Public Hearing on March 30th, 2023

Improving Access to In-Community and At-Home Health Care

Sumana Harihareswara
PO Box 721160
Jackson Heights, NY 11372

Dear Committee on Health: April 2, 2023

Thank you for considering Int 0814-2022, "A Local Law to amend the administrative code of the city of New York in relation to requiring an annual report indicating the quantities and locations of automated external defibrillators placed in public places." I'm sorry I wasn't able to present oral testimony at the meeting on March 30th, and hope this written testimony can help you amend and support this bill.

I. My father's death, and wanting to be a good neighbor

I'm not a health care expert. I'm the daughter of S.K. Harihareswara, a man who died of a sudden heart attack thirteen years ago. And I'm a New Yorker who wants to be a good neighbor – that's why I took a CPR class a few years ago. The instructor taught us how to use automated external defibrillators (AEDs) and told us to look for public access AEDs around NYC. I thought it would be a good idea to learn the locations of the AEDs closest to my home and office, just as I'd like to know ahead of time where the emergency exits are in my building.

But I couldn't, because New York City doesn't publish its list of public AEDs.

That's why I started learning more about this topic, and asked Councilmember Krishnan's office to look into it. I want to have a better shot at being a good neighbor and helping prevent heart attack deaths, and I want all New Yorkers to have that better shot, too.

II. The context: why New Yorkers need AED location data to be public

A. AEDs can save lives – even untrained bystanders can use them

On average, when a New Yorker calls 911 because of cardiac arrest, emergency responders get to the scene in 10-11 minutes -- but **for every minute they don't get circulation back, the chance of survival goes down about 7-10%** (American Heart Association guidelines, 2010). The American Heart Association fact sheet on out-of-hospital cardiac arrest, "A Race Against The Clock" (attached to this testimony) explains what AEDs are and how effective they are:

> There are more than 357,000 EMS-assessed out-of-hospital cardiac arrests (OHCA) each year in the United States, and nearly 90 percent of OHCA's are fatal. Time is one of the most important factors in determining whether an individual experiencing cardiac arrest will survive. Victims of cardiac arrest who receive prompt medical attention including cardiopulmonary resuscitation (CPR) to increase the blood flow to the heart and brain and/or an electrical shock from a defibrillator to stop the abnormal heart rhythm are much more likely to survive than those who do not receive swift medical intervention....
>
> When CPR cannot restart normal heart rhythm during cardiac arrest, rescuers can also turn to automated external defibrillators (AEDs). An AED is a simple-to-use portable device that is used to shock the heart of a person suffering a cardiac arrest to return the heart to a normal rhythm. AEDs are available in a variety of public settings – from schools to offices to airports. Used by both trained emergency responders and bystanders, the AED is attached to the victim and delivers an electric shock when it detects a dangerous heart rhythm. The devices provide audible step-by-step instructions to the user and independently determine if a shock is needed, making them very easy for almost anyone to use.
>
> In cardiac arrest emergencies where bystanders used AEDs before emergency medical services arrived, patients were over two and a half times as likely to survive their cardiac arrest and had better functional outcomes than those who did not receive bystander defibrillation. Lay responders play a crucial role in achieving high survival rates....

AEDs are designed to be used safely and effectively without training. When a user applies an AED to a patient, the AED analyzes the patient's heart rhythm to check whether it'll respond well to shock, and won't deliver a shock if shocking won't help. This also prevents pranks or more serious misuse. Increasing New Yorkers' awareness of their nearest AEDs does not increase the risk of misuse.

During the hearing on March 30th, an assistant commissioner of New York City Department of Health and Mental Hygiene (DOHMH) mentioned concerns that people need training to use AEDs effectively. But **untrained bystanders can save lives**; researchers in 2010 found: "Success of 40% by lay persons emphasizes that speed is more important than training." As results from "Survival After Application of Automatic External Defibrillators Before Arrival of the Emergency Medical System" state,

> Survival was 9% when CPR was performed before EMS arrival, but an AED was not applied (Group 2). Of the cases in which an AED was applied before EMS arrival (Group 3), 24% (69 of 289) survived, and of those who received a shock from an AED applied before EMS arrival (Group 4), 38% (64 of 170) survived.....The survival of 38% with shock by a bystander using the AED should encourage broader awareness of the AED, which may prompt increased use by bystanders even for those lacking medical training.

More recently, "A Call to Shock" in 2019 (*The Lancet*) advises:

> median survival is even higher (53·0%, range 26·0–72·0) when a non-dispatched lay first responder administers public-access defibrillation, regardless of the qualifications of the individual performing it, which indicates how important early defibrillation is in the chain of survival.

B. Our public access AEDs are underused

The American Heart Association's current resuscitation guidelines say that "the use of public access defibrillators by lay rescuers remains low" and add:

> The key drivers of successful resuscitation from OHCA are lay rescuer cardiopulmonary resuscitation (CPR) and public use of an automated external defibrillator (AED). Despite recent gains, only 39.2% of adults receive layperson-initiated CPR, and the general public applied an AED in only 11.9% of cases.

New York City also follows this pattern, as far as we can tell, and may be doing far worse, with **only 2%** of out-of-hospital cardiac arrests getting AED application by a bystander. Also attached to this testimony is DOHMH's 2010 report on Public Access Defibrillator usage in New York City, which was the most recent data I could find on PAD usage in NYC. "Combining information from REMSCO and FDNY it may be concluded that PADs were deployed in 2% of all out-of-hospital cardiac arrests in NYC (i.e., 182 reported PAD uses out of 8,783 total cardiac arrests)." 150 of those uses were in nursing homes; only a handful of them were in NYC parks, government buildings, and similar places.

People can't use AEDs if they don't know they're there. In one 2016 study, of individuals who were about 100 meters from an AED in a public place (train station, city mall and public park), only 16% knew where the closest AED was. And the public OpenAEDMap is only aware of 5 AEDs in all of New York City.

We've already invested in ensuring that this safety equipment is placed where people can use it, but if they don't know it's there, then that investment is a waste.

C. Open data lets us do better outreach, education, and placement

Several US localities have published their AED locations as open data. Examples include: Washington, DC; Boise, Idaho; and Kansas City, Missouri.

Once the registry is public, DOHMH, Fire Department of NY, and other city agencies can fairly easily publish maps of AED locations, using existing City tools. Other municipalities and regions in the US do so and leverage those maps in their public health outreach efforts: see for example Contra Costa County, California, San Diego, California and Manatee County, Florida. This enables individual institutions to make and share targeted maps on their websites, such as this AED location list and map at the University of California, San Diego.

Other agencies, activists, local nonprofits, and schools can reuse that data to annotate local maps and make translated handouts for specific neighborhoods -- Bengali in Jackson Heights, Chinese in Flushing, and so on. This would particularly help low-English-literacy residents. Local health advocates can reuse this data to enrich their existing classes, mailings, first aid kits, and other outreach.

We can find "AED deserts," densely populated neighborhoods with very few public AEDs compared to the likelihood of cardiac arrest, and improve them. Councilmembers' offices could donate AEDs to local nonprofits in those neighborhoods, or work with local businesses. We could prioritize telling those local merchants' associations that there's a state tax credit for buying an AED ("The credit is equal to the purchase cost of the unit, or $500, whichever is less.") so the bodega on the corner can afford to keep an AED on hand.

Local organizers can follow the lead of the MyHeartMap challenge in Philadelphia and make a game to incentivize New Yorkers to take selfies with AEDs, learning their locations along the way.

Google, Apple, and other tech companies could integrate these locations into their map data, so if you ask "is there an AED nearby?" into your phone, it could tell you.

III. We have this data and can open it to the public

A. Who holds it and has access to it

New York City Council bill number 0211-2004 was enacted as Local Law No. 20 for the year 2005 (amending Chapter I of Title 17 of the New York City Administrative Code to add a new section § 17-188), mandating AEDs in some public places.

Per the New York State Department of Health policy statement 09-03 (2009) on Public Access Defibrillation, each regional emergency medical services council holds a PAD registry. In New York City, that is NYC REMSCO, a nonprofit organization. New PAD providers must file a "Notice of Intent to Provide Public Access Defibrillation" (NY State Department of Health form #4135) and a Collaborative Agreement (sample) with NYC REMSCO, and inform NYC REMSCO within 48 hours of a PAD AED usage. Also, "A written Site-Specific Response and Maintenance Plan, including written practice protocols, is required and must be made available to the DOHMH upon its request" (per DOHMH's PAD fact sheet provided by NYC REMSCO). NYC REMSCO also requires that the PAD provider file a new Collaborative Agreement every two years.

NYC REMSCO shares AED locations with 911 dispatchers. If someone calls and reports a cardiac arrest, the 911 operator can advise callers if there's a PAD at or near the address they're calling from. The dispatcher can say: "You keep doing CPR, but if someone else is there who can run a block to [x location], they can grab their AED."

Per DOHMH's 2006 report on Local Law 20 and PAD usage, NYC REMSCO has "an online registration system intended to facilitate registration, reduce paperwork, and improve the

scope and accuracy of future reporting to City Council", and this was developed in coordination with DOHMH.

The Fire Department of NY (FDNY) developed and advertised a mobile app, "Be 911", to help bystanders perform CPR. While guiding the user through CPR, the app also used data from the NYC PAD registry to tell the user about the 3 AEDs nearest the user's location. While "Be 911" was last released in 2019, this does demonstrate that the PAD registry data is available in a digital form, and that FDNY has digital access to it.

