

HEALTH AND HUMAN SERVICES COMMITTEE

OF THE

SUFFOLK COUNTY LEGISLATURE

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, March 18th, 2010 at 2:00 p.m.

Members Present:

Legislator Kate Browning - Chairperson
Legislator Vivian Vilorio-Fisher - Vice-Chair
Legislator John Kennedy
Legislator Jack Eddington
Legislator Tom Muratore

Also In Attendance:

Presiding Officer Bill Lindsay - District #8
Legislator Steve Stern - District #16
Legislator Lou D'Amaro - District #17
George Nolan - Counsel to the Legislature
Tim Laube - Clerk of the Legislature
Jason Thomas - Intern to Legislator Browning
Jack Caffey - Aide to Presiding Officer Lindsay
Linda Bay - Aide to Minority Caucus Leader Losquadro
Paul Perillie - Aide to Majority Caucus Leader Cooper
Justin Littell - Aide to Legislator D'Amaro
Ginny Suhr - Aide to DPO Vilorio-Fisher
Debbie Harris - Aide to Legislator Stern
Susan Eckert - Aide to Legislator Nowick
Gail Vizzini - Director/Budget Review Office
Craig Freas - Budget Analyst/Budget Review Office
Allen Kovesdy - County Executive's Office
Ben Zwirn - County Executive's Office
Steve Tricarico - County Executive Assistant
Christine Malafi - Suffolk County Attorney
Gail Lollis - Deputy County Attorney
Greg Blass - Commissioner/Department of Social Services
Ed Hernandez - Deputy Commissioner/Department of Social Services
Linda O'Donohoe - Asst. to the Commissioner/Dept of Social Services
Linda Mermelstein - Acting Commissioner/Department of Health Services
Janet DeMarzo - Deputy Commissioner/Department of Health Services
Dr. James L. Tomarken - Nominee/Suffolk County Health Commissioner
Dr. Francis Safina - Division of Mental Hygiene/Dept of Health Services
Art Flescher - Deputy Director/Division of Mental Health
Dot Kerrigan - 4th Vice-President/AME
Mary Finnin - Taxpayer of Central Islip/Nursing
Chris Destio - John J. Foley Nursing Facility
Linda Ogno - John J. Foley Nursing Facility
All Other Interested Parties

Verbatim Transcript Prepared By:
Alison Mahoney - Court Stenographer

*(*The meeting was called to order 2:15 P.M. *)*

CHAIRPERSON BROWNING:

Okay. In the interest of time, we're running a little behind, we will start the Health and Human Services Committee with the Pledge of Allegiance led by -- we'll have Legislator Stern.

Salutation

Okay, good afternoon. We have a few cards here, so -- there's only two. So we'll start with Public Portion, and the first speaker is Dot Kerrigan.

MS. KERRIGAN:

Good afternoon, members of the Legislature. First let me say I feel -- I'm talking for -- about John J. Foley, the nursing home, and I'm a representative from AME, the County workforce.

First let me say I feel sorry for the residents of our County nursing home and their families. They know exactly what it's like, with payment and care at private facilities and they are, once again, scared, and so are staff and their families, to think that they will be let go eventually in this economic climate. And what Mr. Levy is doing to the bottom line of this now well run facility, it's sad. There have been secret meetings, deals made behind closed doors and, in one person's mind, finalized, and I'm referring to Mr. Levy who, in my opinion, does not believe in open government; he seems to operate as an Island.

On the other hand, there have been open meetings, first every other week and then once a month, and these meetings were run by the Presiding Officer of this Legislature, and it's called the John J. Foley Oversight Committee. And it works to represent and listen to labor, management and the Legislator -- Legislature. Together we identified problems and we worked alongside each other to fix it, and this is exactly what Suffolk County government should do at the Executive level. Mr. Levy has never even been to John J. Foley or an Oversight Committee meeting, and he is welcome in both places. The John J. Foley Oversight Committee has had a tremendous and positive effect on the facility's bottom line. Instead of publicizing his plans in the newspaper, Mr. Levy should have come to the Oversight Committee and talked of his impatience with our progress.

Since inception of this Legislative committee, billing, reimbursement and bed-hold have all been positive. The staffing levels have gone down to industry standards and the nursing staff took a 4% decrease in their salaries. There will be additional savings in reimbursements, but this isn't a race, it's a process. The County nursing home was run inefficiently for many years and is it the reward of the oversight -- the Oversight Committee gets for its positive effects? There are many more things to be done. Our next scheduled meeting of the Oversight Committee is next Friday at 9:30. Remember, we are not alone. Our neighbors to the west found the ways and means to run their County nursing home. And if this private and secret deal of Mr. Levy's is to be approved, he must stop spending the taxpayers' money in the form of grants for the benefit of the private citizen. In the past year we have renovated the fifth floor to a subacute and rehabilitation unit and millions of additional monies are scheduled to be spent any day on the renovation of the lobby and the front facade, with a planned cafe-look, tables, chairs, new landscaping and such.

In addition, a state-of-the-art electronic medical record system, also on the State taxpayer's dollar, which has the ability to capture much more revenue through documentation, is now completely installed. Do we really want to sell off \$1.2 million worth of brand new equipment, never before used, to a private person and layoff newly trained staff before it has even had a chance to be up and running? This electronic medical record system is scheduled to go on-line in May. Shouldn't we give this very expensive system a chance to work for the taxpayers who foot the bill?

This facility is a valuable asset to Suffolk County. The beds are full, the EMR is ready to go, the building has been renovated. This is a great deal for Suffolk County, not meant for the benefit of one private owner.

CHAIRPERSON BROWNING:

Dot, your time is up. I didn't set the timer, but you are up.

MS. KERRIGAN:

Are you sure, Kate?

CHAIRPERSON BROWNING:

Absolutely.

MS. KERRIGAN:

Okay.

CHAIRPERSON BROWNING:

I actually gave you a little bit more. If you can wrap up.

MS. KERRIGAN:

Okay, I have two more sentences. We should not ever think of going to public hearings at this time, I believe, because it would mean a substantial loss of revenue, as historically the Census crashes every time Mr. Levy makes headlines with selling the place. And we really need the opportunity to have the electronic medical record system work for the County taxpayers. Thank you.

CHAIRPERSON BROWNING:

Thank you, Dot.

D.P.O. VILORIA-FISHER:

Thank you.

CHAIRPERSON BROWNING:

Mary Finnin?

MS. FINNIN:

Good afternoon, everybody. I'm Mary Finnin, I'm a Registered Nurse and taxpayer in Central Islip community. I'm here today to speak in favor of the work that needs to be done to provide a health center that's state-of-the-art for the Bay Shore, Brentwood and Central Islip community.

In December, the Central Islip clinic was closed. In the worst winter that we've had in 20 years, we've made the poor people try to find their way to Brentwood to get care, it was difficult for transportation -- even if you could drive, there wasn't adequate parking there -- and the only changes that were made in that center were the revision of several rooms. The County has received and accepted -- well, I don't know if they received it, but they accepted \$5 million in HEAL money from the State which was to build a regional health center for the Central Islip, Brentwood and CI community. We have space. I know that there's been disagreements about where the space is. I'm from Central Islip, I know there's not only space but there's buildings that can be used in the Central Islip community, and I'm sure the same applies to areas in Brentwood and CI.

