

HEALTH AND HUMAN SERVICES COMMITTEE
OF THE
SUFFOLK COUNTY LEGISLATURE
Minutes

A regular meeting of the Health and Human Services Committee of the Suffolk County Legislature was held in the Rose Y. Caracappa Legislative Auditorium of the William H. Rogers Legislature Building, Veterans Memorial Highway, Smithtown, New York, on Thursday, July 30, 2009 at 2:00 p.m.

MEMBERS PRESENT:

Legislator Kate Browning, Chairperson
Legislator John Kennedy
Legislator Tom Barraga
Legislator Jack Eddington
Legislator DuWayne Gregory

ALSO IN ATTENDANCE:

Sarah Simpson, Assistant Counsel to the Legislature
Barbara LoMoriello, Deputy Clerk of the Legislature
Diane Dono, Budget Review Office
Craig Freas, Budget Review Office
Dennis Brown, County Attorney's Office
Greg Blass, Chief Deputy, SC Department of Social Services
Dr. Chaudhry, Commissioner, SC Department of Health Services
Matt Miner, Deputy Commissioner, SC Department of Health Services
Paul Perillie, Aide to Majority Caucus
Maxvel Rose, Aide to Legislator Gregory
Josh Slaughter, Aide to Legislator Browning
Debra Alloncius, AME Legislative Director
Stephen Dewey, Senior Scientist, Brookhaven Lab
Bob Delagi, Acting Director/Division of EMS
Max Velazquez, Vaperclub.com
Spike Babaian, Long Island Vapers Club
William Friedman, Long Island Vapers Club
Josh Gregory, Long Island Vapers Club
Patsy Hirschhorn, Smithtown Youth Bureau
Kelsi Johnson, Smithtown Youth Bureau
Joanne Polarsek
Other Interested Parties

MINUTES TAKEN BY:

Lucia Braaten, Court Stenographer

MINUTES TRANSCRIBED BY:

Lucia Braaten, Court Stenographer
Kim Castiglione, Legislative Secretary

[THE MEETING WAS CALLED TO ORDER AT 2:11 P.M.]

CHAIRPERSON BROWNING:

Good afternoon. We will start the Health and Human Services Committee with a Pledge of Allegiance by Legislator Barraga.

(*Salutation*)

CHAIRPERSON BROWNING:

Good afternoon. We have a couple of presentations, but I think we're going to start with the agenda; we do have a short agenda. Okay.

TABLED RESOLUTIONS

Tabled Resolutions: 1223 - Directing the Suffolk County Department of Health Services to establish an online healthcare directives registry for Suffolk County residents (Gregory).

LEG. GREGORY:

Motion to table.

LEG. EDDINGTON:

Second.

CHAIRPERSON BROWNING:

Motion to table, Legislator Gregory; second, Legislator Eddington. All in favor? Opposed? Abstentions? Motion's tabled. ***(Vote: Tabled 5-0-0-0)***

Okay. ***1290 - Adopting a Local Law to enact a grading policy for food establishments (Losquadro).*** It's still a public hearing?

MS. SAMPSON:

Yes.

CHAIRPERSON BROWNING:

Okay. Make a motion to table for Public Hearing.

LEG. KENNEDY:

Second.

CHAIRPERSON BROWNING:

Second, Legislator Kennedy. All in favor? Opposed? Abstentions? It's tabled. ***(Vote: Tabled 5-0-0-0)***

1347 - Adopting a Local Law banning e-cigarettes in Suffolk County. Okay. That needs to be tabled also for public hearing.

LEG. EDDINGTON:

Second.

CHAIRPERSON BROWNING:

I believe I made the motion; seconded, Legislator Eddington. All in favor? Opposed? Abstentions? Motion's is tabled. ***(Vote: Approved 5-0-0-0)***.

I.R. 1570 - Accepting and appropriating \$115,326 in 100% grant funding from the New York State Office of Temporary and Disability Assistance, which represents a supplemental allocation for the intensive case services component of the Sanction

Intervention Program in the Department of Social Services. I guess I'll make a motion to approve and put on the Consent Calendar.

LEG. EDDINGTON:

Second.

CHAIRPERSON BROWNING:

Second, Legislator Eddington. All in favor? Opposed? Abstentions? ***(Vote: Approved 5-0-0-0)***.

Okay. And we're done with the agenda. We do have some cards here. Where's the order? Okay. Forgive me if I don't keep them in the right order, I'm not sure which one came first. We will start with William Friedman.

MR. FRIEDMAN:

Good afternoon, Legislators. I just want to start by letting you all know that we do know that 1347 has been tabled again, but myself and my associates would still like to take this opportunity to speak.

CHAIRPERSON BROWNING:

The Public Hearing on it is still open, that's why we had to table it. So it will be up in the Public Hearing again next Tuesday.

MR. FRIEDMAN:

Okay. Hello, Legislators. My name is William Friedman and I am standing here today to ask the Health and Human Services Committee to please reject Introductory Resolution 1347. As representatives of the people, you have a moral obligation to do so.

The Constitution of this great country grants the government rights to make laws that govern property ownership and to prevent people from infringing upon the rights that all people hold to pursue life, liberty and happiness. I.R. 1347 does not fit into that Constitutional model. I.R. 1347 is directly aimed at dictating the behavior of people that are not infringing on the rights of others.

I am a resident of Suffolk County and I am entitled to the same rights as every other resident of Suffolk County. However, if I.R. 1347 is allowed to move forward, my rights will fall in jeopardy. I am a nonsmoker and I have a legal entitlement to protection from secondhand smoke. Suffolk County knows this better than most counties, as evidenced by the fact that Suffolk County was one of the first jurisdictions in the country to prohibit smoking in public spaces and workplaces.

I.R. 1347 is asking you to prohibit the use of personal vaporizers in public with the exception being to allow them in designated smoking areas. This resolution offers no scientific data and no legal justification for restricting this activity into designated smoking areas. No evidence has been presented or referenced that would show any legitimate justification. I.R. 1347 is rooted in fear, intolerance, and ignorance. Allowing this resolution to move forward would be to promote intolerance and prejudice.

You will hear today from Commissioner Chaudhry. He will tell you the FDA has released a report indicating personal vaporizers are dangerous. This is not the truth about the FDA report, and when presented with such a notion, the Committee should question it and question it heavily. The FDA's report is one of preliminary findings that is based on estimations and initial impressions. It is not a scientific study and holds no value as scientific data. He is going to tell you the FDA has discovered nitrosamines in personal vaporizers. This is the truth. What he is not going to tell you is these same nitrosamines are found in virtually all smoking cessation products that are FDA approved. What he will not tell you is nitrosamines exist in many foods that we consume regularly. The FDA has standards for the maximum allowable levels of nitrosamines and there is no evidence given to suggest that the level of nitrosamines found in personal vaporizers exceeds the FDA's existing standards.

CHAIRPERSON BROWNING:

Can you wrap up? Your time's up.

MR. FRIEDMAN:

He is going to tell you that because these nitrosamines exist in personal vaporizers, the exhaled vapor is dangerous and the individuals exposed to it. That is emphatically not true. The FDA has not presented any evidence strong enough to support the idea that these nitrosamines exist at all in exhaled vapor. And a previously conducted study indicates that the exhaled vapor is essentially neutered of the presence of nicotine, so there is no legitimate reason to believe anything else potentially harmful is still present in the exhaled vapor. If Legislator Cooper wants this resolution passed, he has an obligation to every resident of Suffolk County to provide some kind of evidence that a potential hazard actually does exist. To date, he has failed in providing any evidence in such -- of such an idea. That is the reason that the Health and Human Services Committee must strike down I.R. 1347 until a time comes that Legislator Cooper can provide at least cursory evidence of any potential health risk.

CHAIRPERSON BROWNING:

Thank you.

MR. FRIEDMAN:

Thank you.

CHAIRPERSON BROWNING:

And next is Babaian. I probably didn't say your name right.

MS. BABAIAN:

I have something I would like to hand out, little handouts for everybody; they're clipped. Since I'm handing them out, I'll save some time, because you're going to be reading most of what I'm planning on talking about, so I'll make it very brief.

Essentially, the FDA has said that, as Friedman said, there are nitrosamines in electronic cigarettes. This is not relevant, because there are nitrosamines in hot dogs, and tap water, and ice cream, and plenty of things that we eat all the time. What they want to do is scare people and tell them that they're dangerous, and what it comes down to is there are no facts and no evidence that say that they are dangerous.

The FDA states that, in their preliminary study, they estimated things. If you look at the highlights on the sheets that I gave you, it says "FDA". There's an FDA packet in there and that is the FDA's preliminary study. It's eight pages long. It's not that long, and I've highlighted all the relevant parts that show you that in their study, there are -- the letters "ND" on the charts that you'll see, all those letters, "ND", the "ND" stands for nondetectable, and what that means is that there was no detectable level of any of these cancer-causing agents in most of the tested cartridges. So that's the simplest way that I can explain it to you is to look at a chart and see that most of them had no detectable level of any cancer-causing agent. And then for them to say that they're dangerous and toxic is just -- it's a lie. It's like saying Chantix is safe. It doesn't even make any sense.

The fact sheet that I attached also is a fact sheet on electronic cigarettes which talks about statistics on a number of different things that the FDA said in their study, which, again, is highlighted. But the main thing that I did want to point out is the second half of the fact sheet is all about the Nicotrol inhaler. The Nicotrol inhaler is a device that is approved by the FDA. The Nicotrol inhaler is approved by the FDA as a smoking cessation device. If they want to make this a smoking cessation device, that's their decision, but to ban it and say it's not approved when they've proven that it's healthier than their own device that they approved for smoking cessation doesn't make any sense.

So, if you can take a look at the fact sheet that I handed out, and take a look at the FDA study that I

handed out that shows you highlighted where they basically said, "We estimated our results, we don't really know" -- in fact, on Page 6, there's a big blank spot -- yeah, Page 6 of the FDA study has a big blank spot that says, "Extraction with", and the reason that it's empty is because they never studied the Nicotrol inhaler. They're trying to show you there that the Nicotrol inhaler, which was used as a control in their preliminary study, was, you know, safer, but they can't because they never -- they never tested it. They never tested the Nicotrol inhaler for toxins or for nitrosamines. They didn't test it, they just approved it. They said, "Sure it's approved, it's safe." And it's actually with formaldehyde, acetaldehyde and ammonia, and they allow -- they say it's okay to use those indoors. Essentially, what Legislator Cooper is saying is that these are dangerous to use indoors. If the FDA approves the use of a Nicotrol inhaler, the main difference is when you use a Nicotrol inhaler when you exhale the vapor, you don't see it.