B. The PAD registry includes addresses, usage, and category of location

During the March 30th hearing, Councilmember Krishnan asked several questions about the PAD registry: "Does DOHMH currently have a framework or list of the location of all AEDs in New York City? Is there an existing system that keeps track of the number of AEDs that have been issued and to whom? Is there an exact number or estimate on how many AEDs are currently available in public places in New York City?"

The PAD registry does answer these questions for public access AEDs. The PAD registry includes:

- the street addresses of buildings with AEDs
- the "agency" type ("agencies" including "Physician's Office", "Transportation Hub" "Stadium", "Business" and other categories)
- the number of trained providers and AED units at each location

The PAD site is also responsible for documenting each use of the AED and immediately reporting such usage to NYC REMSCO in accordance with NY State Public Health Law §3000-b, per NYS DOH BEMS policy statement 09-03.

Councilmember Krishnan also asked: "Is there a maintenance system in place to regularly check on the condition of AEDs? Do we know how many AEDs are in good working condition and ready for use in the event of an emergency?"

NY State Public Health Law §3000-b says that "The public access defibrillation provider shall cause the automated external defibrillator to be maintained and tested according to applicable standards of the manufacturer and any appropriate government agency." However, to the Councilmember's point, I believe there is no pre-emptive inspection program run by NYC, NYS, or NYC REMSCO.

C. NYC OpenData can host this data

Kansas City, Missouri publishes its AED location data in an open data portal similar to NYC OpenData (I believe they use the same data portal software platform). The dataset they publish has eight fields:

1. AED Owner (the organization in charge of the site)
2. AED Manufacturer
3. AED Model
4. AED Serial #
5. AED Street Address
6. ZIP code
7. AED Physical Location (a more specific location: for example, "On wall between shop and office")
8. AED Geocoded Location (the street address, automatically translated into latitude and longitude for use in mapping software)

NYC OpenData can easily accommodate and display this number of fields, and can handle the number of PAD registrations, as you can see from the restaurant inspections data (27 fields) as an example. We may not even need to publish the AED manufacturer, model, or serial numbers, nor provide a geocoded location since mapping software can generally perform this translation itself. And the size of the dataset won't be a problem, either. As of the 2010 DOHMH report, NYC had less than 6 thousand PADs registered; the restaurant inspection dataset covers more than 200,000 inspections.

NYC OpenData already holds a dataset of AED locations under the oversight of the Parks Department.

Conclusion

Too many New Yorkers die when AEDs could have saved them. And this is more important than ever: COVID has weakened many New Yorkers' cardiovascular systems, and led to more heart attacks. Let's get this data where more people can get at it.

Please let me know if additional information would be helpful. Thank you.

Sincerely,

Sumana Harihareswara

Jackson Heights, NY

written April 2, 2023

Appendices:

American Heart Association fact sheet, "A Race Against The Clock"

NYC DOHMH 2010 PAD report

FACT SHEET

A Race Against the Clock
Out-of-Hospital Cardiac Arrest

OVERVIEW

Cardiac arrest occurs when the heart malfunctions and abruptly stops beating. While it is often confused with a heart attack, cardiac arrest is caused by an electrical malfunction in the heart that prevents the heart from beating normally. A heart attack is caused by a circulation problem in the arteries that prevents blood from reaching the heart. Not all heart attacks cause cardiac arrest, however heart attack is a significant risk factor associated with cardiac arrest.[1,2]

There are more than 357,000 EMS-assessed out-of-hospital cardiac arrests (OHCA) each year in the United States, and nearly 90 percent of OHCA's are fatal.[3] Time is one of the most important factors in determining whether an individual experiencing cardiac arrest will survive. Victims of cardiac arrest who receive prompt medical attention including cardiopulmonary resuscitation (CPR) to increase the blood flow to the heart and brain and/or an electrical shock from a defibrillator to stop the abnormal heart rhythm are much more likely to survive than those who do not receive swift medical intervention. Research suggests cardiac arrest victims who receive CPR immediately have double to triple the survival rates of those who do not.[4] Accordingly, cardiac arrests that occur outside the hospital are significantly more deadly than in-hospital cardiac arrests (IHCA)—nearly 2.5 times as deadly in adults and almost 4 times as deadly in children[3]—as those experiencing OHCA are not surrounded by medical professionals that can provide them with aid.

Education about and awareness of cardiac arrest and the importance of providing immediate medical aid can help improve survival outcomes. Unfortunately, public surveys[5,6] suggest a general lack of awareness about cardiac arrest and the need for prompt medical intervention. Even those among the public who are aware of cardiac arrest and the benefit of providing early invention may not do so because of lack of confidence in administering aid, concerns about hurting the victim, a belief that someone else may be able to provide aid more effectively, and personal liability.[6] Providing education about cardiac arrest and training in intervention techniques that are accessible to lay people can improve the likelihood that cardiac arrest victims are identified and provided with the assistance they need to survive.

WHAT IS CARDIAC ARREST?

The human heart has a complex electrical system that regulates and synchronizes the beating of the heart. When this system malfunctions, the heart can be sent into a dangerously erratic rhythm that prevents blood from pumping normally and can lead to cardiac arrest. Unlike the heart attack victim who may exhibit early warning symptoms, such as chest pain or shortness of breath, cardiac arrest strikes without warning. One minute a person may feel fine, and the next be unconscious and close to death.

CAUSES AND RISK FACTORS

Cardiac arrest may occur in individuals with no known history of heart disease.[7] However, heart conditions, including those that are undiagnosed, are often the causes of cardiac arrest.[7] Risk factors of cardiac arrest include:[8]

- Abnormal heart rhythms (arrhythmias)—like ventricular tachycardia, ventricular fibrillation, or bradycardia
- Scarring of heart tissue—due to prior heart attack or other heart trauma
- Thickened heart muscle (cardiomyopathy)—due to high blood pressure or heart valve disease
- Heart medications—including those that are prescribed to prevent arrhythmias
- Electrical abnormalities in the heart—like Wolff-Parkinson White syndrome and Long QT syndrome
- Blood vessel abnormalities
- Use of certain recreational drugs like cocaine or amphetamines

WHO SUFFERS CARDIAC ARREST?

While adults are more likely to suffer cardiac arrest than children, cardiac arrest can affect anyone, regardless of age.[3] Cardiac arrest mortality is high among very young children (<1 year old). Cardiac arrest decreases from ages 1 to 14 and increases each subsequent year from age 15 onward.[3] The mortality rate from cardiac arrest has declined in the past 20 years.[3]

Rates of cardiac arrest also display historical patterns of health disparity. Research suggests racial and ethnic minorities like blacks and Hispanics suffer higher rates of OHCA than their white counterparts.[3] Meanwhile, OHCA rates in lower socioeconomic census tracts are higher than rates in higher socioeconomic census tracts.[3]

SURVIVING CARDIAC ARREST

Treatment of cardiac arrest is a race against the clock. The combination of early, immediate CPR and defibrillation can significantly improve a victim's chance of survival.

The American Heart Association recommends implementing the **Chain of Survival**[9] to rescue cardiac arrest victims:

- Immediate recognition of cardiac arrest and activation of the emergency response system
- Early CPR with an emphasis on chest compressions
- Rapid defibrillation if indicated
- Basic and advanced emergency medical services
- Advanced life support and post- cardiac arrest care

TRAINING CURRENT AND FUTURE LIVESAVERS

Administration of CPR is critical to the survival of victims of cardiac arrest. Unfortunately, not enough people are able to deliver effective CPR. Expanding the population of bystanders-turned-rescuers through training and education can help empower non-medical professionals to identify the signs of cardiac arrest and act to assist victims.

A growing body of research is exploring what aspects of training and education will affect the willingness of bystanders to intervene in cardiac arrest emergencies, provide quality medical intervention, and improve patient outcomes.[4] Evidence suggests both instructor-led and/or self-directed CPR training sessions with real-time or delayed feedback can be effective at preparing bystanders to respond to cardiac arrest.[4] Periodic refresher training courses that focus on developing skills and confidence to intervene are also beneficial.[4] Traditional CPR training teaches both compression and ventilation techniques, but newer evidence suggests compression only CPR training may also be appropriate and effective.[4]

In the fall of 2017, there were 59.5 million students enrolled in public, public charter, or private primary or secondary schools.[10] With the proper training and education, these millions of students represent an enormous population of bystanders-turned-rescuers. Universal CPR training in high schools can teach a substantial portion of the population how to deliver this lifesaving technique and help increase the likelihood that individuals suffering a cardiac arrest will receive high quality CPR. As of 2018, thirty-eight states and Washington, DC require CPR training as part of their high school curriculum.[11] Still, there are 12 states that do not require such training. Training students in every state across the country in CPR will fill schools, as well as entire communities, with lifesavers.

GREATER ACCESS TO AEDS

When CPR cannot restart normal heart rhythm during cardiac arrest, rescuers can also turn to automated external defibrillators (AEDs). An AED is a simple-to-use portable device that is used to shock the heart of a person suffering a cardiac arrest to return the heart to a normal rhythm. AEDs are available in a variety of public settings – from schools to offices to airports. Used by both trained emergency responders and bystanders, the AED is attached to the victim and delivers an electric shock when it detects a dangerous heart rhythm. The devices provide audible step-by-step instructions to the user and independently determine if a shock is needed, making them very easy for almost anyone to use.