We -- you know, I spoke against closing the CI clinic. The problem is not only with access but safety issues. And as you know, there have been major hearings in Central Islip and Brentwood with regard to the drug problems and this kind of thing. There is a committee of the health -- of the Legislature that was formed to look at financial review of the health centers. I think you have to look at all of these centers, all of the health care, the cost of care that we provide in the jail. We're here ready and ask no questions about the cost that a care -- of primary care to the inmates, but

we're cutting the cost of care and the access to care for community residents who are law-abiding people. I think we need to have you look at more money in drug treatment, and also in-patient drug treatment because that's something that's really lacking and it's a major problem that's causing issues in our community. It's not just an FBI and a Police problem, it's a health problem with the drug use.

So I'm asking you to take more global look at financing health care in Suffolk County and not just looking at keeping access to care away from the Brentwood, CI and Bay Shore area. Thank you.

D.P.O. VILORIA-FISHER:

Can I ask a question?

CHAIRPERSON BROWNING:

Mary, if you could hold up? Mary, if you could come back?

Legislator Fisher has a question.

D.P.O. VILORIA-FISHER:

Hi, Mary. Thank you for coming down and thanks for your advocacy. It was my understanding, and I'll be asking Dr. Mermelstein about this later on; weren't HEAL monies used for the renovation at the Brentwood Clinic?

MS. FINNIN:

I went down there and walked through the clinic. They may have used the million dollars they saved in cutting staff and closing the CI clinic, but no \$5 million was used to renovate that rental property down in Brentwood, and I walked around. So I believe that money should still be available. And it was given to us to set up a state-of-the-art center and that's what it should be used for, or else it should be given back, in my opinion.

D.P.O. VILORIA-FISHER:

Okay. Well, I'll be asking the question of the Health Department to see how that was directed. I also want to ask you, Mary, do you have any anecdotal evidence of people who couldn't get to the health center because of the snow and other factors this winter?

MS. FINNIN:

I have no personal documentation except for myself. I went down three days after the storm, couldn't park near the place and the -- it was difficult for me to get in, and the parking wasn't there. I talked to staff, there is inadequate parking for the staff. I talked to the Islip Town Planner, he thinks everything is fine and grand, but he hasn't been down there with two children and a stroller trying to get off the train and walk down into the clinic area or trying to park a car when there's three feet of snow.

D.P.O. VILORIA-FISHER:

How far is the train? And you're saying it was difficult to walk from the train station?

MS. FINNIN:

From my point of view, yes, it was. I walk with a cane and it was very slippery, it was difficult, and I had to park way down at the further end beyond the clinic.

D.P.O. VILORIA-FISHER:

Okay. Thank you very much, Mary.

CHAIRPERSON BROWNING:

Thank you, Mary. Is there anyone else who would like to address the committee? Come on up, state your name for the record.

MS. OGNO:

Linda Ogno, John J. Foley. I just came up here to say that sitting and watching about closing John J. Foley or closing these clinics, I was in this room just a few weeks ago to hear Mr. Levy's plan on the future of Suffolk County, and he talked about our aging population. Who gets hurt by this closing of Foley, turning it over, not being a County facility, our clinics. The only people that are hurt here are the poor and where people have nowhere else to go. We're all in a crisis, we're all in the same crisis together. This is not the time to get rid of our precious resources. Thank you.

CHAIRPERSON BROWNING:

Thank you, Linda. Is there anyone else that would like to address the committee?

Okay, with that, we have a few presentations and -- so we will start. We have Dr. Francis Safina and Art Flescher, Deputy Director of Mental Health, you guys want to come up and speak about on the Suboxone issue. There were some questions about IR 1186, so I believe that's what you're coming to speak on.

ACTING COMMISSIONER MERMELSTEIN:

Just by way of introduction, I'm Dr. Mermelstein, the Acting Health Commissioner. I just want to thank Legislator Browning for giving us the opportunity to speak again about this resolution which we would like you to reconsider. I know it went to the full Legislature, but we feel it's a very important issue.

We know that you had questions, the Health Committee had questions about the Suboxone resolution and the plans, so that's why we're here, to present the detail and try and answer your questions. So with that, I'd like to introduce Art Flescher and Dr. Francis Safina from our Substance Abuse Programs.

MR. FLESCHER:

Thank you very much.

D.P.O. VILORIA-FISHER:

You need to keep your finger pressed on the base.

MR. FLESCHER:

Thank you very much. Please excuse my laryngitis, I'll do the best I can. As mentioned, my name is Art Flescher, I'm Deputy Director with the Division of Community Mental Hygiene. It's a pleasure to present before you today.

We distributed a packet which we would ask you to look at in terms of the materials I'm going to be covering. On the right -- on the left side is an article from the Journal of American Medicine which kind of talks about a study that was done with Suboxone and adolescents. On the right side is a packet that I'll be going through. I would ask that we start on the second page past the flow chart because those will be my talking points. Thank you.

The first point we want to make is that heroin is the tip of the iceberg. It's only part of a larger problem of illicit Opiate abuse. And as most of you know, many people today are abusing Opioids that they're getting from medicine cabinets through diversion from pharmaceutical situations over the Internet.

*(*Presiding Officer Lindsay entered the meeting at 2:29 P.M.*)_*

Heroin is one part of that; generally it's toward the end of a cycle of Opioid and Opiate abuse. The difference between prescription Opioids and heroin is not one of degree but of kind. Basically there are greater or lesser strengths of Opiate medications, but they all have the same addictive properties, and if one uses them too much and too often, they will, in fact, develop addiction.

While only recently recognized by the media and the public at large, the current pattern, widespread use of prescription Opioids and ready access to low-cost heroin, was well established by the mid 1990's. Dr. Safina, who's with us today, can attest to the fact that we have been seeing an increase in heroin use in Suffolk County for several years, but it has drawn a great deal of attention in most recent years and that's why we are reacting to some degrees with this program, particularly among adolescents.

Abuse of prescription Opioids and the onset of dependence in these drugs often precede heroin use and subsequent dependence in younger populations; again, it's usually a progression. Obviously it's more accessible to get diverted prescription drugs or prescription drugs from the Internet than it is to purchase drugs on the street and to get involved with the drug dealing networks that are out there. Also, heroin, as one progresses through the use, frequently people move towards intravenous use which is a riskier behavior and not something that one begins with, generally speaking. Not to mention that Opioids are usually not the first drug category the young people are involved with. Usually kids begin with tobacco, alcohol, marijuana as the gateway drugs, as we call them.

In-patient detoxification is not the most effective treatment for individuals that have become dependent on Opioids. More often than not, people are kept in detoxification units for a very short amount of time and, treatment providers will report, people will leave detox units still in withdrawal, very prone to relapse and thus creating difficulties. Only about one-in-ten individuals will sustain abstinence following a short-term course of detoxification on an in-patient setting.

Medication assisted out-patient treatment of Opioid dependents, including supervised withdrawal, is an effective and safe form of treatment. We have demonstrated this over time here in Suffolk County through the provision of Methadone treatment, which we have done for many years. I myself began in that system in 1983 and we began providing Methadone in the early 1970's. Recent research, albeit limited, conducted by the National Development and Research Institute, NDRI, suggested adolescents with shorter histories of Opioid dependence can respond well to medication assisted therapy through the use of Suboxone; Suboxone or Buprenorphine. And that drug presents a variety of safety measures that don't exist with some other narcotics because it is what is known as a partial agonist meaning that it's very difficult to overdose and also serves as a blocking effect for the use of other Opiates.

D.P.O. VILORIA-FISHER:

Can you say that again, please?

MR. FLESCHER:

Suboxone is what is known as a partial agonist, which means as compared to heroin and other Opiates, they are full agonists in that they fill the receptive site and allow people to get the peak effects from it, and the more you use the higher the effectiveness. Suboxone is what we call a partial agonist in that it also has an antagonist or blocking factor. So if you use other Opiates with Suboxone, it does not -- there is a ceiling effect in terms of the amount of euphoria somebody will get, thus diminishing the likelihood of abuse. Also, it makes it very difficult to overdose on Suboxone as compared to some of the other Opiate medications.