You know that we've -- you've seen, I'm sure, videos and news stations show the use of the electronic cigarette where it makes a vapor in the air, and it's visible because it's the same stuff that comes out of a fog machine. On the Nicotrol inhaler, which is FDA approved, when you exhale the vapor it's invisible, because it doesn't get hot, they don't heat it up. So it's the same exact -- well, it's not the same exact thing, it's a much more dangerous substance, and the information that I handed out shows that.

The statistics that are listed on this fact sheet that I handed out are all going to be shown on vapersforum.com. We're going to have a link to a page that shows you where all of these statistics came from, and we'll highlight them all so that they're easy to find.

CHAIRPERSON BROWNING:

Thank you.

MS. BABAIAN:

Thank you.

CHAIRPERSON BROWNING:

Max Velazquez.

MR. VELAZQUEZ:

Good afternoon. Good afternoon, Ladies and Gentlemen. It's been nine months since I embraced this new technology known as the electronic cigarette. As I have embraced it, so have many of my family and friends. For many years I've tried many different ways to quit the smoking habit, and, unfortunately, I have been smoking since the age of 14.

Not only -- the reason why I wanted to quit smoking was because of its proven, its proven dangerous effects on one's health. But that's not the only reason why. The other reason why I wanted to quit smoking was because of the segregation and the isolation for mothers due to the proven, again, proven effects of secondhand smoke. Since I started vaping, not only have I stopped smoking cigarettes and cigars, but I now enjoy quality time in the company of all my family and friends. This new device has greatly improved my quality of life, and I'm sure the quality of life of many others like me.

The proposal to ban this device from being used in areas that commonly ban smoking on a mere speculation that secondhand vapor can be or may be harmful to others in my opinion is absurd. This ban will eventually cause all my family and friends to believe that secondhand vapor is dangerous to them as well, and although at this time there is no concrete evidence and proof that this is the case. This will result in me being asked once again to separate myself from my loved ones each time I wish to use my personal vaporizer. Not only would this segregate and isolate me from my family, but, at the same time, force me to be exposed to the very same secondhand smoke that I wish at all costs to avoid.

Due to the lack of evidence, I personally believe that this has more to do with getting offended in

public areas observing someone smoking with a device that appears to be a cigarette and one appearing to be smoking. Tell me, if at a family restaurant a family gets offended because someone is sitting on a table next to theirs listening to an I-Pod with music that's extremely loud or they find offensive, would the manager of that restaurant ask this person to step outside to listen to their music? If a group is offended at the vulgar language used by another group of people at a sports bar, is that group asked to go outside to continue their conversation? If a person on a plane has an offensive body odor to others on board that same plane, is that person asked to catch another flight? No. No, of course not. So tell me, if people get offended at the fact that I am using a device that appears to be a cigarette, why should I be asked to remove myself?

In conclusion -- in conclusion, as a retired Police Officer, I believe and have faith in our justice system where everyone is innocent until proven guilty based on legitimate facts, testimony, and evidence. I ask that you do the same and base your decision on whether or not there is enough evidence and there is enough facts to ban the use of our electronic cigarettes in public places. Doing so unjustly will greatly impact not only my quality of life but the quality of life of many others. Thank you very much.

CHAIRPERSON BROWNING:

Thank you. Josh Gregory.

MR. GREGORY:

Hello. The FDA recently went public with misleading information about the safety of electronic cigarettes and the marketing of these devices, not only using its clout, but recruiting other prominent organizations to demonize a product that has great public health benefit and potential.

A group of prominent doctors and tobacco researchers, including Dr. Michael Siegel at the Boston University School of Public Health, Dr. Joel Nitzkin of the AAPHP Tobacco Control Task Force, and Dr. Brad Rodu, Endowed Chair, Tobacco Harm Reduction Research University of Louisville, challenge the FDA to provide the full quantitative data of the study upon which the FDA has based its warning against electronic cigarettes. They are concerned that the FDA's disingenuous targeting of electronic cigarettes through a biased presentation of the scientific data has had significant negative impact upon the public perception of electronic cigarettes when the best available evidence suggests that these have shown that the devices offer great potential to reduce serious health issues among traditional tobacco smokers.

Regrettably, the FDA has used bias reporting of the small and inconclusive study to complete results of which have not been made public. To secure the vocal support of groups such as the American Academy of Pediatrics Tobacco Consortium, the Institute of Global Health and American Lung Association in their attack on electronic cigarettes. These researchers argue that it is absurd to consider taking electronic cigarettes off the market when it is the conventional ones which have been shown to be killing people. Further, the electronic cigarette community calls for accurate and fair reporting relative to the findings and statements of prominent medical professionals in favor of this new and important technology, and challenges the media to tell the other side of the story.

"The FDA's laboratory findings actually indicate that electronic cigarettes are much, much safer than conventional cigarettes," and that was a quote from Dr. Michael Siegel. "The traces of carcinogens present are also present in nicotine replacement products. The FDA and anti-smoking groups have fallen into a huge analytical trap as they fail to ask the appropriate question. The question they are asking is: 'Are electronic cigarettes safe?' That is not the right question. The right question is: 'Are electronic cigarettes much safer than traditional ones?'"

Dr. Rodu states, "The FDA tested e-cigarettes for TSNAs using a questionable sampling regimen, and the methods that were so sensitive that the results may have no possible significance to users. The agency failed to report specific levels of these contaminants, and it has failed to conduct similar testing of nicotine medicines that have been sold in the U.S. for over 20 years. These are not the actions of an agency that is science-based and consumer-focused. These pseudo-scientific actions

were clearly intended to form the justification for banning a category of products that are probably 99% safer than cigarettes." That's all I have to say.

CHAIRPERSON BROWNING:

Thank you.

MR. GREGORY:

Thank you.

CHAIRPERSON BROWNING:

And, again, I did say, you know, next Tuesday the Public Hearing is still open on this. I know you guys were there in Riverhead. It starts at 2:30 in the afternoon --

MS. SIMPSON:

No.

LEG. KENNEDY:

No.

MS. SIMPSON:

It's at six.

LEG. KENNEDY:

It's an evening meeting.

CHAIRPERSON BROWNING:

Oh, it's an evening one.

LEG. KENNEDY:

Six-thirty.

CHAIRPERSON BROWNING:

What do I know? Six --

LEG. KENNEDY:

Six-thirty.

CHAIRPERSON BROWNING:

What time is this --

MS. LOMORIELLO:

It's here in Hauppauge.

CHAIRPERSON BROWNING:

Yeah.

LEG. KENNEDY:

Six-thirty.

CHAIRPERSON BROWNING:

What time does the public hearing start, though?

MS. SIMPSON:

I think it starts at 6:30.

CHAIRPERSON BROWNING:

Okay. Hold on a minute. What time does the public hearing start, then.

MS. SIMPSON:

Six-thirty.

CHAIRPERSON BROWNING:

Six-thirty? Okay. So Public Hearing will start here at 6:30 next Tuesday night. And you do have five minutes to speak, so you're welcome to come back then again.

MR. GREGORY:

Thank you.

CHAIRPERSON BROWNING:

Thank you. And the last card is Joanne Polarsek.

MS. POLARSEK:

Good afternoon.

CHAIRPERSON BROWNING:

Hi, Joanne.

MS. POLARSEK:

Honestly, I'm quite not prepared for this as well as I thought I would be. I am here, though, to ask this Committee to consider some type of a bill or a law in Suffolk County for deadbeat parents who refuse to pay child support and don't work on the books. This in Suffolk County alone is a very big issue. In my case it doesn't affect the roles of Social Services, and that's another big issue. There are families that earn above that income there are no safeguards for, there are no safety nets for. But it doesn't help the fact that the welfare rolls increase each time -- I don't want to say Suffolk County, but New York State as a whole fails to collect. When administrative and judicial procedures have failed, there's nothing in Suffolk County, especially for, as I said, parents of higher income.

So I do have a lot of literature on these things. Westchester County does have a phenomenal program in place. They also have a JET Program. There's a lot of numbers to consider and things to factor in, but I just wanted to run it by the Committee today. I do have every intention of speaking next week, that would be after my trial for child support in Suffolk County. A little further on this; you said we get five minutes? If you would take into --

CHAIRPERSON BROWNING:

Well, no, it depends. The five minutes is -- the Public Hearing is on certain bills --

MS. POLARSEK:

Okay.

CHAIRPERSON BROWNING:

-- Local Laws.

MS. POLARSEK:

Okay. So we're limited to three still?

CHAIRPERSON BROWNING:

But, you know, our Commissioner is here from DSS and maybe you could talk to him. I absolutely understand what you're saying, because I see you're a constituent of mine. You live in Pine Hills, right?

MS. POLARSEK:

I do now. I lost my home in Rocky Point.

CHAIRPERSON BROWNING:

Okay. I will give you my card so you can stay in touch with me. But I can tell you, I deal with that on a regular basis --

MS. POLARSEK:

It has to stop, it really --

CHAIRPERSON BROWNING:

-- single moms with deadbeat fathers and it's --

MS. POLARSEK:

It's not -- no, you see, and that's where -- and I don't mean to correct you. I sit in those rooms in the courthouse in Family Court. It's not just fathers.

CHAIRPERSON BROWNING:

No, no.

MS. POLARSEK:

It's mothers.

CHAIRPERSON BROWNING:

Yeah.

MS. POLARSEK:

There so many factors out there. The bottom line is, if they don't work and -- you can't watch a family go into demise because someone chooses not to work, for whatever the reason, you know. Maybe we need to help them find a job. I'm tired of losing, to be honest with you, and I don't think it's fair for other parents in Suffolk County that aren't strong enough to fight like me. I don't have babies, thank God. The women that have two-year-olds and three-year-olds, there's no answers in New York State. Suffolk County needs to adopt something on our own.

CHAIRPERSON BROWNING:

Okay.

MS. POLARSEK:

Thank you.