In cardiac arrest emergencies where bystanders used AEDs before emergency medical services arrived, patients were over two and a half times as likely to survive their cardiac arrest and had better functional outcomes than those who did not receive bystander defibrillation.[12] Lay responders play a crucial role in achieving high survival rates, and more AEDs and CPR training for these individuals are needed to provide this life-saving treatment. Despite widespread public support for increasing federal funding for cardiac arrest research, education and treatment, such funding has been cut.

THE ASSOCIATION ADVOCATES

The American Heart Association advocates for a comprehensive approach to addressing out-of-hospital cardiac arrest, including:

- Greater research into its underlying causes.
- Improved data collection on out-of-hospital cardiac arrest; how it affects different populations; and the effectiveness of treatment methods.

- Promoting the use of recognized emergency medical dispatch protocols and appropriate quality improvement programs among 911 dispatch agencies to assure that bystanders promptly receive effective CPR coaching and support for efforts to train dispatch personnel to provide pre-arrival medical instructions.
- Supporting legislation and policies that encourage bystander CPR, including requiring all students to be trained in CPR and AED prior to graduating from high school.
- Championing public policy initiatives that promote the development of Medical Emergency Response Plans (MERPS), which includes placing AEDs in public places where cardiac arrest is likely to occur.
- Advocating for funding the *Rural and Community Access to Emergency Device Program* at the FY 2005 level of $9 million annually, so that more lives can be saved each year.
- Extending Good Samaritan law coverage to all AED users and program facilitators.
- Increasing public awareness of out-of-hospital cardiac arrest and its causes through activities such as CPR and AED Awareness Week each June.[1]

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2010 Report to City Council on Local Law 20 of 2005: Public Access Defibrillator Use In New York City

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Thomas Farley, MD, MPH
Commissioner

July 7, 2010

Prepared by the
Division of Health Promotion and Disease Prevention
Bureau of Chronic Disease Prevention and Control
Cardiovascular Disease Prevention and Control Program

Executive Summary

In March 2005, the New York City Council enacted Local Law 20 (LL20) requiring the placement of Automated External Defibrillators (AEDs) in specific public places. This is the 5th and final report of the quantities and locations of AEDs in New York City (NYC) as required by LL20. Other registered AEDs in NYC are also described. Finally, the impact of LL20 on saving lives is considered.

New York State (NYS) law requires that all AEDs that are placed in a publicly accessible area in NYC, otherwise known as 'public access defibrillators' (PADs), be registered with the Regional Emergency Medical Services Council of New York City, Inc. (REMSCO). REMSCO reports that as of May 31, 2010, 5,492 PADs are registered. Last year at this time, there were 5,296 registered PADs.

All non-governmental entities and city agencies mandated under the law, including the Department for the Aging, Department of Citywide Administrative Services, Department of Parks and Recreation, Department of Transportation, and NYC Health and Hospitals Corporation report to Department of Health and Mental Hygiene (DOHMH) that they have met the requirements of the regulations.

There were 182 documented PAD uses reported to REMSCO for the period of June 1, 2009 through May 31, 2010. During this time period, the Fire Department of New York (FDNY) reported a total of 8,783 out-of-hospital cardiac arrests. While acknowledging gaps in the existing data, the reported data shows that only 5 out of the 8,783 out-of-hospital cardiac arrests were responded to by use of a PAD required pursuant to the requirements of LL20. It was reported to DOHMH that the outcome of 1 of these uses was patient survival to hospital discharge with meaningful neurological function. However, patient outcome associated with the remaining 4 uses is unknown due to limitations of available data.

The City is preempted by NYS Public Health Law Sections 2812 and 2801 from enacting and enforcing any regulations for hospitals, which by definition includes private nursing homes. NYS does not currently require PADs in nursing homes although many have registered devices. While survival from out-of-hospital cardiac arrest associated with PAD use in nursing homes is not available locally, data included in this report show that nursing homes represent the single most reported location of PAD use in NYC.

It is well documented that PADs located in high traffic areas (e.g., airports, other transportation hubs) and in places where people at a high risk for sudden cardiac arrest live or congregate (e.g., nursing homes, senior centers) have a higher likelihood of saving lives and supports targeted PAD placement in these locations. One recent study estimates that PADs placed in locations with at least a 12% annual likelihood of use can be a good investment.

AEDs are currently in use by FDNY, the New York City Police Department (NYPD), Port Authority Police Department (PAPD) and in other private settings. FDNY maintains AEDs on most fire trucks, NYPD utilizes AEDs within many of its units, and PAPD maintains AEDs at the airports, with some patrol units and at some PATH train hubs. Considered in combination with LL20 mandated placement, DOHMH recommends no further expansion of existing PAD placements under local authority. The DOHMH does recommend mandated PAD placement in private nursing homes; however such a requirement could only be enacted at the state level.

Report on Local Law 20 of 2005:

Public Access Defibrillator Use in New York City Since Implementation

Attachments:

- Local Law 20, 2005
- NYC DOHMH Rule Implementing Section 17-188 of the Administrative Code Requiring Placement of Automated External Defibrillators in Certain Public Places
- New York State Public Health Law §3000-b

1.0 Introduction

In March 2005, the New York City Council enacted Local Law 20 (LL20) requiring the placement of Automated External Defibrillators (AEDs) in specific public places. LL20 also mandated that the New York City Department of Health and Mental Hygiene (DOHMH) provide a report on the quantities and locations of AEDs following the first year of enactment and annually thereafter until 2010. Now at the completion of year five of LL20's enactment, and in accordance with this mandate, we submit this fifth and final report for the reporting period of June 1, 2009 through May 31, 2010.

LL20 and the DOHMH rules state that any AED acquired, possessed and operated, be done so in accordance with New York State Public Health Law §3000-b (NYS PHL §3000-b). NYS PHL §3000-b requires registration of the devices with the Regional Emergency Medical Services Council of New York City, Inc. (REMSCO) before they can be in public settings.

LL20 requires AEDs in specific public places that may be used by non-medical personnel and NYS PHL §3000-b describes the requirements governing this type of AED placement. Sites covered by LL20 that offer a higher level of emergency care are exempt from the AED requirement (e.g. stadia that provide a higher level of emergency medical care during events). Neither LL20 nor NYS PHL §3000-b cover the use of AEDs as part of medical response by emergency medical systems (EMS) personnel, including emergency medical technicians and paramedics, nor does it govern the use of AEDs in medical facilities that have more advanced levels of medical care.

LL20 requires first, that all entities covered under LL20 must possess and place AEDs with the required signage for their specific type of establishment as set forth in Section 24-04 of NYC Administrative Code 17-188. Secondly, all AEDs must be registered in accordance with New York State law per section 24-05 of the NYC Administrative Code 17-188. Possession of an AED and registration with REMSCO is self-reported by all entities covered by LL20 in this report. To register, the entity needs to submit a site-specific response plan including deployment location(s), location of signage, training of staff, medical oversight, emergency response and maintenance procedures and all procedures for documentation of usage. The site specific response plan is submitted to REMSCO with the initial and all subsequent registrations. All AEDs must be registered every two years. Additionally, any use of AEDs in the covered entities is also self-reported to REMSCO. Mandated sites which are not pre-empted by state law and therefore covered by LL20 include the following facilities: DCAS buildings, Parks, golf courses, DOT ferry terminals, HHC nursing facilities, stadia, arenas and DFTA senior centers.

Throughout this report, AEDs that are placed in publicly accessible areas and may be used by a lay rescuer are referred to as 'public access defibrillators' (PADs).

Although not mandated by the LL20 reporting requirement, limited available data from REMSCO and the Fire Department of New York (FDNY) on AED uses and outcomes is also reported here in an attempt to assess the impact of this law. For those readers

becoming newly acquainted with LL20, the original legislation and the related the DOHMH regulation is attached.

See attachments:

- Local Law 20, 2005
- NYC DOHMH Rule Implementing Section 17-188 of the Administrative Code Requiring Placement of Automated External Defibrillators in Certain Public Places
- New York State Public Health Law §3000-b

2.0 Data Sources

PAD location, quantity, use, and cardiac arrest data in this report come from the following sources:

The Regional Emergency Medical Services Council of New York City, Inc. (REMSCO) - REMSCO is designated by NYS PHL §3000-b to accept and maintain registration documentation for PADs within NYC and to maintain records on all PAD use. The time period for data included in this report is 6/1/2009-5/31/2010.

LL20 covered entities – Data was supplied to DOHMH by all affected city agencies. In addition, DOHMH contacted all 24 covered government and non-government entities by phone for their self-report on meeting the requirements of LL20.

The Fire Department of New York (FDNY) Division of Emergency Medical Services (EMS), Office of Medical Affairs - This office maintains records on all patients entered into the municipal 911-EMS system. Limited data on all out-of-hospital cardiac arrests in NYC was made available for this report for the time period of 6/1/2009-5/31/2010.