A very important part of this drug, in the back of the packet there's a discussion that talks about Suboxone a little bit, but certainly Dr. Safina can expand upon that when we move further, if you like.

The current resources for care of adolescents and young adults abusing or dependent on Opioids in Suffolk County where Suboxone is utilized are splintered and uncoordinated. It's only been a few years that Suboxone has been used by private physicians. They must go through an eight-hour training program only, which is not very long. They're required or it's expected that they be involved with treatment practitioners for behavioral health care, however that is done in an inconsistent way. In many cases, particularly adults are receiving Suboxone care without the accompanying counseling and so many other things that are required. One of the reasons we've

moved into this is, particularly with adolescents, we feel it is essential that there be therapeutics involved with this and a clear protocol as to how the program should be operated.

The Department of Health Services, Division of Community Mental Hygiene, is spearheading a coordinated effort to address adolescent and young adult Opioid abuse. And along with that, there are some important operating premises which I would like to mention. The first is that families, when we're talking about teen-agers, families are often unaware of the full-range of options available and frequently experience difficulty accessing appropriate services. And I'm sure you've all heard that at various points, that people talk about the inability to get somebody into care. One of the things, by us providing the service, we'll be providing a gateway for many people to get into the proper care they need, and when I show you -- when I go through the flow chart with you in a moment, you'll see that that's the case.

Due to a lack of accurate and consistent information, families may not be open to consideration of specific forms of treatment, whether it be out-patient or medication-assisted treatment. We need to work with families and help them to see the value in certain types of treatment over others. In many cases, there are some that are contradicted because of a situation of the young adult or the adolescent. For example, if somebody is abusing a wide array of drugs, is out of control in virtually every aspect of their lives, a program like ours that we're proposing would not be appropriate in that case, and we will be referring to our partner agencies that I'll be talking about.

In addition, families often have unrealistic expectations regarding the outcome of interventions, particularly addition to Opiate medications. It changes biochemistry in a manner that it makes it very difficult to alter that. And families often have an expectation, understandably that people would like to see this, that someone will enter treatment, a loved one, an adolescent in this case, and with some miraculous ability will be able to stop that use and they will never want to use again. Obviously addiction is an extremely complex illness in which we need to work with the behavioral changes that somebody needs to make. You may have heard -- those of you that have heard about 12-step programs, they talk about changing people, places and things; it's an essential part of recovering from addiction. There is no magic bullet, there is no one way of doing that, it needs to be done over time by virtue of building relationships and helping people to change lifestyles. So families need to be educated about that and they need to understand that they themselves have a role in this. You will hear that one of the key components of our program is that families will be expected to be actively involved in every aspect of it because, again, we're talking about a program geared towards young people younger than age 19, minors, people that require their parents to be involved if we're going to be successful.

Opioid dependence is a serious problem and treatment requires extensive involvement on the part on the parents as well as the identified patient, and it must be understood that the process of recovering may include setbacks along with progress. Again, there is a difference between a lapse and a relapse; although it is hopeful that it does not occur, it is part of the recovery process very often and it needs to be worked with rather than be viewed as a failure and thus creating a defeatism that sometimes will discourage somebody from continuing to work on their recovery. So that's part of our educational responsibility in working with families.

There are a variety of strategies we're going to be implementing. The division and its partner agencies will develop brief, structured pre-treatment education and engagement groups known as "Clean Connections", okay. And these groups will be geographically dispersed throughout the County, there will be two sessions, probably about two hours each, and the first session will address how family members feel about somebody's use, it will introduce them to such things as Al-Anon and Nar-Anon, the nature of enabling behavior and codependency, some issues in our field; they talk about how this illness effects everybody in the family system. We'll then begin to talk about how you can begin to address this with your loved one, and by the second session we will have gone through all the options available and have connected those that are interested with actual treatment. And because it will be part of a coordinated system, we're expecting that there won't be the lags in care that some of you may be concerned about.

Clean Connection groups, as I said, will be held in geographically dispersed locations and we'll find a way of publicizing that as well. So that basically for any family that's interested in getting involved in this, there will be a Clean Connection group starting virtually every week that they can attend, okay. And it may be that they have to travel a little bit, but by and large, we're going to find a way so that these groups are running continuously, pretty much, so that -- again, to increase awareness and to create readiness for their entry into treatment.

The Division of Community Mental Hygiene Services will build off of its extensive experience in treating chronic Opioid addiction and developing a medication-assisted treatment initiative for adolescents, again, up to age 19 that incorporates the use of Suboxone, this Buprenorphine I mention, but also the Opioid antagonist Naltrexone or ReVia which would be used at the conclusion of the program, towards the tail-end. ReVia serves as an Opioid antagonist meaning that when somebody attempts to use drugs like heroin or other Opioid medication, it will not be effective at that time. So while they're still in treatment, we'll be helping them to address cravings with the knowledge that they, in fact, won't be able to use, so it will kind of be a security for them toward the tail-end of the program. A very important part of it and it's tailored on the work of the National Drug Resource Institute, and we all know we have a support letter from as a partner in this because they've done a lot of work in terms of working with adolescents by using Suboxone early on and tailoring it to ReVia and Naltrexone toward the end of the program.

This Suboxone-to-Abstinence Program will include a comprehensive mental health assessment and, if needed, mental health treatment will be integrated on-site into the individualized clinical services plan. Family therapy will be a core component and as well as parent support groups and vocational/educational assistance. The counseling portion of the program will be occurring at our Farmingville Mental Health System, in our clinic itself, and other mental health care --

P.O. LINDSAY:

Keep your hand on the button.

MR. FLESCHER:

Oh, I'm sorry. The green light is on.

P.O. LINDSAY:

Use that mike, it stays on.

MR. FLESCHER:

I apologize. I hope most of this was heard.

P.O. LINDSAY:

Yes, it was.

MR. FLESCHER:

Oh, okay. In instances where longer-term care is required, the division will partner with licensed out-patient and in-patient providers across a spectrum of care, including selective private practitioners. Because one of the things we'll be doing is this will be a very clearly time-limited program; again, I will discuss that in a moment. Perhaps we can move to the flow chart at this point and I'll explain that.

As mentioned, this is a program geared towards adolescents. There are a variety of decision points that will be made. The key thing with Suboxone, which we believe leaves us very well suited to provide this program, is there is a period of time called the induction period, and the induction period can take a matter of a few days till sometimes a couple of weeks if there are several dose-changes required. This will be dependent upon the degree of addiction that the young person presents. Obviously if they are using very high levels of heroin or other Opioid medication, they'll require higher dosages of Suboxone. We will be providing that service in our Wireless Boulevard Methadone Clinic during hours where the clinic is generally closed, so as not to mix the population

with the Methadone clients. The idea there will be the individual will come every day, hopefully with parents at that point, and we will be adjusting medication accordingly. After there's been a period of stabilization, we will then move the service to Farmingville where they will receive the family therapy, the mental health work if needed, the family support groups and an array of other things, including vocational services. At that point, the parents will be given a prescription for medication, probably not for more than a week at a time, because one of the things we don't want to do is simply give the medication to the parents and then not have the family participate in the therapeutic part of the program, because some people would be apt to do that. So we will give the prescription for a short period of time with the understanding and education of the parents that they will be the ones to dole out the medication. Again, the expectation is that the entire family is involved with this process with the awareness that this will not necessarily be a smooth road, but it's absolutely essential that from a family systems perspective, everybody participates.