CHAIRPERSON BROWNING:

The Commissioner is in the back of the room, if you'd like speak with him. I mean, I know you're talking about some kind of legislation here in Suffolk County. I'm not sure what we can do. Greg, do you want to come up or --

COMMISSIONER BLASS:

Good afternoon, Madam Chair, Members of the Committee. We do have something that Ms. Polarsek is eluding to known as the Early Intervention Program where we sent noncustodial parents with a court order, usually, to the Department of Labor. The Department of Labor would then channel them to employment and report back to the court through this early intervention program, how they were doing. The difficulty -- I worked on this last year when I was a Deputy. DOL finally told us they did not have the staffing anymore to continue it. And we tried to work out a compromise, and the compromise was that we would -- instead of having the Department of Labor actually assign people to sign them in and sign them out and monitor them, they sign themselves in and themselves out, but that still constituted a report that went to the Family Court. I can give you some data on how that program has worked in the past year or so, if you'll just bear with me a minute, because I didn't bring my --

CHAIRPERSON BROWNING:

I think she was talking about some things that are done in other counties and I'd like to see --

MS. POLARSEK:

Yes.

CHAIRPERSON BROWNING:

You know, are we -- do we -- you know, I'm not asking you to talk about it now, but if we could, at some point --

MS. POLARSEK:

There are options.

CHAIRPERSON BROWNING:

-- sit down and talk about it --

COMMISSIONER BLASS:

Sure.

CHAIRPERSON BROWNING?

-- to see if there is something that we can implement here in Suffolk County that may be more helpful.

COMMISSIONER BLASS:

Absolutely, we'll do that. And if we come up with some common ground on that point, we'll get back to you, and maybe that could be a form of a suggestion that we'll share with you and with the Executive.

CHAIRPERSON BROWNING:

Thank you.

COMMISSIONER BLASS:

Thanks very much.

MS. POLARSEK:

Thanks.

CHAIRPERSON BROWNING:

Thank you. Okay. There are no more speakers. We do have two presentations, and we are going to start with Commissioner Chaudhry. However, I strongly recommend, if anyone is able to stay, Steven Dewey, he's from Brookhaven Lab, works in the Medical Department, I think, if you stick around and listen to his presentation, you'll be very impressed, and -- but before, I guess we will start with Commissioner Chaudhry. Thank you.

COMMISSIONER CHAUDHRY:

Thank you very much, Madam Chair. Good afternoon, everyone. Before I turn the microphone over to Bob Delagi, who is our Acting Director of Emergency Medical Services, I wanted to share with you a little bit of an update on the H1N1 Swine Flu situation.

In terms of Suffolk County's numbers, we have seven confirmed deaths and 161 confirmed cases. I mention those number with the caveat that both the CDC and the World Health Organization are actually moving away from numbers, the confirmed numbers of cases, recognizing that there are probably many times that number out there that we just don't know about. It's been, thankfully, very mild across the world, across the country. And so the actual numbers of cases in the CDC, according to the CDC, may be such as many as one million in the United States. So public health

experts are moving away from specific numbers because they don't tell the whole story.

With that said, two other additional pieces of information as an update. Yesterday, the Advisory Committee on Immunization Practices of the CDC, as some of you may have heard, issued guidelines in anticipation of the swine flu vaccine becoming available, hopefully next month or the month after that, in terms of who should get it, recognizing that there may not be sufficient doses, at least early on for the entire population, and they had some very specific recommendations as to who should get them. And even if there are fewer than those, there's some specific recommendations that go beyond that as well. So these will be -- I don't want to take up the Committee's time to go through each of those guidelines now, but these will be communicated, obviously, through our department and will implement as appropriate.

The other thing I'll mention is on Friday, August the 7th, next Friday, the New York State Health Commissioner, Richard Danes, has called for a mandatory meeting of all local Health Commissioners and Public Health Directors up to Albany. The last time they did that was about five years ago. And the purpose of that is for us to spend a day, talking about some of the lessons learned from our management of H1N1, both at the County level and at the State level in terms of interactions and communications, and to be prepared for anything that could happen in the Fall, in terms of dispensing vaccine through our PODs, the points of dispensing process that many counties have in place. I should mention that the National Association of Counties this past year recognized Suffolk County for its drive-thru POD, something we did last year, which was a little bit innovative, in which some of you may have seen this. We did this in the parking lot of the Dennison Building where we found that you could actually have a lot more people get medication or a vaccine. We used seasonal influenza vaccination as the methodology to get many people to come through that process in terms of throughput. So we'll be utilizing all those processes as necessary in the Fall.

I should also stress, finely, that the H1N1 vaccine is not a substitute for the seasonal influenza vaccine. That's something the CDC stressed in their press release yesterday. Both vaccines are certainly going to be recommended. In fact, the recommendation for the flu vaccine, the seasonal flu vaccine, is going to be stronger in the area of children. This past year it was sort of a soft recommendation that they feel, especially since H1N1 hit children so much, that the seasonal flu vaccine should also be given to children above the ages of six months as a hard recommendation, strongly recommended by public health experts.

With that, I'm going to turn the microphone over to Bob, who is going to share with you some fascinating software that we now have in place in Suffolk County in our Health Department, which when this H1N1 situation hit at the end of April this was kind of something being piloted by the department, but recognizing that this was a good opportunity to utilize it, I asked Bob to implement it and we did. And He'll share with you some of the details of the software and how useful it has been up to now and likely will be later on this year. Thank you.

MR. DELAGI :

Thank you, Commissioner Chaudhry. Madam Chair, Members of the Committee, thanks again for your interest and for your invitation to present this. For the sake of time, I'll try to keep it brief, but I will try to give you as much information as I can to make it useful and meaningful for you.

The biosurveillance software is just a very small piece of a very large active and passive surveillance program that the Health Department runs. It is part of our early event detection and early surveillance -- syndromic surveillance process here in Suffolk County. The funding source for this particular product came to us, 100% pass-through funds, from the UASI FY 05 Domestic Preparedness Homeland Security Grant. We chose this product because it was already a commercial off-the-shelf product that was fully integrated with the ProQa Medical Priority Dispatch System that our County Fire, Rescue and Emergency Services, as the County's primary PSAP, runs.

Obviously it's endorsed by the International Academies of Emergency Medical Dispatch, and the scientific information that's contained in this platform is certainly based on recommendations from

the Centers for Disease Control. And, importantly, this is something that kind of resides in the background and it is completely transparent to day-to-day operations by the dispatchers.

Realtime data surveillance is important to us because it involves continued analysis to identify patterns and trends as they emerge. And this is a program, when it's online, refreshes itself with new data every three minutes and provides us with a waving baseline of activity and specific chief complaint codes, and I'll show you some examples in a minute. And the beauty of this program is that not only does it establish the day-to-day baseline, but it also gives us an accurate, contemporary, very timely piece of information when we have call volumes that exceed the normal daily occurrences, and it uses call data that comes into the 911 system for emergency medical alarms.

And out at Fire, Rescue and Emergency Services they run a program called Emergency Medical Dispatch, which effectively has 33 determinant codes. Eighteen of those 33 are for medical conditions, and 15 of those are specific for trauma type situations. And the dispatchers are our true first responders, as you've heard us talk about many, many times. They collect essential information from the caller, they codify the call by chief complaint, they assign a determinant code, and they also assign it a priority based on acuity level. And in addition to that, where they really come into play as true first responders, as you've heard before over the years, they provide telephone first aid instructions, things like cardiopulmonary resuscitation, how to use an AED if one is present but nobody is there who's trained to use it, emergency childbirth. I know there was recently a FRES dispatcher who was honored because of her performance as a first responder.

Most recently, we undertook an initiative where we now have our dispatchers telling callers with chest pain to take an aspirin while they're dispatching an ambulance, and we're very, very proud of that. And there are many other things that they do in that realm as well.

Through guidance from the State Health Department, the National Academies of Dispatch and the Centers for Disease Control, we have identified that 13 of those 33 EMD codes are potential indicators of either a clandestine release of a contaminant or a naturally occurring or man-made occurrence producing increased numbers of peoples with similar casualty patterns or complaints. And this software gives us realtime information on clusters of calls by call type based on dispatch code, clusters of call location by geography, street address and zip code, and clusters of hospital arrivals, all with patients with the same similar chief complaint.

As I mentioned earlier, this does enhance the existing efforts of the Department of Health Service by adding another layer of surveillance into a very robust program that currently exists. This, as a standalone by itself, would not really provide much information to us at all. And What this does, as I mentioned, is it monitors daily occurrences within the community, it establishes a baseline for activity and gives us early warning for increases in baseline, and it does that by sending an E-mail notification to select staff members when spikes against defined patterns indicates suspicious trends. And there is a mathematical formula that the program applies that has been scientifically validated. And, obviously, we can adjust that here locally when we see our numbers, due to normal seasonal changes in activity, occur.

Here's a picture of one, it's a webshot picture of what this will -- what it actually looks like. And if you take a look at the green line, you can see the green line represents the average events on a particular day. And this particular screen shot is from the 17th of June to the 23rd of June. The blue line that's right behind that are the actual events, and the red line, based on that mathematical formula, is the threshold level. So if a blue line spike were to exceed that threshold, we would get the E-mail alert and we would take a look a little bit closer at that. And this one, as you can see, was a particular shot that was monitoring the respiratory chief complaint code.

So, in terms of real world application, when the Swine-Origin Influenza A outbreak occurred, we worked with FRES and other PSAPs through the County to implement the severe respiratory illness protocol. And What this really did was enhance our surveillance activity for syndrome-specific

anomalies by including the human element and professional judgement, on the part of the dispatchers initially and our public health officials secondarily, on the intake side of data collection. And When folks called in with a chief complaint that put them in the sick category, the respiratory category, the chest pain or the headache categories, we would have our dispatchers ask an additional line of questioning that was focused towards the influenza outbreak ongoing by asking specific questions about persistent cough, sore throat, nasal congestion, You can see the list for yourself.

And actually, we're able to collect some additional information that provided the dispatchers with the ability to yield an FC designation, FC, radio language for fever and cough, which was transmitted to the responding ambulance with other relevant dispatch information. This gave us an increase in situation awareness, prompted people to use personal protective equipment, and very, very importantly, gave hospitals early notification that inbound patients might be potentially contagious, because on the other side of the house, on the hospital side, they were being pushed to make sure that they don't segregate sick patients with folks that may not be sick.

So this surveillance software passively monitors call types for escalations above baseline and identifies clusters by complaint, by location and by receiving hospital.

Built into the program is a biosurveillance combination, which is particularly useful to us because the computer will now take calls that fit into several categories; chest pain, neurologic disorders, certain medical disorders, and give us a biosurveillance combo based on CDC recommendations. And again, you can see the same webshot with the biosurveillance combo, the green showing us the average, the blue showing us the actual, and then, of course, the red the threshold.