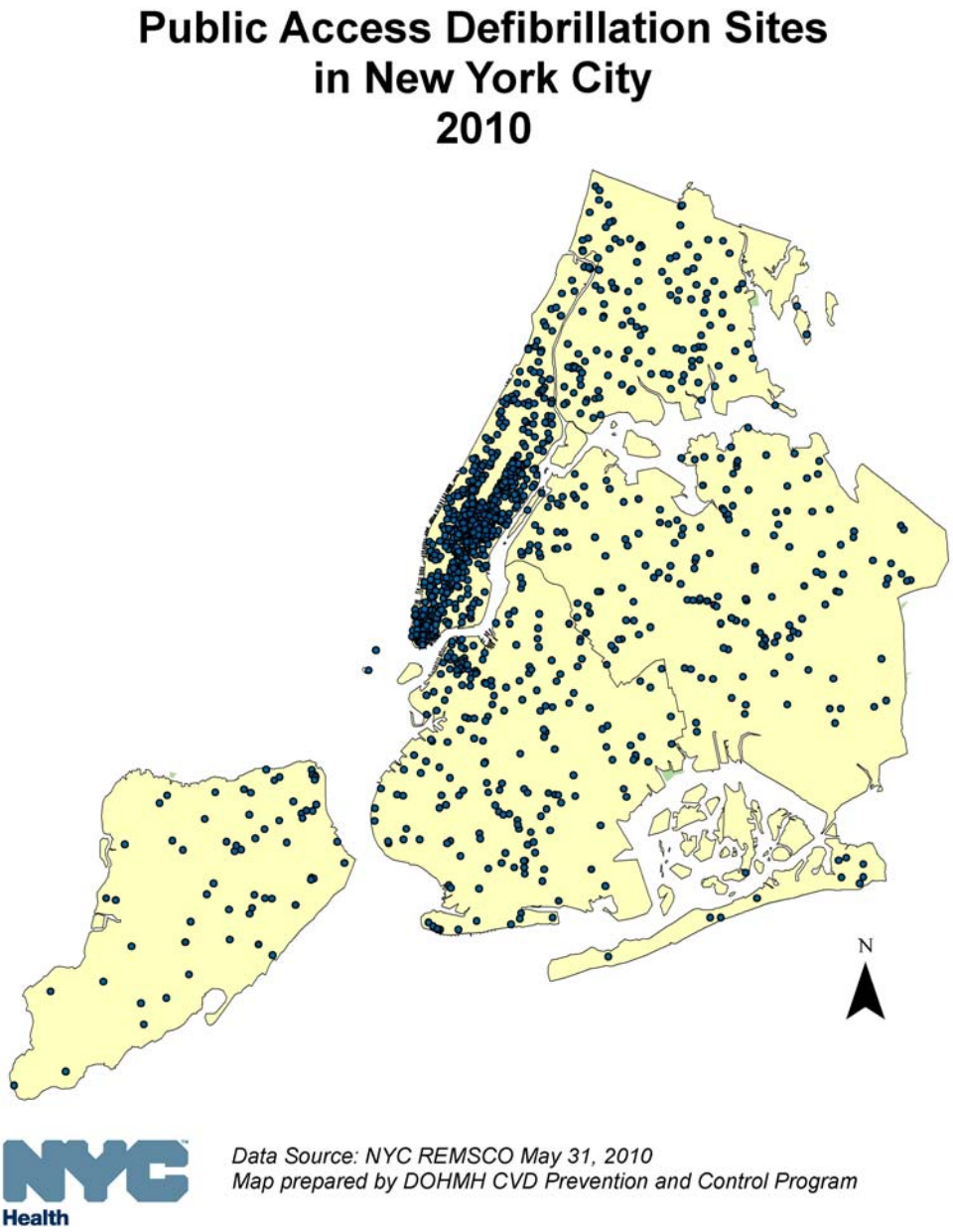
3.0 PAD Locations

3.1 PAD Quantities and Locations

According to REMSCO data, 5,492 PADs are registered throughout the five boroughs. During this reporting period, a total of 196 new PADs were registered with REMSCO. None of those newly registered are required under LL20, but some may have been placed by NYC Agencies. It is estimated that 554 PADs are covered by LL20.

3.3 Map of all PAD Locations Registered in NYC (includes those not required by LL20)

The following map displays all registered PAD locations in NYC as reported by REMSCO. Boundaries represent the borough districts and each blue dot represents a PAD site. Multiple PADs may and in some cases do exist at one location or address. Registered PAD sites in NYC are most concentrated in Manhattan.



Note: *This represents only PAD sites and does not include AEDs used by medical personnel in an official emergency response capacity. While all AEDs maintained by the Department of Education are registered with REMSCO, this map does not include these locations.*

3.4 Non-Government Locations Covered by LL20

Stadia and Arenas
Fifteen NYC stadia and arenas report to DOHMH that they have placed PADs on the premises and report that they meet all the requirements of LL20. Six NYC stadia and arenas report to DOHMH that they offer a higher level of medical care when events are held thus requiring no PAD and report that they meet all the requirements of LL20.

Private Golf Courses
The 3 private golf courses in NYC report to DOHMH that they have placed PADs on the premises and report that they meet all the requirements of LL20. All other golf-courses in NYC are operated by the Department of Parks and Recreation (Parks) as discussed in section 3.5 below.

3.5 City Agency PAD Placement Covered by LL20

Department for the Aging
As outlined in LL20, the Department for the Aging (DFTA) is required to maintain PADs at senior centers serving 3 or more meals per week. DFTA reports to DOHMH that they have 314 locations that meet these criteria and have placed a total of 314 PADs in those locations and report that they meet all the requirements of LL20. DFTA reported 316 locations in the prior reporting period.

Department of Transportation
As outlined in LL20, all ferry terminals owned and operated by the City and served by ferry boats with a passenger capacity of 1,000 or more are required to have PADs. DOT reports to DOHMH that they have placed 38 PADs and reports that they meet all the requirement of LL20. There have been no changes to the numbers and locations of PADs placed by the Department of Transportation (DOT).

Department of Parks and Recreation, including Public Golf Courses
As outlined in LL20, the Department of Parks and Recreation (Parks) is required to identify six parks in each borough where devices will be placed and that at least one of these parks in each borough be over 170 acres in size. Parks reports to DOHMH that they have placed PADs in a minimum of 10 parks in each borough and reports that they meet all the requirements of LL20. Additionally, public golf courses are required to have PADs. Parks reports to DOHMH that they have placed PADS in all golf courses within the Parks system and reports that they meet the requirements of LL20. Parks also reports that it is in the process of placing and registering an additional 20 AEDs at public beaches. These placements are in response to the amendment of Section 225 of the NYS Public Health Law, Subpart 6-2, which requires at least one AED at each ocean surf beach.

Borough	Number of Parks with PADs	Total Number of PADs in Parks
Bronx	12	12
Brooklyn	12	12
Manhattan	18	22
Queens	10	10
Staten Island	13	14
Citywide	65	70

Data Source: NYC Parks Department, 2010

Department of Citywide Administrative Services

As outlined in LL20, the Department of Citywide Administrative Services (DCAS), Division of Facilities Management and Construction is required to have PADs in all places in its buildings where the public is regularly invited or permitted on most business days and which do not require an appointment or special authorization or permission to gain admission. DCAS reports to DOHMH that they have placed a total of 112 PADs, throughout their facilities and reports meeting all the requirements of LL20. This is up from 110 during the previous reporting period. DCAS reports both number of buildings covered and number of PADs since many of the covered buildings have more than one PAD to meet the requirements of the NYC Administrative Code 17-188.

Borough	Number of DCAS Buildings with PADs	Total Number of PADs in DCAS Buildings
Bronx	6	13
Brooklyn	11	20
Manhattan	22	52
Queens	7	16
Staten Island	7	11
Citywide	53	112

Data Source: NYC Department of Citywide Administrative Services, 2010

NYC Health and Hospitals Corporation-run Nursing Homes

LL20 covers only NYC Health and Hospitals Corporation (HHC) -run nursing facilities of which there are 3. One of these facilities reports to DOHMH that they have 24-hour advanced life support on the premises and is therefore exempt from the LL20 requirement The remaining two facilities both report to DOHMH that they have placed PADs on premises and report meeting all the requirements of LL20.