So if somebody comes to our program and they have the level of addiction to Opiates only, this will not work. This drug does not work if somebody is abusing other drugs such as cocaine, that is not an appropriate population. But if it's the case where it's appropriate, we would then go through an evaluation in which we make a variety of decisions. As I alluded to before, there are going to be many instances where we're going to refer somebody to one of our partner agencies, and they're located on the right of this flow chart. For example, on one of the partner agencies, Outreach House II, is a long-term residential program for adolescents. And certainly, if we get younger adolescents who are abusing a wide array of drugs -- poly drug abuse, as we call it -- and are not attending school or are truant in a lot of ways, not abiding by any parental rules whatsoever, then life is such that it's out of control and we would want to refer to outreach at that point.

The good news is that outreach has, on a trial basis, begun to admit children, adolescents who are maintained on Suboxone, but they don't have the ability to do the induction process. So in that case, we may choose to get the young person stabilized on Suboxone through the short-term induction and refer directly to outreach done in collaboration. That to us is a pretty exciting way of doing this and may, in fact, be quite successful.

Obviously, we're going to get people that are above 19, 19 or over, and we're going to refer them to a variety of different from providers. There are several that are offering Suboxone care, including Seaford Center which offers Suboxone care to people above age 16, but they must, for induction purposes, go inpatient in their rehab program which some people can't afford, nor is it perhaps always necessary, but if they're certainly over 19, they'll be referred to that program. South Oaks is also beginning to develop something on an outpatient basis, and several other providers may do so as well over time.

As mentioned, this is going to be a six to nine month program. The stabilization period, which you could view it as the first three or four months, is following the build-up to the proper doses of Suboxone. We engage in all the adjunctive behavioral therapies I mentioned before. By the fourth month or so, we're going to be talking to the family about beginning to wean or detoxify the young person from the Suboxone and replacing it at the end of that process with Naltrexone, the antagonist I mentioned before, which would block the effects of the use.

Now, there are going to be many young people that are going to be doing quite well at that point, their lives will have stabilized, they'll feel very confident about their situation and their families may feel good about it as well. They may, in fact, try to lobby for staying on maintenance doses of Suboxone. This is a choice the families can make, but it's not the intention of our program to be a provider of that service. Because what that will do is it will begin to change the program into a long-term maintenance project which will limit the amount of people that we can accept into care, for one thing, and also take away from the protocols and models that we're developing.

We're very anxious to have something that is very structured, time-limited with clear outcomes and clear protocols throughout. So if the family decides that they would like to be -- like to have the young person maintained on Suboxone at that point, a referral will be made to a variety of private

practitioners whom we are going to develop partnerships with. We're familiar with many of them and some of them are quite competent. We will be expecting that they will be providers who do have relationships with some of our community-based drug treatments that they also, even though they're maintaining the young person on the Suboxone, they will also receive the counseling and other support services they need. And maybe it won't be at six or nine months, maybe after a year or so they will get off the drug at that point; that will be a choice. Again, there's no cookie-cutter approach to this, everybody needs to approach it differently, but for our program we're going to be very specific about what the expectations are. We'll be demanding, in a sense, in order to participate, here is what needs to occur, and we think that's very important.

Again, we will move towards Naltrexone towards the end of the project, somewhere around that four or five month period, probably. And at that point, the young person would stay on this Opiate blocker medication, we continue with the counseling and we complete them from our program and perhaps refer them for ongoing counseling elsewhere at around that nine month period. But at that point, they will have had some period of time where they're off Suboxone and they're also now in a situation where they feel somewhat more confident because they've had this period where they're off Suboxone and have not used Opioid or Opiate medications.

So that's pretty much an explanation of the program. I'll be happy to take any questions, but it's something we're quite excited about. You'll notice in your packet, there are support letters from a variety of our partners, including the National Drug Research Institute. I was pleased that some of you were able to participate in the call with the Medical Director from OASIS, Dr. Kitmus, the other day. And as you heard there, he's extremely enthused about our project and is very much in support and will provide technical assistance and will be working very closely with our partners from OASIS on this project as we evaluate it, because we haven't done this before, so we're looking forward to learning as we go along. Thank you.

CHAIRPERSON BROWNING:

Okay. Thank you. I think we have a couple of questions.
Legislator Lindsay?

P.O. LINDSAY:

Yeah, forgive me, I've been in and out of the room taking phone calls. And I wasn't briefed prior to this meeting, so it might be something that was covered already. What's -- what is the difference between this drug and Methadone?

MR. FLESCHER:

I'll defer to Dr. Safina, our Medical Director, who will be happy to answer that.

DR. SAFINA:

Basically Methadone, it occupies all the receptors in the brain, the receptor receptors. Suboxone is a medication that's partially -- occupies the receptors. So you don't get the highs, you get -- also, one of the beneficial effects is a ceiling effect with the Suboxone is that you get to a certain dose and they -- you know, you're not going to get any more response. So with Methadone, you could increase and increase, there's a tolerance built up and you go into higher and higher doses, and that's basically the difference.

One of the other differences that Suboxone is a Suboxone molecule and also a naloxone molecule, so this drug cannot be used intravenously. One of the big things that we're always looking for is preventing people from using intravenous medications where there's a high incidence of infectious disease like Hepatitis C, HIV and, you know, Hepatitis B.

P.O. LINDSAY:

From what I know about the subject, which is very little, Methadone is an addictive drug as much as the Opiate; am I correct?

DR. SAFINA:

It is. It is.

P.O. LINDSAY:

Okay. Would it be fair to say that this drug is less addictive than Methadone?

DR. SAFINA:

Yes. Yes, much so.

P.O. LINDSAY:

Okay. Then it makes sense to me. Thank you.

CHAIRPERSON BROWNING:

Okay. Vivian?

D.P.O. VILORIA-FISHER:

Thank you, Madam Chair. You mentioned at the beginning of your presentation that three to five day period where they try to detox in a such a short period of time, it's very ineffective. Is that insurance driven, is that why it's such a short period of time? Insurance won't pay for a longer stay?

MR. FLESCHER:

It's insurance driven to some degree in terms of what the protocols are in terms of accepted length of stay. But you should know that there's also a process with addiction to these substances called proactive withdrawal, and it goes -- it's less severe than that initial horrific severe case of the flu kind of feeling that people have, but it leads one to tremendous cravings and difficulties. So the one-in-ten figure I mentioned about people staying off the drug after detoxification is really the key point, which is that it's a very short window where somebody is in a safe environment and cleanse to a degree, probably not for long enough, but the degree of success versus the cost, most people feel that it doesn't warrant it because it really doesn't work as well. And withdrawal from this category of medications is not life threatening, so it can be managed on an outpatient basis quite readily. And with the aid of this drug, we can get somebody comfortable in a very short amount of time; as Dr. Safina mentioned the other day, in really a few -- you know, a matter of 20 minutes, half hour, you can begin to get them comfortable. And in truth, they're coming out of a detox after four days extremely raw and very uncomfortable, and Dr. Kitmus had mentioned that even in the Rockland County Addiction Treatment Program he's involved with, they have people coming out of detox coming into a longer-term rehab and they're giving them Suboxone in there, even though supposedly they were detoxed, but they're still very, very uncomfortable. So it's just not the most effective way to deal with this, both in terms of long-term recovery and short-term comfort.