What it also does is it gives us a pie chart graphic of the percentage of calls in the biosurveillance combination that actually alluded to those -- the comprehensive data. So in this pie chart you can see that 13.4% were cardiac, 6% were GI, 12% neurologic, 18% respiratory and 50% other. Collectively, they make up the biosurveillance combination.

This is just a graph for gastrointestinal. And We might see some very interesting data here where there are food borne outbreak in a particular restaurant, in a particular geography. We might see clusters of patients showing up, initially calling EMS with a gastrointestinal complaint, and then when we look at the map, you can see that there are three or four triangles, one up in the -- between Cold Spring Harbor and Fort Salonga, one just above Brentwood, and one just above Coram. Those three triangles each represent separate calls in that time period for patients with GI complaint.

Now, imagine were there an outbreak that occurred in a particular restaurant where the community congregated to eat and we saw clusters appear by having multiple triangles in a same geographic area. That would give us a heads-up that something was going on in that area.

In addition to that, we can drill down by taking a look by call as to how many of those chief complaints in any specific category we search on and which hospital they went to. And you see, I have blacked out under the patient call and origin the actual call location, because we didn't want to put people's addresses out there for obvious reasons.

You can see that there are hyperlinks. If we click on the hyperlink, we can actually drill right into the FRES CAD record and get all of the information on that call; where it originated from, who called it in, and so on and so forth. You can see on the immediate column to your right the ambulance company that transported that patient.

Now, I was prepared to go to the web and show you some realtime. I will leave that to your discretion. You won't see the graph move at all. It does refresh every three minutes, but it's not something that you're going to actually see. So, in the interest of time, if you would like to go to the web, I would be happy to do that, but if not, I would appreciate any questions that you have.

CHAIRPERSON BROWNING:

Any questions?

COMMISSIONER CHAUDHRY:

And actually, before -- Madam Chair, if it's okay, let me just add two other comments. One, so in a nutshell what this meant for me, as Health Commissioner, was at any time if there was an increase in 911 calls for fever and cough, fever and cough being the two primary signs and symptoms for influenza or seasonal influenza or swine flu, above a threshold that we set in the Health Department, I would instantly get an E-mail 24/7, even at home, because I keep my blackberry with me, letting me know that something's going on. That would prompt further questions and trying to determine, working with EMS, working with FRES, working with our Division of Public Health, what's going on, do we actually have a situation where we have a lot of these calls coming in. So I was very pleased to have this software implemented.

After the first couple of weeks, I even remember calling Bob and saying, "Bob, is the software working, because I'm not getting any E-mails." And He said, actually, the call volumes have not hit the threshold, so that was a good thing. But, of course, things may be different in the Fall, so I think knowing this, that the software exists, is important.

The other point is something to stress is what Bob eluded to, and that is that this software does not supplant or replace the human element. It is, at the end of the day, a technical piece of information that's recorded. All of you should know that the Health Department, the Division of Public Health here in Suffolk County, every single morning, 365 days a year, contacts every single emergency department in Suffolk County to get a sense of what's happening above and beyond numbers. You know, do you have a particular pattern of people presenting overnight or over the last several days, to get a sense of what's happening, again, to be proactive and anticipatory in terms of what's happening in the County. So with that, we'd be happy to take any questions.

CHAIRPERSON BROWNING:

Legislator Kennedy.

LEG. KENNEDY:

Thank you, Madam Chair. I think I know the answer to this one, but let me ask both, because we've spoken a little bit about this in the past, and I should have paid a little bit more attention when you were identifying the categories earlier on. Overdose, drug overdoses, things of that nature, is that something that's a reported category in the first instance that this software is going to extract, or is it specific to what we're looking at here regarding flu issues or food poisoning?

MR. DELAGI:

There is an overdose determinant code used by the dispatchers, and if there were determinant codes for overdose issued by the dispatcher, it would show up in this software. It's not part of the biosurveillance combination, for obvious reasons, but as a freestanding chief complaint code determinant, it's something that we could monitor.

LEG. KENNEDY:

So, as this software goes forward -- now you've had it in place for what, a couple of months, I guess?

MR. DELAGI:

It's been in place for probably six to nine months, but we've increased our efforts in working with it over the last several months, as the Commissioner had mentioned before.

LEG. KENNEDY:

Okay. If we wanted to try to aggregate, and again, I'll go back to some of the questions that we've had about the elusiveness sometimes of trying to gather that contemporaneous data, is that something that we would actually -- should I write and ask if this is a category that you could identify for monitoring purposes?

MR. DELAGI:

I think all we would need to do -- because the program does have a finite amount of determinant codes, it can monitor at any one time. I think it would be very easy to take one of the ones that we have out and add the overdose one for that specific purpose.

LEG. KENNEDY:

Okay.

COMMISSIONER CHAUDHRY:

The other thing I would add, Legislator, is that this information, while very valuable, is just one piece of information at the end of the day.

LEG. KENNEDY:

Of course.

COMMISSIONER CHAUDHRY:

It does not pick up people who, let's say, are driven to an emergency department or to a hospital or who visit a doctor who may have fever and cough and other signs of symptoms. It does give us a -- kind of a piece of the bigger picture, which is why it's called surveillance software. It's meant to supplement the human element of getting information through other means. So, yes, it is a product and service that can be of great use to us above and beyond influenza, fever and cough. I would just caution that the information would not be complete, though, in terms of what one might be looking at.

LEG. KENNEDY:

Your point's well taken, Doctor, and it's one of the things where I don't want to take up the Committee's time now, but it's an issue that we've kind of looked at it. And, as a matter of fact, as you know, our next presenter is somebody who's going to speak to us about what's going on with some of the drug overdose issues. Being able to comprehensively quantify, measure and do so contemporaneously seems to be a challenge that I'm just still struggling to understand. But nevertheless, thank you.

CHAIRPERSON BROWNING:

Thank you. Does anyone else have questions? Okay. I think there may be -- I may have some questions later -- I don't want to hold up Mr. Dewey -- about the healthcare centers. Maybe you can hang around for that. We appreciate this presentation. I'm very enlightened and we're getting ahead here in technology. It's great.

MR. DELAGI:

Thank you.

COMMISSIONER CHAUDHRY:

Thank you.

CHAIRPERSON BROWNING:

With that, Steven Dewey, if you could -- what I'd like you to do is you'll do better than me to introduce who you are. I do want to say you came to see myself and the Presiding Officer and we were blown away by what you said and what you do, so that's why I thought it was so important that you come today.

LEG. KENNEDY:

Can they see in the back, the audience?

CHAIRPERSON BROWNING:

Everybody in the back of the room, can you all see this screen? If you want to move up.

LEG. KENNEDY:

Madam Chair, we're joined with Elaine Economopoulos from Smithtown Horizons Drug Center, and Ms. Hirschhorn, who's the head of Smithtown Youth Bureau, as well as some of my staff. We were all very interested in what you have to say today, Doctor.

MR. DEWEY:

Thank you very much.

CHAIRPERSON BROWNING:

You have to hold it down so you can speak.

MR. DEWEY:

Hold it down, okay. I'll try to be very brief, even though there's a lot of work. Just to give you a background, I'm kind of a local kid. I grew up in Port Jeff, went to college, and then I went to -- completed what was called an MSTP program, which is a medical science training program, where I got my M.D. and my PhD, and then I became board certified as a neurologist. And I've been interested in substance abuse for the last 25 years. And we have been studying substance abuse at Brookhaven National Lab for at least that long. For those of you who don't know where it is, it's Exit 68. It's a fifty-five hundred acre site. But we've been studying substances abuse there for almost a quarter of a century.

And what I thought I would do is show you some of the work that we do. I started an outreach program as President of my local Board of Education in 1994. I live in Eastport, and at that time there were four or five hundred kids in our district, so I reached four or five hundred kids. Today I get to about 150,000 kids across Suffolk County and Nassau County. Every year I get into the schools and I speak to the kids about the work that we do, and I show them the pictures that you're going to see. You can see for yourself what we see every day. This is something that I started, again, in '94, and I've been doing on my own ever since.

We use a very sophisticated imaging technique at Brookhaven that's quite unique to what everyone is used to. We're all used to the kind of anatomical imaging techniques, which includes CAT scanning, MRI and X-ray. These are techniques that allow us to see how something looks, not how something lives. So these are very powerful tools, obviously, but we need actually a way to look at how something lives, because as we all know, diseases, regardless of their origin or their type, they all initially start out as a change in function, not as a change in anatomy.

So we built at Brookhaven a PET scanner, positron emission tomography. This is a camera that allows us to see how the body lives as opposed to how the body looks. For those of you who've never seen a PET scanner, this is a typical PET scanner. We have two of these at Brookhaven. These are state-of-the-art machines. They allow us to study the human body from head to toe. And, again, they allow us to see how the body is living as opposed to how the body looks.

As I mentioned before, we've studied every drug of abuse that's out there. If it's abused, we've studied it. If it's abused by little kids, we've studied it, and if it's abused by adults, we've studied it. We have looked at short-term, long-term and chronic use. We've looked at single users, we've looked at kids who have used just a handful of times. We have studied, again, every drug of abuse that's there, and we've studied them in young kids, we've studied them in middle school kids, high school kids, college kids, adults, people up into their 70's and their '80's.

There's a couple of things that we can say about every drug of abuse. One of them is that every drug of abuse -- the most common drug of abuse in the world today is caffeine, but every drug of abuse, including caffeine, works by elevating a chemical in our brain called dopamine. We all have it, we all need it, and we all use it. Dopamine is the primary chemical in our brain that allows us to move. When we have Parkinson's Disease this is a loss of brain dopamine. Our sense of novelty-seeking, how willing are we to do something different, is directly related to brain dopamine.

And I've always been fascinated by the fact that substance abuse is an issue that we really deal with primarily in adolescence. There is an interesting statistic. If you haven't abused a drug by the age of 22, the likelihood that you will later on is less than 5%. So what happens is kids get into this stuff early on, they become hooked, and that's where the problems start. So we're obviously very interested in the adolescent issue.