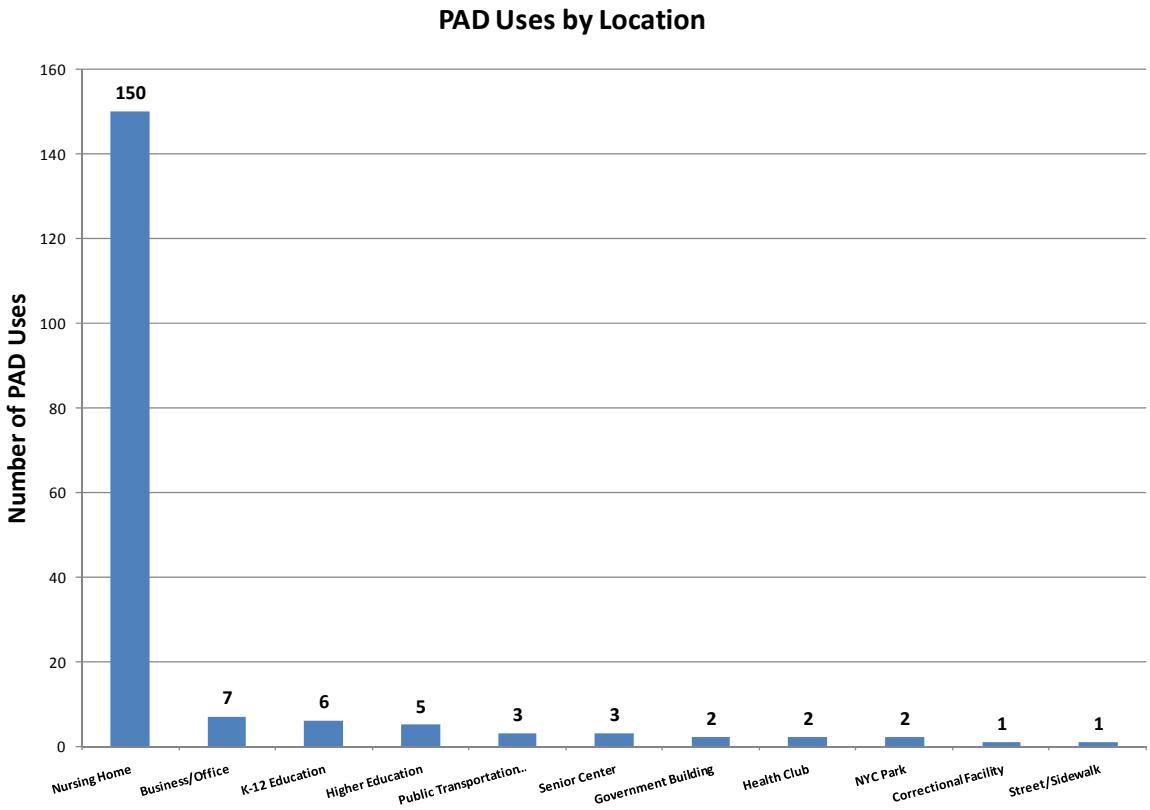
4.0 LL20 Complaints from the Public

Under normal procedure, 311 calls regarding AEDs or complaints about facilities not having AEDs are routed to the Cardiovascular Disease Prevention and Control program of the DOHMH. Complaints regarding a health club or other facility not covered by LL20 but covered by New York State law are referred to the to the New York State Attorney General's Office. In addition, DOHMH contacts the facility, notifies them of the complaint and sends information explaining NYS PHL §3000-b and their obligations under it. During the June 1, 2009 through May 31, 2010 reporting period, DOHMH received no complaints from the public regarding AEDs.

5.0 PAD Uses

5.1 REMSCO Reported PAD Use by Location in New York City

REMSCO receives reports of PAD use in NYC and DOHMH requests use data from REMSCO.

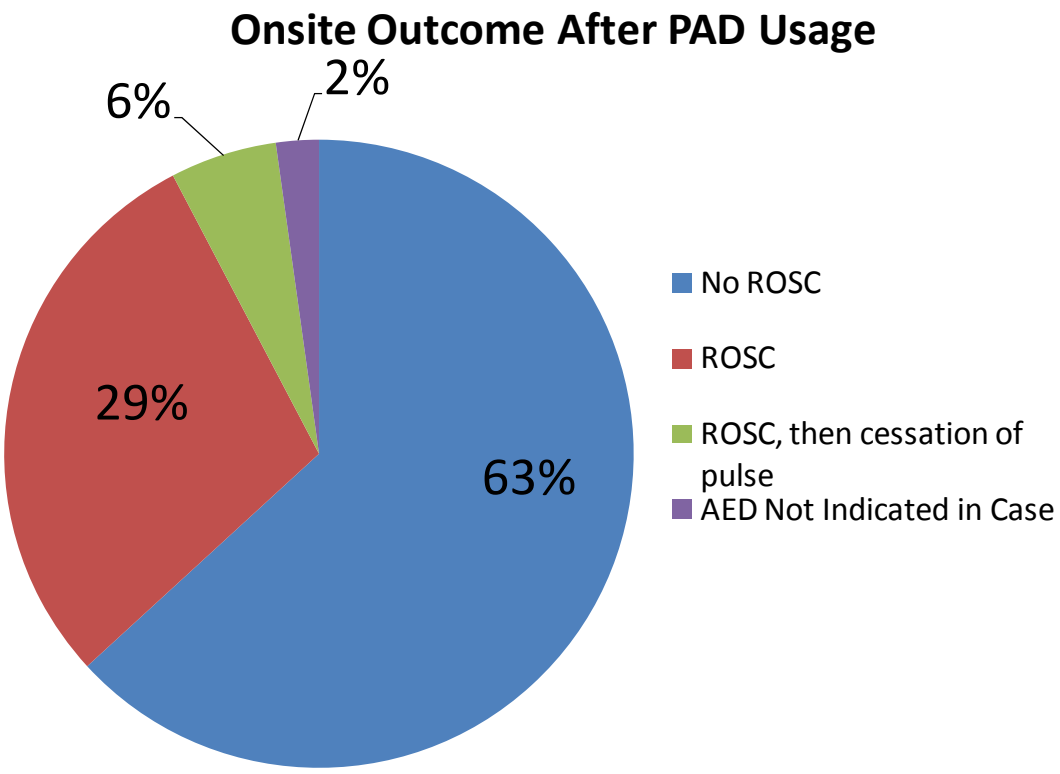


Data Source: Regional EMS Council of New York City, data from June 1, 2009 – May 31, 2010 (Includes LL20 mandated and non-mandated entities)

A total of 182 PAD uses were reported to REMSCO from 6/1/2009 – 5/31/2010. PAD use in nursing homes made up the majority (150/182) of uses reported to REMSCO during this reporting period, similar to prior reporting years. However, only 3 of the estimated 178 nursing homes in NYC are covered by LL20 since the law only applies to HHC-run nursing facilities. All the reported uses in nursing homes during this period were in private nursing homes.

5.2 REMSCO Data on Return of Spontaneous Circulation

REMSCO PAD use data report on return of spontaneous circulation (ROSC), defined as a return of a pulse when it had been reported as absent prior to PAD use. ROSC related outcomes reported here are categorized as follows: 'ROSC', 'No ROSC' and "ROSC & Subsequent Cessation of Pulse." Additionally, supplemental documentation indicated that there were several cases, initially categorized as ROSC, where an AED was applied to a patient who had not lost circulation. These cases were re-categorized and are represented as "AED not indicated" in the accompanying graph



Data Source: Regional EMS Council of New York City, June 1, 2009 – May 31, 2010

According to REMSCO data, of the 182 uses of registered PAD use, 115 (63%) uses were associated with no ROSC, 53 (29%) were associated with ROSC, 10 (6%) were associated with ROSC, then cessation of pulse, and 4 (2%) were cases where AED was not indicated. REMSCO does not collect information on long-term outcome (e.g. survival to hospital or survival to hospital discharge) therefore actual survival rates associated with use cannot be reported.

5.3 Impact of LL20

During the period from 6/1/2009 to 5/31/2010, use was reported in 5 LL20 mandated PAD placement locations. Of these 5 reported uses, three were in senior centers and 2 were in NYC Parks. DFTA reported to the DOHMH that 1 of the 3 uses that occurred in a senior center resulted in ROSC and regaining of consciousness immediately after use and a subsequent survival to hospital discharge with minimal to no lasting neurological deficits. The outcomes from the 4 additional uses are unknown due to data limitations.

FDNY provided to the DOHMH EMS data on out-of-hospital cardiac arrests in NYC. The following chart displays the number of out-of-hospital cardiac arrests occurring during the 12 month period from 6/1/2009-5/31/2010.

Out-of-Hospital Cardiac Arrests Responses by FDNY	
Category	**Citywide Totals**
Transported	4,359
Transported with ROSC*	1,446
Not Transported (Deceased on Scene)	2,978
Total Cardiac Arrests	**8,783**
* ROSC defined as 'Return of Spontaneous Circulation'	

911-EMS Data, *June 1, 2009 – May 31, 2010*
Data Source: Fire Department of New York, Office of Medical Affairs, 2010

Combining information from REMSCO and FDNY it may be concluded that PADs were deployed in 2% of all out-of-hospital cardiac arrests in NYC (i.e., 182 reported PAD uses out of 8,783 total cardiac arrests). Since 5 of the 182 reported uses were from LL20 covered entities, it may further be concluded that 5 out of 8,783 or 0.06% of out-of-hospital cardiac arrests were responded to with a PAD required and placed in accordance with LL20.

6.0 Data Limitations

Data utilized for this report has limitations. First, because possession of a PAD is self-reported by the covered entity, we are unable to determine if all PADs in NYC are registered with REMSCO as required. Therefore the total number of devices reported to us by REMSCO may underreport the true total in place in NYC at large. Second, because the use of PAD is also self-reported by the covered entity to REMSCO, we are unable to determine if all PAD use is appropriately reported and may therefore also be underreported.

REMSCO data includes report of 'return of spontaneous circulation' (ROSC) following PAD use, but provides no further information on individual outcome, such as survival to discharge from the hospital. To provide context for the overall potential impact of PAD use in NYC, this report also includes available data from FDNY. FDNY maintains records from the patient care reports generated by their electronic documentation system. These data report on out-of-hospital cardiac arrests responded to by EMS personnel and includes detail on EMS transport to hospitals and ROSC during pre-hospital resuscitation attempts. While this provides an estimate of the total number of out-of-hospital cardiac arrests in NYC, only outcome in the field is reported; survival to hospital or survival to hospital discharge data is not reported.

7.0 Conclusions

LL20 mandated the placement of PADs by both public and private entities. As described, city agencies specified in LL20, which include DCAS, DFTA, Parks and DOT report to DOHMH that they have met the requirements of the law. Additionally, HHC-run nursing facilities, as well as all private and public golf courses and all stadia and arenas in NYC also report meeting all the requirements of LL20.

There were 8,783 out-of-hospital cardiac arrests in NYC over the time period covered by this report. There were 182 reported PAD uses in NYC of which 5 were in facilities which are currently covered by the LL20 mandate. It was reported to the DOHMH that the outcome of 1 of these uses resulted in survival to hospital discharge with no known neurological deficits. The outcomes associated with the remaining 4 uses are unknown.