D.P.O. VILORIA-FISHER:

Okay, thank you. I have a question for Budget Review. I'm concerned about this program, vis-a-vis the budget models we looked at a couple of days ago; let me explain why. As I look at the funding and how it's going to be used to support this program and listen to the description, I wonder with all of the staff cutting that the model called for, clearly we're going to need people who can follow-up on -- clerical staff follow-up, appointments -- disseminating the information for those, what are they called, clean connections. If we're going to have a great impact on staffing, how is that going to impact a program like this, and should we be concerned about that? You're looking like maybe we won't be, because I'm seeing counselors and medical professionals --

MR. FREAS:

I think it's a legitimate question. The bill in question, 1186, contained funding for the drug counselors and -- who would help the patients to make these connections to other community service agencies. You know, I'd have to defer to the department about their expected, you know, caseload and everything, whether the funds contained in the budget actually provide what they're anticipating as a caseload.

MR. FLESCHER:

If I could just mention in terms of the Clean Connections Program, that will be operated by community-based agencies. We are going to learn the process of preparing the curriculum and we're going to be training those staff members to provide this. We already fund a cadre of drug educators that exist out of several of our agencies and they will be providing, that's what makes this really nice, because those Clean Connection groups will be geographically dispersed throughout community-based organizations. So those resources are --

D.P.O. VILORIA-FISHER:

Contract agencies?

MR. FLESCHER:

I'm sorry? Yes, contract agencies. And so that will already be in place. And as for the rest of the program, we have asked for two drug counselors and a nurse, as well as position time per diem and some other things that we believe -- we're beginning with the premise that we're going to operate with a census of 60, which we will build up to obviously. By adhering to our timeline and protocols we've set up, we will have sufficient turnover that we won't be inundated, we don't think, and we have also built in to the per diem line some ability to be flexible should that demand exceed what we expect. So we're pretty comfortable with what we're asking for. Thank you.

D.P.O. VILORIA-FISHER:

But it seems to me that this system requires some navigation, some patient navigation, and that requires clerical staff. And I have to say that there have been people who have spoken to me off the record and said, "You know, I'm a drug counselor, I'm a mental health provider and I have no staff," and it's really hard to work under those conditions. And I don't want to see this fail, it's very, very important. So you're saying there's no money that we have here that's set aside for any staff.

MR. FLESCHER:

For support staff, no.

D.P.O. VILORIA-FISHER:

A doctor can't run his office without clerical staff, someone who is filing the files. And you do have to do a lot of patient navigating here.

MR. FLESCHER:

And we view --

D.P.O. VILORIA-FISHER:

And I want to make sure we have the clerical staff in place to help that navigation.

MR. FLESCHER:

We have built it in that the caseloads will be low enough. That part of the roll of a drug counselor or a social worker is to do that kind of navigation, to do the case management and you're mentioning. Also, because the program will be operating in the Farmingville Mental Health Clinic, we have some case management support there and we're going to be able to use a variety of different options to make sure that happens. We agree wholeheartedly that the key thing to all of this is the collaboration and coordination, because there are going to be instances where there's going to need to be contact with other entities. We don't view -- we view that as a professional task, however, and not one that we would normally leave to support staff, because it's a negotiating kind of thing in terms of getting people into other programs or a variety of different things that are required.

D.P.O. VILORIA-FISHER:

Okay. Thank you.

CHAIRPERSON BROWNING:

John, go ahead.

LEG. KENNEDY:

Thank you, Madam Chair. Thank you for being here and thank you for OASIS for facilitating the conference call the other day. As a matter of fact, Dr. Kitmus was very informative. And I certainly got a better idea, I guess, of some of the parameters that are associated with this.

Dr. Safina, I'm curious to hear a little bit more about how this program will operate at the physical location over on Wireless, but yet not comingle this younger population with our existing range of Methadone patients that presently come?

DR. SAFINA:

Basically speaking, the Methadone clinic will be closed when we're bringing in these patients for induction, so there will be no contact, and that induction will take from a few days to a week in some instances. Thereafter, the patient will be counseled at the Farmingville facility.

LEG. KENNEDY:

So is it safe to stay, in other words -- and it occurs to me I probably ought to get a handle on even what we have as far as current numbers. How many patients do we treat under our Methadone program now, approximately?

DR. SAFINA:

Approximately eleven hundred.

LEG. KENNEDY:

About eleven hundred patients that we have now?

DR. SAFINA:

Right.

LEG. KENNEDY:

Okay. And so in those sites, we have four Methadone sites that we operate, I believe, and those patients. When I was out in Riverhead in the County Clerk's Office, I was familiar with the Riverhead site. Patients would arrive starting at 6:45, seven o'clock in the morning, they go upstairs, they would see the nurse, I guess, receive their medication and go about their business for the day; is that how the center over in the industrial park on Wireless operates?

DR. SAFINA:

Similar, yes.

LEG. KENNEDY:

Okay. So that will operate from whatever time, early morning maybe up to, what, one, two o'clock in the afternoon, and then it will convert over for our adolescent population?

DR. SAFINA:

Right. One of the things that we have there is we're going to be dispensing the medication, and this is the -- we have the facility to dispense the medication for the induction, and that's the key thing. There has to be safety in that respect.

LEG. KENNEDY:

You have a narcotics cabinet, you have the medications set up --

DR. SAFINA:

Absolutely, yes.

LEG. KENNEDY:

-- you have everything already.

DR. SAFINA:

Right.

LEG. KENNEDY:

-- for the Methadone side, so it's very simple to go ahead and implement the Suboxone.

DR. SAFINA:

Yes.

LEG. KENNEDY:

And the induction period, as you said, you go through this timeframe, three days, four days, five days, six days, now it seems you have --

DR. SAFINA:

Stabilized.

LEG. KENNEDY:

-- a maintenance dose --

DR. SAFINA:

Right.

LEG. KENNEDY:

-- that an adolescent will be able to work with and you begin to engage some of the other things that you're looking at, the mental health components and the other pieces.

DR. SAFINA:

Right.

LEG. KENNEDY:

Okay. Just a couple of questions as you were going through the description and naught. You spoke a lot about engaging the family. Clearly, absolutely, you know, that's who's coming to us and talking about, "We need to get our child admitted," or we need to go ahead and get our child a service. What happens where you get the adolescent that doesn't have a motivated family? What if you have the adolescent that's actually a casualty of the dysfunctional family? Maybe the school is the intervenor, maybe, I don't know, church or a religious community or somebody else. What happens there as far as possibility for service?

MR. FLESCHER:

We've given that a lot of thought, because that will happen. And you're right, I mean, one of the issues there is what do you do when you know somebody needs help, yet nobody is able to authorize the treatment, in a sense. Because keep in mind, we're talking about minors; we can't have an adolescent with this kind of care without parental approval and consent.

LEG. KENNEDY:

Okay.

MR. FLESCHER:

So we would have to make -- we would do our best to try to get some family member, a guardian maybe, maybe we would be working with CPS if it was really out of hand in terms of what could be done because this person is out of control and the family refuses to even talk to us. But we're hoping that there will at least be some entre to somebody in the family, one of the two parents or a guardian, that we can engage.

LEG. KENNEDY:

Okay.

MR. FLESCHER:

But it will be a challenge. That will happen from time to time.

LEG. KENNEDY:

Well, let's go to the other side of the spectrum, you have a very engaged family. But as everybody knows these days, folks are lucky if they're working one job, usually they're working two jobs; two parents, three jobs, four jobs. Will we have our sessions outside of the normal Monday to Friday, 9-5, are we going to have evening hours, are we going to have weekend hours? What are we doing there?

MR. FLESCHER:

Yeah, we will -- we will have evening hours because, as I said, the therapeutics will be out of the Farmingville Mental Health Clinic and that clinic is open four nights a week. If there was a tremendous need for opening Saturday we could do that; at this point, we're not planning that. During the induction phase, at the clinic it would be more restricted, but again, we're hoping that will only be a matter of days. Once we have some stabilization, yes, we'll be able to accommodate families in a variety of ways.