We've done work looking at adolescents. In novelty-seeking, you can go into any high school, any middle school, any elementary school, and you can ask the kids to point out the kids that will try anything. You can have the kids point out the kids that won't do anything. And we've studied those kids and we see real differences in their brains. It's very easy to see, it's very easy to measure, it's very easy to reproduce. So we've done a whole host of studies just looking at novelty-seeking kids. And we specifically did series of studies where we looked at people who like to bungee jump. These are people who bungee jump out of hot air balloons, so that's obviously far more risky than bungee jumping off of a static platform, and those brains were remarkably different than kids who wouldn't bungee jump at all, or kids who would bungee jump off a fixed platform. So we have a very good understanding of why adolescents are drug abusers, because they have a profound difference in brain dopamine relative to people my age. Your sense of well being, how you feel in the morning is directly related to brain dopamine. Your dopamine levels tend to be lower in the morning than they are in the middle of the afternoon, and they tend to be higher on a Friday afternoon than they are on a Monday morning. And, of course, addiction. Every drug of abuse works by increasing brain dopamine.

Now, just to give you a perspective, I have a 17-year-old son who's a senior in high school. He's not a terribly good math student, but if he gets a 95 on a math test, his brain dopamine levels might increase 10 or 15% and he feels pretty good about it. He's not a very good math student. But that same 17-year-old boy, if he took a hit of methamphetamine, his dopamine levels would go up between seven hundred and 800,000%. So what we're talking about is a difference of between 10 or 15% for feeling good about a test score, to seven or 800,000% from a single hit of methamphetamine. So these are the differences that we're looking at, these are the changes that we see, and we see them every day.

Now, we've heard some issues today talking about nicotine and smoking. We looked at the brains in people who smoke. We know that the statistics in smoking are out there, they're readily available. It's estimated that roughly 7% of people who smoke get lung cancer, 93% do not. If you look speak to the kids, as I do, and ask them why they smoke, they'll tell you that they don't believe that they're going to get cancer; the data suggests they're not going to get cancer. Their parents smoked for 50 years and they don't get cancer. And the statistics suggest that they probably will not get cancer. Of course, they will get emphysema, they'll get cardiovascular disorders, things of that nature, but they're willing to take those risks.

If you look at the human brain in individuals who smoke, the differences are quite striking, and this is in 100% of people who smoke. What you're looking at on the left is a 22-year-old female. This is a classic, typical PET scan. The rainbow scale, if you remember back in elementary school, ROY G BIV, the red is a lot of activity, blue is very little. This is a normal human brain. The individual's eyes are here. And we're looking at a very specific chemical in the brain called monoaminoxidase. This is a 22-year-old smoker. You can see as well as I can see, and all the kids can see, that smoking destroys this chemical in their brain. This isn't five out of 100, it's not 10 out of 100, this is 100% of people who smoke. One hundred percent of people who smoke, whether it's cigarettes, pipes, they smoke tobacco products, destroy this chemical in their brain. Same with people who chew, people who consume tobacco by mouth.

The chemical in the brain here is called monoaminoxidase. Monoaminoxidase is a chemical that breaks down brain dopamine. If we didn't have monoaminoxidase in our brains we would all walk around high because our dopamine levels would increase. Now we have a very good understanding why substance abusers, they're so comorbid for cigarette smoking, because if you smoke, you destroy the very chemical that breaks down the dopamine that you've increased by using cocaine or

alcohol. So we have a very good understanding of now comorbidity between substance abuse. This is also the case for secondhand smoke. Individuals who are exposed to secondhand smoke also lose monoaminooxidase. So it occurs on a dose-dependent manner. That is, those who smoke the most lose the most. Those exposed to secondhand smoke lose less, but they still lose some. Unlike every other image you'll see today, this is a reversible effect. That is, if you get away from the smoke, the monoaminooxidase comes back, and it comes back in what we call -- in about nine days. And we use a six half-life rule, six times nine is 54. So 54, 55 days after your last exposure your monoaminooxidase has returned to normal.

But the point here is, when we speak -- when I talk to the kids, there is a consequence of smoking. They will lose this chemical, they will destroy this chemical in their brain, and by doing so, they potentiate all those things that we saw before. If you start to alter dopamine, which is what happens when you smoke, you have issues of movement disorders. You see it all the time in chronic smokers. Changes in depression, it's very common, changes in their sense of novelty, and, of course, they become addicted.

We spent a lot of time on marijuana. THC is a very common drug that's used in all schools. I'll ask you just to focus on the two images on your left. The two images on your left actually represent the summation of 4,000 patients, and what we're looking at is you can see three bright spots quite easily. There is a spot in the middle that's orange and two purple spots. Now, I hear all the time, time and time again, that nicotine -- that pot's not addictive and that it has -- produces no changes in the brain. Nothing could be further from the truth. THC or marijuana meets DSM-IV criteria for addiction, and we can go into what those are if you're interested. But more importantly, they produce permanent and profound changes in the brain that we can see, we can measure, and we can quantify.

This part of the brain, the middle part of the brain, the, hypothalamus, is a part that's associated with hormone control; it's also associated with feeding behavior. If you've ever talked to anyone who smokes pot they'll, tell you they get the munchies. The reasons they get the munchies is because they're altering their hypothalamus. When you start to alter your hypothalamus, you produce changes in hormone release. When you produce changes in hormone release, you produce changes in the way the body develops. So you can cause kids to go through puberty prematurely, and you can cause those who have gone through puberty to go back the other way. And these changes, again, are permanent. When you alter your hypothalamus, you alter your body's ability to regulate temperature, so they can become febrile much easier. They alter their respiratory rate and they alter, obviously, hormone release and balance.

As a sidelight, if you just want to think about the feeding behavior issue, which is something that kids are interested in, people have now done studies looking at what are some of the feeding behavior diseases. Well, there are basically three of them. There's anorexia nervosa, there's bulimia, and there's obesity. These are the three eating disorders that we think of commonly. People have done studies where they've correlated the use of THC and these eating disorders, and they came up with a correlation of about .7. Now, what that means, very simply, is if I put my hand on a table and I hit it with a hammer, every time I do that it's going to hurt. That's a correlation of one. That's a one-to-one event, that's a cause and effect. Every time I hit my hand with a hammer, it hurts. With a correlation of .7, that's not cause and effect, but it's a very strong correlation. So when we think about people who smoke pot, smoke a lot of pot, we need to think about eating disorders.

It gets a little more complicated, obviously, because anorexia is typically a female disease. Ninety-three percent of all anorexics are females, only 7% are males, so there is clearly a sex difference between boys and girls with the use of THC. Nonetheless, there are profound changes in THC.

These two spots that you see here, the purple spots are the amygdala. The amygdala, whether you believe it or not, is what keeps you alive every day. As we sit in this room, if we hear a trail whistle

off in the distance, we don't think much about it. It doesn't really mean a lot to us, it has no significance. However, if we're driving home tonight and we're crossing railroad tracks and we hear a train whistle, the relevance of that train whistle becomes much higher. Your amygdala sits there every second of every day and analyzes your environment and tells you what you need to pay attention to.

They've done some very interesting studies in New York City where they look at if you're walking in New York City on a street on a busy, you know, workday and there's thousands of people in the City, nobody gives a lot of thought to stepping off the curb, walking across the street, and stepping up the curb. But if you watch, you look at the tapes that people have done and you watch the number of people who have tripped and fallen, and then you go and you get those individuals and you correlate them with the THC use, the correlation's about .8. So what you see is, as you smoke more pot, you destroy your amygdala. Your amygdala plays a role in making you pay attention to things you pay attention to, and as you destroy that, you start to see increases in accidents. The number one cause in household accidents is THC abuse, and now we know why, because we permanently change our amygdalas bilaterally, that is both sides.

We've done a lot of work with alcohol, obviously. Alcohol is the number one killer of kids in high schools. We've done studies, clearly done a number of studies where we take an individual, this is a normal individual, 25 years of age. This is his brain before he gets intoxicated, and you can see the reds and yellows as well as I can. We get him intoxicated and you can see that the reds disappear and this part of the brain actually shuts off. So what can we say about that? What we can say is in the presence of alcohol, when you're intoxicated, your brain doesn't work very well, and, in fact, it's not working as well as it can. Well, we don't need to do fancy PET scans to tell you that that's what happens, because we see it all the time.

But let's look at the disease of alcoholism. On your left is 55-year-old normal control. You can see a normal PET scan. On your right is a 54-year-old alcoholic who hasn't had a drink in over 20 years. This is an alcoholic who is abstinent from alcohol. So you can see that alcoholism produces a permanent change in brain chemistry. You can see it as well as I do.

Now, it gets a little more interesting. If we take an alcoholic who continues to drink, that is an alcoholic who is not abstinent, when he's sober or she's sober, their brain looks just like this, exactly what you would expect from an alcoholic. When they are intoxicated, their brain looks just like this. So what you see in the disease of alcoholism is in the presence of alcohol, their brain performs normally. And when you ask an alcoholic the number one reason why they drink, the number one answer is it makes me feel normal, and that's exactly what we see. Alcoholics, when they're intoxicated, have brain activity that is just like age-matched controls. So we now know that alcoholism is a disease where the brain actually performs normally in the presence of alcohol.

We have done studies in children born of single alcoholic parents, asking the obvious question that we get asked, or I get asked, all the time, "Is it hereditary?" In fact, it is. If you look at the epidemiology data, about 30% of -- about 30% of people who are alcoholic have an alcoholic history. If you look at kids of an alcoholic parent, about one-third of them will have a response to alcohol just like an alcoholic. It doesn't mean they're going to become one, but it means they have a response consistent with it.

We've done a lot of work with cocaine, obviously. Cocaine is actually a big problem in schools. This is an interesting study. The reason I show it to you is just to show you the power of suggestion. What you're looking at here is a study that we've done, we've done this many times, in fact, where we bring a cocaine abuser into the imaging center. We measure his baseline dopamine levels. We call that 100%, whatever that is. We then show that individual this picture. Now, for those of you who don't know what this picture is, this is a piece of glass with cocaine powder being cut up by a razor blade using somebody's fingers. This is how cocaine is typically snorted. It's cut up so that it's finer. We show the individual this picture and this picture alone, and his dopamine levels go up 500% just by looking at the picture. That goes right to the question, right to the fact that we know.

What is the number one cause of recidivism? It's environmental cues, it's environmental triggers.

If you talk to people who smoke, they'll tell you they smoke -- they crave a cigarette after a meal, they crave a cigarette driving a car, they crave a cigarette when they've speaking on the phone. This is exactly what we see with substance abusers. If you take any substance abuser, and this just happens to be a cocaine abuser, and show him a picture or her a picture, they will go -- their dopamine levels will increase, their skin will become flushed, they're cardiac output will increase, and they'll start to crave, just from showing them the simple picture.