It is paramount that our public health interventions include evidence-based initiatives designed to significantly reduce cardiovascular disease related death and illness at the population level and that evaluation of these programs are ongoing to assure the best use of limited public resources. It is well documented that PADs placed in high traffic areas (e.g. airports, other transportation hubs) and in places where people who are at a high risk for sudden cardiac arrest live or congregate (e.g. nursing homes, senior centers) have a higher likelihood of saving lives.[1-7] Recent literature continues to support the targeted placement of PADs in locations likely to experience a high number of cardiac arrests.[8] One study concluded that placement of PADs where the likelihood of use is at least 12% per year (i.e. 1 use every 9 years) is a good investment.[9] According to available data for this one-year reporting period, there were 182 uses out of 5,492 available PADs in NYC, making the overall likelihood of use of PADs about 3% (about 1 use every 33 years). Furthermore, there were only 5 uses in LL20 mandated placements out of the 5,492 available PADs in NYC (0.09% mean likelihood of use).

The vast majority of reported PAD uses registered with REMSCO were in private nursing homes where the likelihood of use is probably in excess of 12% per year. As such, PAD placement in these facilities appear to be an appropriate measure. LL20 attempted to require placement of PADs in private nursing homes and may have succeeded in increasing these placements, but was preempted from regulation by New York State Public Health Law. Since nursing homes consistently demonstrate the highest usage rate of all PAD locations, we continue to recommend PAD placements in such facilities where they do not already offer a higher level of care. Such legislation covering nursing homes would require state level legislative actions. Expansion of the LL20 mandate to include additional NYC facilities does not appear warranted at this time based on current PAD use data, which suggests that likelihood of use in non-nursing home facilities is well below 12% per year.

Furthermore, AEDs are already in use by FDNY, New York Police Department (NYPD), Port Authority Police Department (PAPD) and in other private settings. FDNY maintains AEDs on most fire apparatus, NYPD utilizes AEDs within many of its units, and PAPD maintains AEDs at the airports, with some patrol units and at some PATH train hubs.

Still, most cardiac arrests are due to underlying causes that evolve over years and can be prevented and treated prior to the onset of cardiac arrest. While under select circumstances PAD use will save lives, use of resources to address smoking, obesity, physical inactivity, high blood pressure and elevated cholesterol effectively as a city will have the greatest impact on reducing cardiac deaths.

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LOCAL LAWS
OF
THE CITY OF NEW YORK
FOR THE YEAR 2005

No. 20

Introduced by Council Members Oddo, The Speaker (Council Member Miller), and Council Members Lopez, Reed, Lanza, Gallagher, Baez, Barron, Comrie, DeBlasio, Gioia, Koppell, McMahon, Martinez, Moskowitz, Nelson, Quinn, Reyna, Rivera, Sanders, Vallone, Jr., Gerson, Brewer, the Public Advocate (Ms. Gotbaum), Provenzano, Clarke, Dilan, Fidler, Gentile, Jennings, Stewart, Weprin, Palma, Gennaro, Katz, Sears, Avella and Perkins.

A LOCAL LAW

To amend the administrative code of the city of New York, in relation to requiring the placement of automated external defibrillators at certain public places.

Be it enacted by the Council as follows:

Section 1. Chapter one of title 17 of the administrative code of the city of New York is hereby amended by adding a new section 17-188 to read as follows:

§17-188 Automated external defibrillators. a. Definitions. For the purposes of this section, the following terms shall have the following meanings:

1. "Automated external defibrillator" means a medical device, approved by the United States food and drug administration, that: (i) is capable of recognizing the presence or absence in a patient of ventricular fibrillation and rapid ventricular tachycardia; (ii) is capable of determining, without intervention by an individual, whether defibrillation should be performed on a patient; (iii) upon determining that defibrillation should be performed, automatically charges and requests delivery of an electrical impulse to a patient's heart; and (iv) upon action by an individual, delivers an appropriate electrical impulse to a patient's heart to perform defibrillation.

2. "Owner or operator" means the owner, manager, operator, or other person or persons having control of a public place.

3. "Public place" means the publicly accessible areas of the following places to which the public is invited or permitted: (i) public buildings maintained by the division of facilities management and construction of the department of citywide administrative services or any successor; (ii) parks under the jurisdiction of the department of parks and recreation identified pursuant to subdivision e of this section; (iii) ferry terminals owned and operated by the city of New York served by ferry boats with a passenger capacity of one thousand or more persons; (iv) nursing homes, as defined in section 2801 of the New York state public health law; (v) senior centers, which include facilities

operated by the city of New York or operated by an entity that has contracted with the city to provide services to senior citizens on a regular basis, such as meals and other on-site activities; (vi) golf courses, stadia and arenas; and (vii) health clubs that are commercial establishments offering instruction, training or assistance and/or facilities for the preservation, maintenance, encouragement or development of physical fitness or well-being that have a membership of at least two hundred and fifty people, and which shall include, but not be limited to, health spas, health studios, gymnasiums, weight control studios, martial arts and self-defense schools or any other commercial establishment offering a similar course of physical training.

b. Automated external defibrillators required. Except as provided in subdivision j of this section, the owner or operator of a public place shall make available in such public place automated external defibrillators in quantities and locations deemed adequate in accordance with rules promulgated pursuant to subdivisions e and f of this section and in accordance with section 3000-b of the New York state public health law. Such automated external defibrillators shall be readily accessible for use during medical emergencies. Any information regarding use of automated external defibrillators deemed necessary by the department in accordance with rules promulgated pursuant to subdivision f of this section shall accompany and be kept with each automated external defibrillator. Any automated external defibrillator required pursuant to this subdivision shall be acquired, possessed and operated in accordance with the requirements of section 3000-b of the New York state public health law.

c. Notice required. The owner or operator of a public place shall provide written notice to the public, by means of signs, printed material or other form of written communication, indicating the availability of automated external defibrillators for emergency use in such public place and providing information on how to obtain automated external defibrillator training. The type, size, style, location and language of such notice shall be determined in accordance with rules promulgated by the department pursuant to subdivision f of this section. Should such rules require or allow the posting of signs made available by the department to owners or operators of a public place to serve as appropriate notice pursuant to this subdivision, the department may charge a fee to cover printing, postage and handling expenses.

d. Reports. The department shall conduct a comprehensive study and submit a report to the mayor and the council twelve months after the effective date of the local law that added this section. Such report shall include, but not be limited to, the quantities and locations of automated external defibrillators placed in public places pursuant to subdivision b of this section and the identification of any additional locations throughout the city of New York that warrant the placement of automated external defibrillators. Twenty-four months after the effective date of the local law that added this section, and annually thereafter for the next succeeding three years, the department shall submit to the mayor and the council a report indicating the quantities and locations of automated external defibrillators placed in public places pursuant to subdivision b of this section.

e. Parks. The commissioner of the department of parks and recreation shall, no later than seven calendar days after the effective date of the local law that added this section, promulgate rules identifying at least six parks in each borough under the jurisdiction of the department of parks and recreation to be considered a public place for the purposes of this section, and determining the quantity and location of automated external defibrillators to be placed in such parks; provided, however, that at least one of the parks identified in each borough must be over one hundred and seventy acres.

f. Rules. The department shall promulgate such rules as may be necessary for the purpose of implementing the provisions of this section, including, but not limited to, rules regarding the quantity and location of automated external defibrillators to be placed in a particular public place or general category of public place; the form of notice in which the availability of automated external defibrillators in a public place shall be made known to the public and any accompanying fee; and any information on the use of automated external defibrillators that must accompany and be kept with each automatic external defibrillator; provided, however, that the department of parks and recreation shall determine the quantity and location of automated external defibrillators placed in parks, pursuant to subdivision e of this section. Such rules shall also include, but not be limited to, required training in the use of automated external defibrillators.

g. Liability limited. Any person who, in accordance with the provisions of this section, voluntarily and without expectation of monetary compensation renders first aid or emergency treatment using an automated external defibrillator that has been made available pursuant to this section, to a person who is unconscious, ill or injured, and any person, owner or operator, entity, partnership, corporation, firm or society that purchases or makes available an automated external defibrillator as required by this section, shall be entitled to the limitation of liability provided in section 3000-a of the New York state public health law.

h. No duty to act. Nothing contained in this section shall impose any duty or obligation on any owner or operator of a public place, his or her employee or other agent, or any other person to provide assistance with an automated external defibrillator to a victim of a medical emergency.

i. Standard of care. Nothing contained in this section shall be deemed to affect the obligations or liability of emergency health providers pursuant to section 3000-b of the New York state public health law.

j. Exception. During such times as an owner or operator of a public place provides, at such public place, advanced life support by a physician, registered professional nurse or advanced emergency medical technician acting within his or her lawful scope of practice, or the use of automated external defibrillators by a physician, registered professional nurse, or advanced emergency medical technician acting within his or her lawful scope of practice, such provision shall be deemed to satisfy the requirements of subdivision b of this section, subject to rules of the department promulgated pursuant to subdivision f of this section. For purposes of this subdivision, advanced emergency medical technician shall mean an advanced emergency medical technician as defined in section three thousand one of the New York state public health law.

k. Public awareness. Within ninety days of the effective date of the local law that added this section, the department shall conduct public awareness and education campaigns in English and Spanish regarding cardiopulmonary resuscitation training.

§2. Severability. If any subdivision, sentence, clause, phrase or other portion of the local law that added this section is, for any reason, declared unconstitutional or invalid, in whole or in part, by any court of competent jurisdiction, such portion shall be deemed severable and such unconstitutionality or invalidity shall not affect the validity of the remaining portions of the local law that added this section, which remaining portions shall remain in full force and effect.