LEG. KENNEDY:

Okay. And what about the additional range of services that adolescents are going to need? Usually you've got poor academic track records that you need to perhaps maybe explore GED.

MR. FLESCHER:

Yes.

LEG. KENNEDY:

Or maybe evoke training referral or maybe some kind of a college-type of a -- what's the gamut of services that you're going to try to engage as you're going through the stabilization period?

MR. FLESCHER:

We will have a Vocational Counselor who is a Master's level person who will do things like work on getting somebody involved in GED if necessary, maybe return to evening night school, perhaps doing an interest inventory in terms of potential vocationalaries they might want to pursue. That's a very important part because, again, you know, one of the things that happens with addiction is emotional maturation virtually stops at the time somebody starts abusing, and obviously other things in life get put on the side. So we're going to be addressing this in a truly holistic way. There will also be probably some nutritional information given out so we can address some health issues. We will have a family therapist with the per diem money, we're hoping to hire somebody who specifically has expertise in family therapy and all the drug counselors will be trained in family therapy as well, because that is different than doing individual therapy. But -- and the parent support groups are becoming very important, too, because they're going to need the support, the example you gave where the parents may be very busy and difficult to get there. They may be very motivated, but they may still not be able to keep their focus on the things they need to do to help their child, so we'll have parent support groups to help them with that.

LEG. KENNEDY:

One last question over to Dr. Safina. Is it -- is there a possibility that you can take an individual who's now presently a Methadone recipient and explore migrating them over to Suboxone, or are the two exclusive?

DR. SAFINA:

Absolutely. We get a lot of patients that --

MS. MAHONEY:

I'm sorry, can you please use the microphone?

DR. SAFINA:

We have a lot of patients that have changed from Methadone to Suboxone and vice versa. I'll give you an example; a pregnant lady on Suboxone cannot continue taking Suboxone, she'd have to go to Subutex. Most of the physicians do not want to get involved in this type of a treatment, especially with OB/GYN's, so they'll refer us to Methadone, and it goes back. You know, once the patient has been on Methadone for a period of time, she can go back on to Suboxone, that's just an example, but it is. The key thing here is getting them at a low dose and in withdrawal when they're induced onto Suboxone.

LEG. KENNEDY:

But if there was a successful migration from Methadone to Suboxone, then the next step might be Suboxone to abstinence.

DR. SAFINA:

Absolutely. Absolutely.

LEG. KENNEDY:

And there is a certain segment of our Methadone patient population now that might be susceptible to that?

DR. SAFINA:

Absolutely.

LEG. KENNEDY:

Okay, and you're looking at that.

DR. SAFINA:

Yes.

LEG. KENNEDY:

Okay. Thank you. Thank you.

CHAIRPERSON BROWNING:

Thank you. Legislator Eddington.

LEG. EDDINGTON:

Yeah, I just wanted to get a little clarification. You know, I'm a licensed clinical social worker, I've always been opposed to a drug treatment for a drug addiction. But what I'm hearing here is that this deals with the intensity of withdrawal? That's what I'm hearing, which -- and that you're going to also have cognitive behavioral therapy connected with it. Now, that sounds like the best of both worlds. My experience has always been that the medication is quickly coming, but the therapy just kind of goes where the money goes. When the money is out, we still get the drugs, but you're on your own, whether it's Ritalin in schools or Methadone or any other type of drug intervention.

Insurance will pay for five to ten session based on your insurance policy. How are you going -- I think Legislator Vilorio-Fisher was talking about it a little bit. How can -- can I support this -- I would support it if I know that that end of the therapy is going to be there all along. And I guess one other thing; is it going to be individual, family or group or a combination?

MR. FLESCHER:

You bring up great points. I think that the way we view the medication is to create a state of readiness for the other therapeutic work that the adolescent and the family needs to do. So yes, the medication helps take care of the physical discomfort and creates an ability to focus and really look at their lives. The reason behind the eventual detoxification from the medication is because you're talking about young people who don't have long histories of addiction and, in fact, deserve an opportunity to try to be truly drug-free and, in fact, can do quite well with that.

A key part of that is the cognitive behavioral supportive therapy you mention. We will be providing individual, group and family therapy as well as psychoeducation groups. We'll be using all of our stakeholders to pretty much incorporate the greatest evidence-based practices we're aware of. And in terms of payment, for those that have insurance we will bill insurance; once insurance runs out, we will then shift somebody over to a sliding scale as we do in the rest of our services which is quite affordable. And one of the things that this program offers to people is affordability and that's a key part of it, because most people that go to private practitioners for Suboxone care, it can really vary but it can be very, very expensive, especially for the induction period where it can be several hundred, if not a thousand dollars, for the initial appointment even. It's very expensive. So we're going to create a situation where families in Suffolk County can afford to get the care they need.

LEG. EDDINGTON:

Thank you very much.

CHAIRPERSON BROWNING:

One last one, John.

LEG. KENNEDY:

Yeah, just one other question with the case acts. We have two that are coming on and -- do they have a caseload max? I thought they have a caseload max like 15 or 20 or something to that effect.

MR. FLESCHER:

Oh, no, it's higher than that. I believe in Methadone it's 50.

LEG. KENNEDY:

Oh, a drug -- a case act can actually go up to 50 clients?

MR. FLESCHER:

The Methadone guidelines allow for 50 clients. We're talking about a sensus of 60 maximum, so there won't be more than 30 per caseload. And even with that, depending upon what per diem abilities we have, we may be able to reduce that further because of the nature of the program. It's going to be very important that caseloads not get unwieldy because you won't be able to provide the families with the assistance they need.

LEG. KENNEDY:

And they're not overlapping between the two departmental. I mean, the Department of Health is what's governing us when we talk about the Methadone dispensing, right? The OASIS is what's talking about what we're doing when it comes to the drug treatment operations.

Look, I think as my colleagues have said, I want this thing to succeed, absolutely, positively, and I applaud you for bringing it forward. And my sense is you're going to get inundated with requests. As soon as you get a telephone number out there, like Jack said, a social worker, a physician --

D.P.O. VILORIA-FISHER:

A guidance counselor.

LEG. KENNEDY:

In-patient outfits, everybody is going to be calling you wanting to get kids enrolled.

ACTING COMMISSIONER MERMELSTEIN:

I have already received requests, actually.

LEG. KENNEDY:

I'm sure you have. I'm sure you have, Doctor, as a matter of fact.

So we're looking at two drug counselors that are going to be committed there. But we have a number of additional drug counselors that are on staff already, right?

MR. FLESCHER:

Yes, we do.

LEG. KENNEDY:

Okay.

MR. FLESCHER:

We do. And I would, again, emphasize, the program is for below age 19. That is going to -- many of the people that we get calls from are older than that, and many of the others that we're going to be assessing are going to require some kind of other treatment because of the nature of their problem. So it may not be -- we don't know, but we're certainly going to be cautious, but we think we're going to be okay with this.

LEG. KENNEDY:

All right. Thank you.

CHAIRPERSON BROWNING:

Okay, real quick. Outreach house? Because I know in our conversation on the phone I had asked you about if they can't stay at home and the parents just can't handle it. Outreach House, do you know how many beds they have, how many they can take in at one time?

MR. FLESCHER:

They have about 50, I believe. I think it was 50 when I interned there, it may be a few more now.

CHAIRPERSON BROWNING:

Do you know what their status is right now, if they're to capacity?