Now, I see you're all old enough -- old as I am, so you can remember that there used to be a commercial that said, "This is your brain on drugs." I guess there's someone -- there's some younger who don't remember, but they used to run a commercial on TV that said, "This is your brain on drugs," and they crack a couple of eggs in a frying pan. What you're looking at here is actually the real deal. This should say cocaine, not heroin. This is a cocaine abuser. Normal control individual, as we're looking at dopamine in their brain. This is a cocaine abuser one month after his last dose. Here he is four months after his last dose. We've looked at him eight years after his last dose and he looks just like this. Cocaine abuse causes permanent loss in brain dopamine and it never comes back. We can take a cocaine abuser, we can look at their brain, and we can tell you how long they've been abusing, how much they've been abusing, and we can see the changes just as easily as you can see them.

If we look at how their brain lives, this again should say cocaine, this is a normal individual. You see the nice bright red spots which are consistent with what we know about brain activity. This is the back of the brain. We scan all our subjects with lights on. The back of our brain is where we see, so you would expect that the back of the brain would be very active. Here's a cocaine abuser one week, three months. You can see as well as I can that chronic cocaine abuse not only causes a permanent destruction in brain dopamine, but it causes a permanent reduction in the way the brain lives.

I get asked all the time how much cocaine. "How much cocaine do I have to use before these changes occur?" This is a very unique case. This is a young lady. She's 16 years of age; she's a diabetic. One of the things we deal with every day is the honesty of our substance abusers. If you ask a cocaine abuser how long he's been abusing cocaine, he'll tell you a couple of weeks, maybe a month, when, in fact, he's been abusing for years. We can look at a PET scan and tell him he's been abusing for years when he tells us it's only been a week.

This is a young girl who drew -- who was a diabetic. She drew blood on herself every day for over four years and recorded it in a notebook, all her strips, so we have her blood for four years. We know she never used cocaine. She went to a party and she used cocaine in the smoked form called crack, which is just the hydrochloride salt. She fell into a coma for a couple of weeks. Her mom brought her to the imaging center and her mom said to me, "This is my daughter, the girl I gave birth to, but it's not the girl that I know." So we took a PET scan. This is the of her brain, this is the bottom of her brain. Where the arrows are pointing are large blew spots. It should be bright orange. With a single dose of cocaine in a cocaine-naive subject, she stroked out more than half of her brain. So when asked how much cocaine, I can say one time.

Now you -- most of you probably remember Len Bias. Len Bias was a basketball player who signed a contract to go pro and celebrated by using cocaine. He was also a first-time user and it killed him. Cocaine is a very powerful vasoconstrictor, it stops the heart, so it can either kill you instantly or it can cause you to stroke out your brain.

Just to give you some perspective, because I hear all the time from people that we shouldn't be studying substance abuse because it's a choice, it's not a disease, it's a choice, people make the decision. Well, Alzheimer's Disease isn't a choice either. This Alzheimer's patient is a GDS-IV, doesn't know who he is, where he is, or when he is. He is completely demented. Many times our GDS-IV Alzheimer's patients have more brain activity than our cocaine abusers. And I only throw

that in there so that we can -- when one wants to have an argument that addiction isn't a disease, we certainly have evidence that diseases we readily think of as diseases have changes that aren't as great as what we see in substance abuse.

The most addictive drug that we have ever seen is methamphetamine. It's here, it's in our schools. It's in every school district that I've been to. I've been asked about it more than I can -- more times than I can count. The reason I show it to you in different colors is because it comes in different colors. In its pure form it looks like ice, hence the name crystal meth. If it's made with red Robitussin it can be red. If it's made with green Nyquil, it can be green. If it's made with Triaminic, which is a yellow cough syrup, it can be yellow. If its' made with {eguanifins}, it can be brown. So it comes in different colors and the kids can tell you which colors are the best, which colors produce the highest high. But, again, it is the most addictive compound we've ever seen.

This is a 12 year old girl on the top. When she was 12 years old, this is what her brain looked like. A normal 12-year-old girl, dopamine receptors, symmetrical on both sides for her age, normal control. She happens to be my daughter at the time when she was 12. This is a 12-year-old girl who got into methamphetamine, consumed it orally in her house. Her parents had left it there in her house and she consumed it. Her six-year-old sister did the same thing, and they are now in permanent vegetative states from a single dose of methamphetamine. Methamphetamine is the most toxic drug we have ever seen. Its abuse rate is extremely high here on Long Island. It's not as high as the opiates. The opiates are higher at this point, but methamphetamine was higher about four years ago.

Just to give you an example, when we opened our clinical trials for methamphetamine in 2005, we didn't have -- we only had two local people that signed up. The rest we had to fly in from the west coast. Now, if we open up a trial with methamphetamine for 100 seats, we'll get 600 people call up to get into the trial. So methamphetamine is the most toxic drug we've ever seen, and, of course, it produces profound changes in the face.

Heroin. Heroin is one of the most common drugs now. It's got the highest rate of increase in use in school districts. Of all the school districts that I have been to, I get asked about heroin the most. It has got the highest rate of increase. It's not the most abused drug, but it's got the highest rate of increase, and we know why. It all starts from prescription pain medications that are prescribed and given to families. These are the OxyContin, Vicodins, Hydrocodone, Hydromorphone.

Opiates, heroin can appear in a host of colors. It's very cheap. If I ask kids in school districts what they're paying for a hit of heroin, it's about four bucks. If I ask them what they've paying for an 80 milligram OxyContin, it's 20 bucks. But every school district that I've been to, that's the same problem. Heroin is around, it's there, and it's cheap. It's about \$4 a hit.

Heroin will produce an increase in brain dopamine between 1,000 and 5,000%. Now, unlike cocaine and unlike methamphetamine, the heroin high lasts much longer, so kids are opting to do it, simply when you ask them, simply because they stay higher longer. The cocaine high or the methamphetamine high is better, they'll report the high is better, but it's very quick, whereas the heroin high is a good high according to them, but it lasts a long time. And, again, it's borne out of these prescription pain medications that contain synthetic morphine.

Just to show you a comparison, this is cocaine on the top, and you can see the decrease in dopamine that I showed you before. Here's alcohol. You can see the decrease in dopamine before. And Here's heroin. You can see the dopamine decrease before. Heroin also destroys dopamine receptors. It does it faster, quicker, and the effects are far longer lasting. It becomes addictive sooner than cocaine, it becomes addictive sooner than methamphetamine. It is probably -- it's not the most addictive drug we've seen, but it's the most consistently addictive drug we've seen, and what that means is some kids don't like methamphetamine, so they won't get addicted to it. Very few kids say they don't like heroin. So it's here, it's in all of our school districts. I haven't been to one district, and I've been in all of them in Suffolk County, where they don't talk to me directly

about heroin problems.

The medical consequences we don't need to go into. We can talk about them if you're interested. They're systemic, they're whole body. We see changes in virtually every organ. There can be system-wide damage.

Some of the statistics: We work closely with the National Institute on Drug Abuse. They also see a huge increase in heroin abuse and heroin use, and, again, we think it's related directly to the prescription pain medications. As an example of what goes on, I had a recent experience with my daughter who had her wisdom teeth extracted and got a prescription for 126 OxyContin, 126 80 milligram OxyContin tablets. Now, normal pain management for wisdom teeth extraction should last for between four and five days, and she got a script for over a month-and-a-half. And what happens is the meds are left in someone's house, and if you go and talk to parents, you go to people's homes, you will find OxyContin, you will find Vicodin, you will find Hydrocodone, Hydromorphone, in their medicine cabinets, and one of the reasons this happens is because of the issues of pain management. Physicians are constantly in trouble for inadequate pain management. If you don't manage the pain of your patient adequately, that becomes a real problem, so what physicians do is they overwrite, and that's exactly what we see. And once you start with an OxyContin, once you start with a Vicodin, once you start with a Hydromorphone, you immediately will transition to something that doesn't cost -- something that costs four bucks as opposed to something that costs 20.

I'll end on this. We study every drug of abuse that's out there, like I said. One of the things that hit me recently, or actually over the last few years, when I get into elementary schools, I get -- they talk a lot to me about inhalant. Inhalants have the highest incidents of drug abuse in elementary schools. This list that you see up here all comes from people, kids. I didn't make them up, the kids have told me. The number one choice is liquid paper that contains acetone. Kids paint their nails with it and sit in class and put their fingers next to their nose and get high. Number two are these air fresheners in cars, you've seen them. Kids will hang these air fresheners. They are shaped like a Christmas tree or a Christmas wreath, so their car smells like an evergreen forest, you know, and they actually contain xylenes and hexanes, which are extremely toxic.

We've done very simple tests at Brookhaven where we've taken kids, 17, 18 year old kids and sit them in a chair and they have a red light and a green light and a foot pedal, or a gas pedal and a brake. When the light is green, they put their foot on the gas, and when the light turns red, they put their foot on the brake and we time them. You then open a bottle of nail polish remover that probably is in all of your homes, and you put it in front of them and just do three wafts. And I can't tell you a concentration, probably 3,000 ppm, and their response time will go from less than a second to over eight seconds. So if you think about it when you're driving your car the next time and the light turns red, just count to eight before you put your foot on the brake and you'll see what happens.

So I'll end there. This is what I get through to the kids. I get out to the school districts every week, I get into school districts every week. I've spoken in I believe every district in Suffolk County and most of them in Nassau County, and this is the message I get out to them. And we get into dialogues with kids. I've spoken for, you know, ten minutes and answered questions for three hours. So I appreciate having the opportunity to speak before you. If you have any questions about anything, any drugs I didn't go over, I'd be happy to answer them.

CHAIRPERSON BROWNING:

Thank you. I'd like to start, because we actually had an issue come into my office about Ketamine and people who are going to probation, and I hate to say it too much, that are using Ketamine, because when they're getting drug tested it doesn't show up. Can you --

MR. DEWEY:

Sure. So Ketamine --

CHAIRPERSON BROWNING:

Well, the question is, is how do you test for Ketamine?

MR. DEWEY:

Ketamine is very easily tested for.

CHAIRPERSON BROWNING:

Okay.