§3. Effective date. This local law shall take effect one hundred twenty days after its enactment into law. Actions necessary to prepare for the implementation of this local may be taken prior to its effective date.

THE CITY OF NEW YORK, OFFICE OF THE CITY CLERK, s.s.:

I hereby certify that the foregoing is a true copy of a local law of the City of New York, passed by the Council on February 16, 2005, and approved by the Mayor on March 7, 2005.

VICTOR L. ROBLES, City Clerk of the Council

CERTIFICATION PURSUANT TO MUNICIPAL HOME RULE LAW §27

Pursuant to the provisions of Municipal Home Rule Law §27, I hereby certify that the enclosed Local Law (Local Law 20 of 2005, Council Int. No. 211-A) contains the correct text and:

Received the following vote at the meeting of the New York City Council on February 16, 2005: 47 for, 0 against, 0 not voting.

Was signed by the Mayor on March 7, 2005.

Was returned to the City Clerk on March 9, 2005.

JEFFREY D. FRIEDLANDER, Acting Corporation Counsel

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
COMMISSIONER OF HEALTH

NOTICE OF ADOPTION OF RULE IMPLEMENTING
SECTION 17-188 OF THE ADMINISTRATIVE CODE REQUIRING THE PLACEMENT OF AUTOMATED EXTERNAL DEFIBRILLATORS AT CERTAIN PUBLIC PLACES

IN COMPLIANCE WITH SECTION 1043(b) and 389(b) OF THE NEW YORK CITY CHARTER (the "Charter") and pursuant to Title 17, Chapter 1, Section 17-188(f) of the New York City Administrative Code, notice is hereby given of the adoption of the following rule implementing Section 17-188 of the New York City Administrative Code requiring the placement of automated external defibrillators at certain public places. The Notice of Public Hearing was printed in the City Record on July 20, 2005. A public hearing was held on August 22, 2005. The Department received four written comments and two testimonials at its public hearing.

STATUTORY AUTHORITY

This rule is promulgated pursuant to New York City Charter Sections 389(b) and 1043(a) and Section 17-188(f) of the New York City Administrative Code. Section 1043(a) of the Charter provides that each "agency is empowered to adopt rules necessary to carry out the powers and duties delegated to it by or pursuant to federal, state of local law". Section 389(b) similarly provides that the "heads of mayoral agencies shall have the powers to adopt rules to carry out the powers and duties delegated to the agency head or the agency by or pursuant to federal, state or local law. Section 17-188(f) of Chapter 1 of Title 17 of the Administrative Code authorizes the Commissioner of the Department of Health and Mental Hygiene to "promulgate such rules as may be necessary for the purpose of implementing the provisions of this section, including, but not limited to, rules regarding the quantity and location of automated external defibrillators to be placed in a particular public place or general category of public place; the form of notice in which the availability of automated external defibrillators in a public place shall be made known to the public and any accompanying fee; and any information on the use of automated external defibrillators that must accompany and be kept with each automated external defibrillator…."

STATEMENT OF BASIS AND PURPOSE

This rule is required to be promulgated pursuant to Section 17-188 of the Administrative Code, specifically subsections (b), (c), (f) and (j) thereof, and is necessary for that law's proper implementation and enforcement. The general purpose of Section 17-188 of the Administrative Code is to make "automated external defibrillators" available in the "publicly accessible areas" of certain "public places" in order to encourage persons to "voluntarily and without expectation of monetary compensation" provide first aid or emergency treatment using an automated external defibrillator that has been made available pursuant to this section, to a person who is unconscious, ill or injured….". Section 24-01 of a new Chapter 24 of Title 24 of the Rules of the City of New York provides the meaning of specific words and terms used in this rule and in

Section 17-188 of the Code and further provides that the meaning of other words and terms used in the rule are as specified in Section 17-188 of the Code. In response to a comment received, the definition of "publicly accessible areas" in Section 24-01(b)(3) has been modified. The revised version makes clearer that this definition was not intended to exclude employees but rather to clarify which areas within these public places are open to the public. The definition of "membership" in former Section 24-01(b)(4) has been deleted from the final version because Section 631 of the New York State General Business Law ("GBL") reflects the State Legislature's intent to preempt the area of automated external defibrillators in health clubs, as now set forth in Section 627-a of the "GBL". Section 627-a, which went into effect on July 20, 2005, establishes statewide requirements relating to the provision of automated external defibrillators in health clubs. Therefore, consistent with Section 631 of the "GBL", those provisions of Local Law 20 of 2005 as they relate to health clubs and related facilities defined in Section 17-188(a)(3)(vii) of the Code are of no force and effect. The definition of "membership" as it relates solely to health clubs and related facilities has been deleted.

Section 24-02 provides that those required to make automated external defibrillators available pursuant to Section 17-188 must in implementing this rule also comply with the requirements of Section 3000-b of the New York State Public Health Law in connection with the acquisition, possession and operation of automated external defibrillators. Section 24-03 provides necessary guidance as to the appropriate location and quantities of automated external defibrillators that must be maintained pursuant to the new law. According to Section 24-03(a), the owner or operator of a public place, as defined in Section 17-188(a)(3) of the Code and limited by Section 17-188(e) of the Code, must "place at least one automated external defibrillator(s) in a prominent location in that public place." Subsection (b) of this section provides that the automated external defibrillator(s) is to be "located or placed so that this equipment can be obtained in a timely manner". Section 24-04 entitled Required Notice: Signage Information, provides the information that is required to appear on the wall sign informing the public as to the availability of an automated external defibrillator at that location and specifies where that wall sign should be placed. It also identifies information that must be included on a second sign and provides that this second sign may be placed either on a wall or on the face of the storage container in which the automated external defibrillator is contained. In response to a comment, changes to Section 24-04 reducing the minimum height of the lettering on the required signage and allowing the use of the abbreviation "AED" have been made. The Department determined that the use of the abbreviation and the size reduction in lettering would not affect legibility and that these changes were necessary to ensure that the language could be accommodated on the signage. Upon further consideration, the Department has deleted paragraph (ii) of subsection (e) of Section 24-04 as unnecessary. The reference to a paragraph (i) has, accordingly, also been deleted. The content of former paragraph (i) remains as subsection (e) of Section 24-04. Section 24-05 specifies what must be contained in a required written Site-Specific Response Plan and provides that the Plan must be made available to the Department upon its request.

In response to a comment, the definition of "On A Regular Basis" in Section 24-01(b)(7) was modified to increase the number of senior centers that would be required to make an automated external defibrillator available by reducing the number of hours of services per week, including lunch, that a senior center has to provide before it is required to have an automated

external defibrillator. A definition of "Advanced Life Support" [Section 24-01(b)(8)] and a section entitled "Nursing Homes" [Section 24-06] have been added as the Department determined that there existed a need to provide guidance to nursing homes as to which facilities would have to make automated external defibrillators available and the number of trained responders that must be specifically required in those facilities.

THE RULE IS AS FOLLOWS:

COMMISSIONER OF HEALTH AND MENTAL HYGIENE RULE IMPLEMENTING SECTION 17-188 OF THE ADMINISTRATIVE CODE REQUIRING PLACEMENT OF AUTOMATED EXTERNAL DEFIBRILLATORS AT CERTAIN PUBLIC PLACES

Chapter 24

AUTOMATED EXTERNAL DEFIBRILLATORS IN CERTAIN PUBLIC PLACES

Section 24-01(a). Definitions.

Words and terms used in this rule, other than those specified in subsection (b) of this section, shall have the same meaning as specified in §17-188 of the New York City Administrative Code.

(b) When used in this rule, the following words or terms shall have the following meaning:

(1)__Department. "Department" means the New York City Department of Health and Mental Hygiene.
(2) _Code. Code means the Administrative Code of the City of New York.
(3)__Publicly Accessible Areas. Publicly accessible areas of buildings operated by the Division of Facilities Management and Construction of the Department of Citywide Administrative Services means the areas within a "public place", as that term is defined in §17-188(a)(3) of the Code, to which members of the public are regularly invited or permitted on most business days and which do not require an appointment or special authorization or permission in order to gain admission.
(4)_Prominent Location. Prominent location shall mean any central location in a public place where the automated external defibrillators can be located and are readily available at all times for use by persons trained in their operation.
(5) Public access defibrillation provider. Public access defibrillation provider means a person, firm, organization or other entity having control of a public place and possessing or operating an automated external defibrillator pursuant to a collaborative agreement, as that term is defined in §3000-b of the New York State Public Health Law.
(6) Trained Responder(s). Employees/volunteers recruited by or, if necessary, designated by the owner/management of those public places specified in §17-188(a)(3) of the Code, to operate automated external defibrillators. Such employees shall have received appropriate training in the use and operation of automated external defibrillators, as evidenced by the

successful completion of a combination cardio-pulmonary resuscitation/automated external defibrillator (CPR/AED) training class.
(7) On A Regular Basis. As used in § 17-188(a)(3)(iv) of the Code, refers to those senior centers offering services, including lunch, to senior citizens at least three days per week.
(8) Advanced Life Support. As used in § 17-188(j) of the Code and § 24-06, advanced life support must include, although is not limited to, the availability of manual defibrillation.

Section 24-02. Compliance with State Law

Any automated external defibrillator required pursuant to §17-188 of the Code shall be acquired, possessed and operated in accordance with the requirements of §3000-b of the New York State Public Health Law.