MR. FLESCHER:

It varies; last I heard they had a couple of openings. But they will work very closely with us. They have been at the table throughout our discussions. And there's also Phoenix House which has an adolescent program, so we really do have a significant amount of in-patient adolescent care in the County, thankfully.

CHAIRPERSON BROWNING:

Well, I hope you don't get inundated. I've got a funny feeling 60 is going to be a low number for you.

Does anybody have any more questions? No. Well, we appreciate you coming. I'm sorry, Dr. Mermelstein, did you want to say something?

ACTING COMMISSIONER MERMELSTEIN:

No, just thank you very much.

CHAIRPERSON BROWNING:

Okay. Well, we appreciate it. And you know the bill is up --

MR. FLESCHER:

Thank you for your indulgence on my voice.

DR. SAFINA:

Thank you.

CHAIRPERSON BROWNING:

No, you're okay. So the bill is up on Tuesday, it's not here at this committee. So we appreciate your help.

I guess if you want to stay here and we'll have Dr. Tomarken come up.

ACTING COMMISSIONER MERMELSTEIN:

Thank you. I have --

CHAIRPERSON BROWNING:

I'm sorry. Dr. Mermelstein, if you would stay up and we'll have Dr. Tomarken come up here and if you want to have a seat. It's a good time to be sick, we've got plenty of doctors in the room, and nurses. So I guess there is a resolution to appoint Dr. Tomarken. Would anybody entertain me taking --

D.P.O. VILORIA-FISHER:

Why don't we just interview the person and then we'll take it out of order.

CHAIRPERSON BROWNING:

Okay. So Dr. Tomarken, if you'd like to introduce yourself and maybe there may be some question.

DR. TOMARKEN:

Good afternoon. Thank you for the opportunity to address the Health & Human Services Committee.

I started my career by earning a Master's Degree in Social Work which gave me the foundation of how people are affected by their psycho/social background. Wanting to also understand the physical aspects of the individual, I pursued a Medical Degree that led to Board Certification in Internal Medicine and Emergency Medicine and the practice of emergency medicine for approximately ten years.

During this time, the practice of medicine required that I become knowledgeable about finances. I had an interest in medical administration, so I pursued an MBA Degree. This combination allowed me to practice medical administration in a variety of settings, including hospitals and Managed Care organizations. During these years, I also led a Methadone Treatment Program that was a model program that included training and a licensing program for Methadone providers. Working under my direction, my team developed a Harm Reduction Program to reduce the spread of HIV and Hepatitis among the substance abusing population.

During this time, it became evident to me that the future of health care would involve a population approach as more people were living with chronic disease and conditions. I chose to pursue an MBH Degree and was presented with the opportunity to work with the Clinton Foundation and Yale University to rebuild the administrative structure of a US-built 500-bed tertiary care hospital in West Africa. This country was emerging from 20 years of Civil War, so this project included reestablishing systems of waste management, food surveillance, water and sewage, supply chain management as well as clinical care. At the end of two-and-a-half years, I'd accomplished the goals originally set out and began looking for a new opportunity.

While looking for future employment, I saw the Internet announcement for the Commissioner of Health position in Suffolk County. In researching this position, I became aware of the progressive approach of the State of New York to public health issues. In Suffolk County, this progressive approach was implemented with extensive direct health care services as well as the mandated public health services. In addition, the County developed proactive programs of helping citizens with smoking cessation, obesity and improved nutrition. I was attracted to these and other programs because it was clear that Suffolk County had a progressive, thoughtful and concerned County government in public Health Department.

In these difficult economic times, we need to be sure our dollars are spent wisely. This means not only planning and implementing programs effectively, but also monitoring and evaluating the results with feedback within a quality improvement framework. The priorities as I see them at this time for the Health Department include the providing of services for the individuals and their families

grappling with a heroin problem. Also, maintaining continued surveillance of H1N1 and the readiness to address a third wave if it should occur. We need to pursue the most cost effective method of delivering the department's services and maximize the use of technology, such as the electronic medical records, to improve quality of care, reduce costs and improve efficiency to better serve Suffolk County residents.

It is important to continue to educate the people of Suffolk County regarding health issues. We need to be more consumer-friendly to help developers requiring permits to open new business so we can foster economic development, and to promote an attitude of helping our established fleet service community in the inspection process.

My goal is to have an open, cooperative and a high quality Department of Health Services. My very background, training and experience put me in a very strong position to effectively lead the Department of Health to accomplish this goal. I look forward to working with the Legislators, the County Executive and the department staff to provide the best public health services to the residents of Suffolk County. Thank you.

CHAIRPERSON BROWNING:

Thank you. Anyone have any questions? Legislator Kennedy, go ahead.

LEG. KENNEDY:

Good afternoon, Doctor. Thank you for coming. I've had an opportunity to take a look at your resume and you have, I guess, what would be called quite a remarkable career. You have done many different things, I guess, in many different places, and I imagine when we look to have somebody come on to head up a department the size of the Health Department, that's a good thing. It's a good thing to have depth and background. Obviously I'm pleased to hear that you have direct care experience associated with the Methadone Program. And now I assume, as a physician, you've got at least a working understanding of Suboxone and must endorse this program.

DR. TOMARKEN:

Yes. In fact, it's interesting because Buprenorphine, which is one of the drugs in Suboxone, we were using 20 years ago in our programs at the Addiction Foundation that I worked at. So I have a familiarity with Buprenorphine which is the main drug.

LEG. KENNEDY:

And this was a program that was in Toronto, I believe?

DR. TOMARKEN:

Correct.

LEG. KENNEDY:

So you were working with an active addict population there in the city itself?

DR. TOMARKEN:

Absolutely.

LEG. KENNEDY:

Clinic-types of settings?

DR. TOMARKEN:

Yes.

LEG. KENNEDY:

Okay. You know, some of the things, I guess, that we look at with the Health Department is, at least in my opinion, is it is a fairly diverse department. Now, I think you've had the benefit of getting an opportunity to see the department hands-on. You've actually been here, part of us since

January, right?

DR. TOMARKEN:

Since February, but fair enough.

LEG. KENNEDY:

February, okay. So we can speak about the medical issues, we can talk about our bus care programs, our mammography programs. But tell me a little bit about your thoughts regarding the environmental side of the equation; groundwater. Ground water in my Legislative District is a huge issue; half my district is under water at any given time. But, you know, the groundwater monitoring, groundwater flows, our pollution sites with the MTBE and PERT out of the industrial park right here. At any given time we probably have 15 to 20 active groundwater pollution sites that are underway throughout the County. What do you see as the Health Department's roll regarding that.

DR. TOMARKEN:

Well, water is of great importance in Suffolk County, obviously. And the department's roll as I see it is to protect that water supply, but at the same time to be as receptive as possible and helpful as possible to developers. So it's a dual-edge responsibility. And I think the key for the department is to have the best qualified advisors and staff and create a culture that provides help to developers and that will protect the environment as well.

LEG. KENNEDY:

You know, you hit on a couple of good points. And as a matter of fact, I think you're wise to speak about meeting people on staff that have that institutional knowledge and ability to go ahead and be good stewards and shepherds. '

We had some staff with us up until a short time ago that were not only locally renowned, but actually nationally renowned with groundwater modeling, and they have since left and moved on. In your roll as the head of the department, do you see that as something that you would advocate or seek to attract? How -- what are you going to do as a Commissioner to make sure you've got the tools in your tool bag to carry out that vision that you have?

DR. TOMARKEN:

Oh, I think there's at least two aspects to that. One is retaining people who are good and qualified, and attracting new people, if the budget permits, and creating a culture in the department that says we're here to help people and protect the environment. So I view it as a high responsibility and a priority and one that we should be able to reach.