MR. DEWEY:

It does show up. Ketamine absolutely shows up in urine and it shows up in plasma. Ketamine is known as Special K on the street. And the reason kids can get is because its number one use is for vet -- is a veterinary application. So you can go to a vet house and order it and get it. Ketamine is no different than phencyclidine, which is PCP. So Ketamine is basically angel dust without a carboxyl group. It absolutely tests, it absolutely shows up in urine, it absolutely shows up in plasma. Kids use it because they get access to it through the veterinary drug suppliers. It's very easy to get Ketamine, Special K, and it acts just like phencyclidine. So they hallucinate, it produces cardiovascular effects. We use it in kids all the time. It's a very short-acting anesthetic. When a kid is having a tonsillectomy, we'll induce the anesthesia with Ketamine, and then put them on propofol or something to maintain the anesthesia. But Ketamine is a safe drug when it's used appropriately. It's used in children specifically, but it's a very, very dangerous drug because it produces hallucinations at the doses the kids use it.

CHAIRPERSON BROWNING:

And I know Legislator Gregory has a question, but I know that we talked a little bit about a new drug that's coming out next year. You know, after we're done with questions, if you can speak on that. Legislator Gregory.

LEG. GREGORY:

Thank you for your presentation, it was very informative. I just have one question. When you started talking about Vicodin and OxyContin as a precursor to heroin addictions, have you studied the -- why there's the curiosity or, you know, the leaning towards those types of prescription drugs?

MR. DEWEY:

I can tell you a couple of things that are -- again, that are very simple. In the presence of pain, these drugs, OxyContin, Hydrocodone, they're not addictive. In the presence of pain they are not addictive. The problem is pain subsides over time, naturally. You know, if you go and you have your wisdom teeth extracted, within a week or so the pain's gone anyway. The problem is, as the pain dissipates the person continues to take the drug. So in the absence of pain they become addicted.

LEG. GREGORY:

Okay. I was taking it a little bit further. I was thinking that the adult was prescribed the drugs, but the children were raiding the medicine cabinets.

MR. DEWEY:

Absolutely. That's exactly what happens.

LEG. GREGORY:

Now what -- now why is --

MR. DEWEY:

Right.

LEG. GREGORY:

What draws a teenager to do that in the first instance?

MR. DEWEY:

So I can tell you that -- what I get told is they hear from their friends that you can get high on OxyContin, you can get high on Vicodin, so they go home and they find Vicodin in their medicine cabinet and they bring Vicodin in and they get 20 bucks.

LEG. GREGORY:

But have you -- is there a study out there that it can -- that will show, I guess biologically or whatever, those that are -- that have tendencies to seek out those drugs --

MR. DEWEY:

Absolutely.

LEG. GREGORY:

-- Just from peer pressure and things?

MR. DEWEY:

Absolutely. There are very -- we've done some very nice studies where we have given -- we do a lot of work with Ritalin. Ritalin is a wonderful drug. If both of my kids had ADHD, I would have put them on it, no questions asked. But what we've done is taken non-ADHD kids and give them a single dose of Ritalin, and what you will find is a handful of kids find it -- they find it very unpleasant. The majority of kids don't feel much from it, and a small percentage of kids really like it. And it's those kids who really like it that will tend to go and get -- they actually will tend towards the opiates. So what you can do and what we have done and what other groups have done to reproduce this work is to select -- is to find out which kids will respond to what kind of a drug challenge. And based on how they respond to a very, very simple Ritalin drug challenge, you can predict with a really high certainty which way they'll go, whether they're going to try something else or whether they won't.

LEG. GREGORY:

Thank you.

CHAIRPERSON BROWNING:

John.

LEG. KENNEDY:

This is absolutely intriguing, Doctor, I have to tell you. It's an outstanding presentation. And, as a matter of fact, this past spring I heard about your work over at Suffolk Community, as a matter of fact, in the CSACs class, so it's amazing, which leads me to, I need to speak to you afterwards. As a matter of fact, we have some people here who we're going to have a ten-district presentation for Superintendents in Hauppauge. But I have another question for you as far as what you're looking at, particularly with heroin. Do you -- have you done any study on the maintenance drugs? Have you looked at Methadone and have you looked at Suboxone.

MR. DEWEY:

Absolutely, and that's a very good question. These drugs are -- Methadone and Suboxone, or Buprenorphine, are drugs that are replacement therapies. So the Methadone story is a very, very simple one. You replace one addiction for another, it's that simple. Actually, Methadone is a more addictive drug than heroin. So Methadone actually has a higher street value than heroin does. So we absolutely have studied both Suboxone and Buprenorphine. What you see with Methadone is exactly what you see with heroin, the exact same pattern, dopamine loss, an addictive liability, changes in cognitive function. What you see with Suboxone or Buprenorphine is, again, the same thing, but at a much slower rate. And that's consistent with the pharmacokinetics of both of these drugs. Suboxone is a faster -- faster acting drug -- I'm sorry, is a slower acting drug than Methadone, so you would expect the effects to be -- take longer with Suboxone, which they do. So

we absolutely have done studies on both Suboxone and Methadone. We see the same changes that we see in heroin. We see them faster with Methadone than we do with Buprenorphine or Suboxone.

LEG. KENNEDY:

How were -- with Methadone, and again, for my laymen's perspective, my understanding is, is once you take addict and they transition off of heroin and -- as a matter of fact, we have Methadone programs here in the County --

MR. DEWEY:

Sure.

LEG. KENNEDY:

-- as you know.

MR. DEWEY:

Yep.

LEG. KENNEDY:

And for all intent and purposes, those individuals are patients, I think, for life.

MR. DEWEY:

Correct.

LEG. KENNEDY:

And now with Suboxone, is it reality that an individual can get titrated down to no drug at all, or is that just part of the drug company hype?

MR. DEWEY:

Right. So let's look at what do the data say. The data say to us that the -- the data are very clear. The likelihood of getting someone off Methadone is probably less than 4%. It's very difficult to get someone off of Methadone. The latest data that we have seen with Buprenorphine is it's about 12 to 15%. So it's a little higher for Suboxone. We are able to titrate them. One of the problems with both of these drugs is if you titrate them down, they become what's called supersensitive, and the abusers will do this themselves. As you titrate them down, they become super sensitive to the drug. That means if they get a bigger hit of the drug, they'll get a bigger high than they ever did. So when you start to titrate them down, you have to be very careful that they don't relapse, because if -- In that case, it can be life-threatening. But the answer to your question is it's -- there is a component of drug company hype, but there also is a component in fact that you can titrate them down, and more effectively with Suboxone than you can with Methadone.

LEG. KENNEDY:

Okay. Thank you.

CHAIRPERSON BROWNING:

Jack.

LEG. EDDINGTON:

Yes. Awesome presentation. I was wondering, have you ever come across Dr. Gerald Edwards from Adelphi? He used to work for the Northeast Regional Training Center.

MR. DEWEY:

I have not. I have spoken at Adelphi, but I have not.

LEG. EDDINGTON:

Okay. I worked for him for 24 years as a drug educator. This is a great presentation. Anything I can do or anybody here to get it into schools or support that, let me know, because I think we're not

even spending \$2.40 on prevention these days, you know. And I think everybody should be mandated to sit with you and see this. It really opens your eyes. And I love the -- you have the background, so you can show the brain chemistry, and I think that's been the piece -- when I used to do my presentations, you just can't -- if you don't have it, you can't give it. You have it and you can give it and I think that's a key element in prevention. So I appreciate it --

MR. DEWEY:

Thank you.

LEG. EDDINGTON:

-- and commend you.

MR. DEWEY:

Thank you.

LEG. EDDINGTON:

Oh, I did have a question. Sorry.

MR. DEWEY:

Yeah, sure.

LEG. EDDINGTON:

You mentioned about with smoking.

MR. DEWEY:

Yes.

LEG. EDDINGTON:

And I forgot, was it {monoxymin} or --

MR. DEWEY:

Monoaminoxidase.

LEG. EDDINGTON:

Okay. That chemical --

MR. DEWEY:

Yes.

LEG. EDDINGTON:

The brain what, destroys that? So the dopamine level is, you know, changed.

MR. DEWEY:

Right. So what we have is in every system in the -- every system in the brain has a system that controls it. If we didn't, we wouldn't be able to function. So when we release dopamine, to move my arm -- for me to move my arm I have to release dopamine. When I stop moving my arm, I've got to get rid of the dopamine that was moving my arm, so monoaminoxidase is what does that. And if I didn't have monoaminoxidase, I would stop moving my arm, but I would continue to have slight tremors. And if you look at people who smoke for long periods of time, they have what are called distal tremors, and that you'll see these slight tremors in their hands, and that's related to a lack of dopamine control. That's the consequence of the loss of monoaminoxidase.

LEG. EDDINGTON:

So is it smoking? It's obviously the chemicals in the smoking.

MR. DEWEY:

Right. So what I can tell you is it's not nicotine.

LEG. EDDINGTON:

Oh, that's where I was going.

MR. DEWEY:

It is not nicotine.

LEG. EDDINGTON:

Okay.

MR. DEWEY:

It is -- in cigarettes there are over 3,000 compounds that we know of, nicotine is one of them. There happen to be in tobacco three well-known monoaminoxidase inhibitors, so we know what those compounds are in tobacco that destroy the monoaminoxidase. It is not nicotine.

LEG. EDDINGTON:

Thank you very much.

MR. DEWEY:

Yep.

CHAIRPERSON BROWNING:

Okay. You mentioned about amygdala and the -- you know, what it does when you're smoking pot. Does that recover if you -- does it get better if you stop smoking?

MR. DEWEY:

In individuals that we've studied who smoked -- now, again, one has to keep in mind that we're not -- one has to keep in mind that people tend not to be terribly honest about their use or the degree to which they use. So with that in mind, when we look at people who smoked a considerable amount of pot, according to them, in the 60's and in the 70's, we see striking changes in the amygdalas today, so those changes seem to be permanent.

We can make another statement that's very simple and very well-known. What's -- The active ingredient in marijuana is THC, tetrahydrocannabinol. In the 60's, there was a standard amount of THC grown in those plants. Today, in 2009, most of the THC is grown hydroponically, it's fed better nutrients, so we now have marijuana that has three orders of magnitude or 1,000 times more THC than the marijuana -- than the pot had in the 60's. So the stuff the kids are smoking today can be as much as 1,000 times more potent.

CHAIRPERSON BROWNING:

Another thing. You know, our Welfare to Work Commission, Kathy Ligouri is here. She's Co-Chair of the Welfare to Work Commission. And we have formed a Sober House Committee and we're re looking to do a Public Hearing. I'm going to contact you and give you that date when we get to it, because you talked about recidivism.