Section 24-03. Quantity and Location of Automated External Defibrillators

(a) The owner or operator of a public place, as defined in §17-188(a)(3) of the Code and limited by §17-188(e), shall place at least one automated external defibrillator(s) in a prominent location in that public place. In those public places maintained by the Division of Facilities Management and Construction of the Department of Citywide Administrative Services, this placement shall be within a "publicly accessible area", as defined in §24-01(b)(3).

(b) Automated external defibrillator(s) shall be located or placed so that this equipment can be obtained in a timely manner. For those buildings operated by the Division of Facilities Management and Construction of the Department of Citywide Administrative Services having publicly accessible areas located more than five (5) floors apart, no such publicly accessible area shall be more than five floors from where an automated external defibrillator is located.

(c) Storage conditions for the automated external defibrillators shall be in compliance with the manufacturer's specifications.

Section 24-04. Required Notice: Signage Information

(a) The owner or operator of a public place shall provide written notice to all persons using a public place, as that term is defined in §17-188(a)(3) of the Code, in the form of a clear and conspicuous wall sign placed at a height between five and seven feet above the floor and which is also in close proximity to the automated external defibrillator unit storage location.

(b) The sign shall contain the following language in lettering and representation (symbol) in the size indicated:

- "DEFIBRILLATOR" or "AED" (minimum height - two (2) inches)
- Automated External Defibrillator (minimum height – five eighths (5/8) inch)
- Heart and lightening bolt logo (minimum height - two (2) inches)

(c) A second wall sign either similarly placed as the one required in subsection (a) of this section or located on the storage cabinet containing the automated external defibrillator must contain the following information in the size indicated:

- In event of emergency call 911 (minimum height –three eighths (3/8) inch)
- **and**
- Contact this facility's trained responder(s) at: (Give contact information for trained responder(s) (minimum height – three eighths (3/8) inch)

(d) In addition to the signs required in subsections (a) and (b) of this section, a wall sign containing the information specified in subsection (c) of this section shall be placed in a prominent location on all publicly accessible floors of a public place. Such sign shall also state that more information on CPR/AED training may be obtained by calling 311.

(e) Exception. The wall signs required by subsections (c) and (d) of this section shall not be required in nursing homes.

(f) Signs in conformity with the requirements specified in §24-03 (b) and (c) shall be made available by the Department, at no cost to the owner or operator of a public place required to have an automated external defibrillator. An owner or operator shall use either the sign provided by the Department or its own sign provided that the sign used meets the requirements specified in this section.

(g) All automated external defibrillators shall be stored with clear concise written or pictorial instructions for their use.

Section 24-05 Site-Specific Response Plan

(a) The owner or operator of a public place, as defined in §17-188 of the Code, must have a site response and maintenance plan as part of the written practice protocols included in the collaborative agreement required by §3000-b of New York State Public Health Law. This plan must be made available to the Department upon its request.

(b) The Site-Specific Plan must specify the following:

1. A list of the trained responders, the specific training they received, how they can be contacted, the locations of the trained responders at the site .
2. The provider of the AED/CPR training received by each trained responder, the date that training was received as well as the due dates for training recertification of each trained responder.
3. The specific location(s) of the automated external defibrillator(s) at the public place. The automated external defibrillator(s) shall be in a location(s) accessible to the trained responder(s).

4. The party responsible for verifying that the automated external defibrillator(s) is in operable condition and for ensuring that the equipment is maintained in conformity with the manufacturer's recommendations.
5. The placement and exact location of the signs required by §24-04(a), (b) and (c) along with the information on how to contact the site's trained responder(s).
6. Instructions on how to identify an on–site medical emergency and a listing of procedures to be followed to notify trained responders of the existence of that emergency.
7. Procedures to be followed to notify the emergency medical services system as to the existence of an on-site medical emergency.
8. How the trained responder(s) at a site will be dispatched to the location of the medical emergency.
9. The procedures to be followed by the trained responder(s) at the location upon their response to the location of a medical emergency.
10. Procedures to be followed by trained responders upon their transfer of care of an emergency to the emergency medical services system.
11. Instructions on how to document each use of an automated external defibrillator and immediately report such usage in accordance with Public Health Law §3000-b.

(c) The number of trained responders in each public place shall be commensurate with the size and configuration of the facility to permit rapid response during regular business hours. The number of trained responders in nursing homes required to make on-site automated external defibrillators available pursuant to §17-188(b) of the Code shall be as specified in §24-06.

Section 24-06 Nursing Homes

(a) Nursing homes not making available advanced life support, as that term is defined in §24-01(b)(8), by a physician, registered nurse or emergency medical technician present on-site twenty-four hours a day, seven days a week or not making available automated external defibrillators to be used by a trained physician, registered nurse or emergency medical technician present on-site twenty-fours hours a day, seven days a week, shall provide on-site automated external defibrillators, as required by §17-188(b) of the Code in the number specified in §24-03(a). Such nursing homes must acquire, possess and operate their automated external defibrillators in accordance with the requirements of § 3000-b of the Public Health Law, as specified in § 24-02.

(b) A minimum of two trained responders, as defined in §24-01(b)(6), shall be present at all times in those nursing homes required to make automated external defibrillators available.

New York State Public Health Law Section § 3000-b.
Automated external defibrillators: Public access providers.

1. Definitions.
As used in this section, unless the context clearly requires otherwise, the following terms shall have the following meanings:
(a) "Automated external defibrillator" means a medical device, approved by the United States food and drug administration, that: (i) is capable of recognizing the presence or absence, in a patient, of ventricular fibrillation and rapid ventricular tachycardia; (ii) is capable of determining, without intervention by an operator, whether defibrillation should be performed on the patient; (iii) upon determining that defibrillation should be performed, automatically charges and requests delivery of an electrical impulse to the patient's heart; and (iv) then, upon action by an operator, delivers an appropriate electrical impulse to the patient's heart to perform defibrillation.
(b) "Emergency health care provider" means (i) a physician with knowledge and experience in the delivery of emergency cardiac care; or (ii) a hospital licensed under article twenty-eight of this chapter that provides emergency cardiac care.
(c) "Public access defibrillation provider" means a person, firm, organization or other entity possessing or operating an automated external defibrillator pursuant to a collaborative agreement under this section.
(d) "Nationally-recognized organization" means a national organization approved by the department for the purpose of training people in use of an automated external defibrillator.

2. Collaborative agreement.
A person, firm, organization or other entity may purchase, acquire, possess and operate an automated external defibrillator pursuant to a collaborative agreement with an emergency health care provider. The collaborative agreement shall include a written agreement and written practice protocols, and policies and procedures that shall assure compliance with this section. The public access defibrillation provider shall file a copy of the collaborative agreement with the department and with the appropriate regional council prior to operating the automated external defibrillator.

3. Possession and operation of automated external defibrillator.
Possession and operation of an automated external defibrillator by a public access defibrillation provider shall comply with the following:
a) No person may operate an automated external defibrillator unless the person has successfully completed a training course in the operation of an automated external defibrillator approved by a nationally-recognized organization or the state emergency medical services council. However, this section shall not prohibit operation of an automated external defibrillator, (i) by a health care practitioner licensed or certified under title VIII of the education law or a person certified under this article acting within his or her lawful scope of practice or (ii) by a person acting pursuant to a lawful prescription.
(b) The public access defibrillation provider shall cause the automated external defibrillator to be maintained and tested according to applicable standards of the manufacturer and any appropriate government agency.
(c) The public access defibrillation provider shall notify the regional council of the existence, location and type of any automated external defibrillator it possesses.
(d) Every use of an automated external defibrillator on a patient shall be immediately reported to the appropriate local emergency medical services system, emergency communications center or emergency vehicle dispatch center as appropriate and promptly reported to the emergency health care provider.
(e) The emergency health care provider shall participate in the regional quality improvement program pursuant to subdivision one of section three thousand four-a of this article.

4. Application of other laws.
(a) Operation of an automated external defibrillator pursuant to this section shall be considered first aid or emergency treatment for the purpose of any statute relating to liability.
(b) Operation of an automated external defibrillator pursuant to this section shall not constitute the unlawful practice of a profession under title VIII of the education law.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/30/23

(PLEASE PRINT)

Name: Emily Ashton

Address: Assistant Commissioner, TCP

I represent: Family and Child Health Administration (DOHMH).

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/30/23

(PLEASE PRINT)

Name: Connor Schiff

Address: Deputy Commissioner, Office of Chronic and Child Health (DOHMH)

I represent:

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/30/23

(PLEASE PRINT)

Name: Duncan Maru

Address: Assistant Commissioner for the Equitable Health System (DOHMH)

I represent:

Address:

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: 3-30-2023

(PLEASE PRINT)

Name: Richard W Flores

Address: Springfield Blvd

I represent: NYSAFP

Address: _____

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: 3/30/23

(PLEASE PRINT)

Name: Greg Mihailovich

Address: 10 E. 40th St 11th Fl NY NY

I represent: American Hotel Association

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/30/23

(PLEASE PRINT)

Name: Emily Ashton

Address: 42-09 28th St, LIC, NY

I represent: The NYC DOHMH

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/30/2023

(PLEASE PRINT)

Name: NEAL SHIPLEY

Address: [redacted] WEST 95ST. NY NY 10025

I represent: NORTHWELL HEALTH

Address: 2000 MARCUS AVE. LAKE SUCCESS NY

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/30/23

(PLEASE PRINT)

Name: John Flanagan

Address: [redacted] Marcus Avenue Lake Success

I represent: Northwell Health

Address: 2000 Marcus Avenue Lake Success

Please complete this card and return to the Sergeant-at-Arms