MR. DEWEY:

Yes.

CHAIRPERSON BROWNING:

And one of the things that we see is these Sober Homes are not regulated.

MR. DEWEY:

Correct.

CHAIRPERSON BROWNING:

Private individuals run them, and, you know, there's a lot of drug use, alcohol use going on in these homes. And what are we doing to these people who are going to programs --

MR. DEWEY:

That's where we actually get most of our subjects.

CHAIRPERSON BROWNING:

From the Sober Homes?

MR. DEWEY:

Yes.

CHAIRPERSON BROWNING:

Wow. Did you hear that, Leslie?

MRS. KENNEDY:

I know.

CHAIRPERSON BROWNING:

Well, that is why I am pushing this issue on Sober Homes, that they need to be regulated, they need to be monitored, and we need to take care of these people. And I would certainly appreciate any of your input --

MR. DEWEY:

Sure.

CHAIRPERSON BROWNING:

-- to prove the point, my point, that, you know, these Sober Homes, the ones that we currently have have got to go and we need them to be controlled better. With that, are there any other questions? Anyone else? And, you know, I'm thinking about it, cigarette smoke and we have the Vapor Club here. Are you familiar with E-cigarettes?

MR. DEWEY:

I am.

CHAIRPERSON BROWNING:

Do you have any comment? Not at this time?

MS. BABAIAN:

She's talking about monoaminoxidase with E-cigarettes.

MR. DEWEY:

Right. You mean -- I do not know if these cigarettes contain monoaminoxidase inhibitors. I suspect they probably do not, but I don't know that. I do know that it's not the nicotine that's destroying the monoaminoxidase. So I don't -- I don't know enough data to speak intelligently enough about it yet at this point.

CHAIRMAN BROWNING:

I think your input would be very helpful. You know, we do have a bill that's pending pertaining to E-cigarettes, and so I'm sure there's a new FDA report on it, and I would certainly be very welcoming of your comments. I appreciate your expertise, what you're doing for our kids in our districts. I know you've been to a lot of districts, specifically Sachem. They were wowed by what you did and they told me that the kids were just so impressed, and, you know, we certainly appreciate what you're doing. Keep getting that message out --

MR. DEWEY:

Right.

CHAIRPERSON BROWNING:

-- And maybe someday these kids will get it.

MR. DEWEY:

Thank you.

CHAIRPERSON BROWNING:

So, With that, thank you very much. I think there may be one question about the health care centers. If you could kind of give us some information on what's going on in the health care centers, Commissioner. There was a notice distributed to patients, I guess, in June that the center and WIC programs are closing by December 31st in 2009. If you can give us an update. You know, I know I spoke with AME. They said that it's not affecting any staffing issues for them. I think one of the concerns on my part is transportation and how do people get from one location to another. And I -- do you have any questions?

LEG. GREGORY:

No.

CHAIRPERSON BROWNING:

No? This is to do with the Islip C.I. Health Care -- Health Center. Okay. Can you fill us in?

COMMISSIONER CHAUDHRY:

Sure. Thank you, Madam Chair. The Central Islip facility, as you all know, is a satellite to our Brentwood Health Center, which is our largest health center by volume, by patient volume. The C.I. site, its lease expires at the end of this calendar year, and one of the things we're doing is, in anticipation of that, we will be very shortly transferring the staff who work at C.I. to the Brentwood Health Center, which is located 2.2 miles away. In order to do that, we -- and the Brentwood Health Center has significant capacity, but in order to assure that all those personnel can be moved, the two specific sites or departments or offices, Employee Health Services as well as the Chest Bureau need to be moved to another facility, which is part of what we're doing.

This is all part of a broader scheme, of course, as it relates to our regional health center, which I know all of you know about. So this is a temporizing measure in some ways. It has, you know, been discussed, been reviewed. We've had discussions with members of the Legislature about this and part of that message was to make patients aware of these necessary changes. Matt?

MR. MINOR:

Yes. The move itself and the consolidation of C.I. into Brentwood, we presented a report back in April to the full Leg., including this committee, and this is kind of a continuation of our efforts to do this in an orderly fashion, to not disrupt either staff or the patients, give them plenty of notice. As the Commissioner said, that we will be moving out two of the units we've had, that they don't see patients, they only see County employees or basically field officers. The Chest Bureau and Employee Health Services will be moving to Coram. There is plenty of room in Coram; that's presently unoccupied and underutilized. We've met with Coram Health Center and there are really no logistical issues there. By freeing up those two bureaus, we will have sufficient exam room capacity to treat effectively the additional volume from Central Islip. We have been in continual conversations and meetings with Southside Hospital, who operates both Central Islip and Brentwood, and they're fully supportive and been very cooperative of our efforts.

One thing I should point out, in a report that was presented in April, Central Islip Health Center does not have a CO in from the State Department of Health, has numerous physical plant issues, which were detailed in that report, and will never be able to get a CO in because of its -- the way it's designed. The consolidation is very consistent with the whole regional plan, which we've received a

5 million dollar grant for. And just an update on that, we did receive proposals. There were seven proposals, and the Health Department, Public Works and the Space Committee, over the next month or so, will be evaluating those proposals with the hope of, you know, moving forward by the end of this year, so that we can be occupying a new regional center; somewhere in June of 2011 is the target date. So we're talking about a temporary consolidation which will lead to a regional center.

CHAIRPERSON BROWNING:

Okay. I'm looking at some notes here that some nurse supervisors, there's a move of two units from Brentwood to Coram?

MR. MINER:

Correct.

CHAIRPERSON BROWNING:

I'm trying to understand, you know, if someone's currently in Central Islip, are they -- is there any time that any of them are going to have to go to Coram, or are they just going to go to Brentwood.

MR. MINER:

No. The only people that are going to Coram are County employees who work in the Chest Bureau or work in Employee Health Services. It's a handful of employees. I spoke to Debbie Alloncius at length yesterday --

CHAIRPERSON BROWNING:

Okay.

MR. MINER:

-- and we discussed all that, and I think she understands what we're doing there. But patients will go to the Brentwood Health Center two miles away on public transportation. And many of those patients utilize the Brentwood Center now because, as the Commissioner stated, Central Islip is really a satellite, so the full scope of services are offered at the Brentwood facility now.

CHAIRPERSON BROWNING:

Okay. And HIV patients who walk to C.I., as far as them being able to get transportation to Brentwood, I mean, I think that's the major concern is making sure there's adequate transportation.

MR. MINER:

Brentwood is very accessible, train and multiple bus lines. It's right on the route now. And again, C.I. is a satellite. It is scheduled to -- it doesn't have a CON, and part of the consolidation and the whole regional approach, this would happen presumably at either that site or another site, but there were several proposals that are being evaluated now.

CHAIRPERSON BROWNING:

And BRO, do you have any comments? And how much -- what's the cost savings on this, doing the transfer?

MR. MINER:

In a report that we submitted to the Leg., we estimated that it was about a million dollars savings, and this savings is really in two areas, a savings with Southside Hospital staff and a savings in the rent.

MR. FREAS:

And that's pretty much what we said in our memo regarding the original legislation. This was originally going to happen as of June and the County Executive deferred the decision to close the facility until later in the year. Both in the course of my work as a Legislative Analyst and as -- you know, when I was with the Health Department, I know that the physical plant issues with the Central Islip facility are ongoing and that, you know, it's been looked at, closure, if it hasn't gotten over to

the Legislature previously; that it's certainly been examined at length. I think, you know, if there would be a concern with regards to the patients, it would be to ensure that the patients were adequately informed that the move was taking place.

Two health centers have closed in the last ten years, the one in Bay Shore, which was closed very rapidly because of physical plant issues in that facility, and patients really weren't adequately informed that the facility was closing and many of them never returned to the health center network. The second facility was closed and then replaced by another at the new Coram facility. There was considerable lead time given to patients to remind them that the place was closing and that they would have to find new routes to come to the new place versus the older location. That facility did not seem to lose any patients between looking at the -- I believe the new facility opened in 2005. Between 2005 and 2006 no patients were lost between the new Coram and old Coram facility. So I think that the main emphasis is just to make sure that the patients know what's going on.

MR. MINER:

And that's one of the reasons why the notices started going out from WIC. And in the report that we did submit to the Legislature, we talked about the importance of following up and tracking those patients, notifying -- giving them plenty of notice, working out the transportation issues as they may arise, and then making sure that we follow up with WIC, Family Planning and Primary Care to ensure that all the patients are making it to the health center and addressing any issues on a case-by-case manner, and that was all, again, in the April report that we submitted.

CHAIRPERSON BROWNING:

Thank you. And, you know, just if you would just keep us informed what's going on over the next few months, we'd appreciate it.

And, you know, on another note, Mr. Dewey talked about prescription drugs, and I know we have had many conversations about the prescription pad issue and the doctors prescribing these drugs. I mean, clearly, he said, you know, why are these doctors prescribing so many OxyContin or Vicodin for something that's really a short-term pain? I think I'd like us to try and talk to these doctors and talk to the Association about trying to get them to understand why is it they give so many. I mean, I know -- I spoke with our Police Inspector in one of our Precincts and he -- you know, he had surgery and the doctor, you know, was going to prescribe him Vicodin, I think, and he said, "No, I don't" -- "I don't think I really need it," and he said, "Well, I'll write you the prescription anyway, you can fill it out if you want." You know, he didn't want it. So why are we pushing this on patients and telling them, "Well, take it anyway"? Hey, now I got a prescription I can tell sell.

COMMISSIONER CHAUDHRY:

Thank you, Madam Chair. And, yes, pursuant to conversations we've had, I have reached out to the Suffolk County Medical Society, and we're also reaching out to the pharmaceuticals industry and their associations in Suffolk County. It's an issue of medical regulation around the country, actually, as Dr. Dewey, in his excellent presentation, eluded to. There's a problem of underprescribing, there's a problem of overprescribing, and physicians and other health care practitioners will do one or the other, depending upon a whole set of circumstances. Some of it is local, some of it has to do with defensive medicine and fears about malpractice issues. But we see far too many tragedies occurring nationally, as well as locally, and it certainly is a germane topic of discussion and should be looked at.

CHAIRPERSON BROWNING:

Thank you. And I think with that, we're done for the day. Motion to adjourn, Legislator Kennedy; second, Legislator Eddington. We are adjourned.

[THE MEETING WAS ADJOURNED AT 3:54 P.M.]