LEG. KENNEDY:

Let's stay on water for just a second, because at the other end of the spectrum we have our sewage treatment plants. And as you know, the Health Department has oversight for more than I think a hundred privately operated sewage treatment plants throughout the County. They're also another critical function, a regulatory and enforcement function that the department performs. Again, any thoughts there?

DR. TOMARKEN:

Well, it's a vital part of the department because it's not just monitoring the water but preventing any spread of contagious and infectious diseases. So it integrates very well with our Public Health Department and its roll to prevent and/or control the spread of contagious diseases. So I view it as part and parcel of our priorities and view it as, again, a very high priority.

LEG. KENNEDY:

I'm going to ask the Chair for just one more area and I'll stay on my water theme; mosquitoes. Vector Control is another area under the Health Department that we have spent hours and sometimes days in this Legislature talking about the policies we'll implement. What -- do you have any background, do you have any experience? How will you go forward to address that?

DR. TOMARKEN:

Well, first of all, I just spent two-and-a-half years in Malaria-ridden countries and --

*(*Laughter*)*

LEG. KENNEDY:

There you go.

DR. TOMARKEN:

-- and trying to avoid mosquitoes like everybody else. And working with USAID, you have to understand the culture and the environment and what's allowed in terms of prevention of the spread of disease in mosquitoes. And what's here in the United States is quite different than in Africa, but it's the same fundamental problem and that is what will we be allowed to do and what are we -- what is the ultimate effect of the control or lack of control of the mosquito population? And it's something that changes all the time so you want -- you have to have an understanding of what diseases can be transmitted and what therapies or countermeasures are available. But it's, again, a very important issue because it does effect the health care of all the citizens of Suffolk County.

LEG. KENNEDY:

And I am pleased to hear you say that. Doctor, I'm sure that you have a tremendous amount of background and experience. I'm glad to see that you have the management background, and I think that you can do well for us here in Suffolk County.

The only caution that I have is when you speak about the budget.

And I will tell you that you're wise, because every level of government is challenged to go ahead and do the jobs that they're charged with with a budget that's provided. But what I'll ask you to do is to advocate for what you need in order to meet the missions.

We're charged with having to wrestle with the budget, and it used to be a process that took up about a third of a year; it now takes up every day of every year, and we will deal with that. But what I'll ask you to do is come to us with what you need to do the job and let us try to deal with what we have to with the budget. Thank you.

CHAIRPERSON BROWNING:

Thank you. And if you miss Africa, you can come to my backyard for a barbecue in the summer time and you'll not miss the mosquitoes.

D.P.O. VILORIA-FISHER:

I would like to ask him a few questions.

CHAIRPERSON BROWNING:

But Legislator Viloría-Fisher has a question.

*(*Laughter*)*

D.P.O. VILORIA-FISHER:

Thank you for being here and thank you for coming to my office to spend some time discussing the issues that are important to us here in Suffolk County. And Legislator Kennedy segued directly into my first line of questioning which is some have characterized delivery of care as a monetary loss to Suffolk County, and I characterize it as the cost of delivery of care. And as the Commissioner of public health, when you are confirmed, I would like to know what your position is with regard -- the mission of government and public health and safety and the cost to government.

DR. TOMARKEN:

I view all of medicine as a service and not a financial issue. And the ability to predict cost in health care is close to impossible, no one could have predicted HIV when it started nor the cost nor the

spread. If another incident or condition like that were to develop, all bets are off in terms of cost.

We have an obligation, those of us in the medical profession and I think, to some extent, the Legislature as well, to provide services for -- in this case, the population of Suffolk County. If we choose to enter into providing care, then we must do it at a level that is -- that meets their needs and that is cost effective. That is the key. It is not that there's no cost, but that we get as much for our dollar as we can, and that we meet the needs. Because ultimately what we are trying to do is keep people healthy and keep them from getting sicker, costing the system, and that's wide-spread. It cost -- not just the health care system costs, the Labor Departments, pensions, etcetera, etcetera. So it is -- at the beginning, we were at the tip of the iceberg in terms of -- if we can control health care issues and prevention, then we can save a lot of money for a variety of departments and programs. But ultimately, the bottom line is our responsibility is to provide the quality of care that we can and costs have to be a secondary issue.

D.P.O. VILORIA-FISHER:

Thank you, Doctor. I'm not going to continuing the questioning, but I do want to say that with the diversity of your background, it certainly seems that you would be very well suited to this position. Because it was clear with what you said regarding the protection of water and with the sensitivity to economic development certainly is a reflection of the MBA and some of the other experiences that you have. And so I'm very pleased to have you here. Thank you again.

DR. TOMARKEN:

Thank you.

CHAIRPERSON BROWNING:

And last but not least, you heard a lot couple of speakers talk about John J. Foley, and there is an HIV population in John J. Foley. With your background, I know you have the compassion and the understanding of the patients that are there. So I just want to ask that you keep in mind the importance of the County facility. And, you know, I know many of the Legislators want it to stay the way it is and to be run efficiently. So I hope you play a very active roll with us in doing what we want to do for the residents that live there.

With that, I know that we did ask Dr. Mermelstein to stay for the -- if anybody had any questions about the Electronic Medical Record Program. But what I would like to do is maybe take out of order IR 1257 which is the confirmation appointment of Dr. James L. Tomarken as Commissioner of Health Services.

D.P.O. VILORIA-FISHER:

Second.

CHAIRPERSON BROWNING:

And we have a second, Legislator Viloría-Fisher. All in favor? Opposed? Abstentions? ***(VOTE: 6-0-0-0 including Presiding Officer Lindsay)***. Okay, we will take it out of order.

So now it's on the floor here --

CHAIRPERSON. VILORIA-FISHER:

Motion to -- oh, I'm sorry.

CHAIRPERSON BROWNING:

1257-10 - Confirming appointment of James L. Tomarken, MD, as Commissioner of Health Services (County Executive); I think that was a motion by Legislator Viloría-Fisher.

D.P.O,VILORIA-FISHER:

Motion to approve.

LEG. EDDINGTON:

Second.

CHAIRPERSON BROWNING:

Second by Legislator Eddington.

LEG. KENNEDY:

Madam Chair, just one more quick question for Dr. Tomarken, on the motion. And my apologies, Doctor, I was listening fully, I was just chatting a little bit before. But John J. Foley in particular, did you -- did you express any thoughts about that or do you -- I mean, I'd like to see you give us a commitment that it's going to remain as a County facility, quite candidly; I'll be pretty blatant with that one.

DR. TOMARKEN:

I'm at the point now of gathering information. And I have asked for a list of all the patients to know what kind of patient population we have, what are their conditions, what sort of services do they require. So I'm in -- really in the information gathering mode right now.

LEG. KENNEDY:

Okay. Well, one of the things that I would encourage you to do, and as a matter of fact, Dr. Mermelstein has been very helpful for me directly in requesting information about admissions, about the age, about the level of care, about the staffing with CNA's, the RN's, about the overtime expense; really trying to take a top-down look at the facility and look very closely regarding the operations.

The one thing that I'll say to you is -- and I think I also did see from your bio, you're from -- you're presently -- you reside in Connecticut, correct?

DR. TOMARKEN:

No, I live in Smithtown now.

LEG. KENNEDY:

Oh, you do? There you go. Maybe you're my constituent.

*(*Laughter*)*

But in any event, the patient population at John J. Foley is somewhat atypical for the balance of our nursing home facilities throughout Suffolk County. So -- and that is one of the reasons that I've been so adamant in supporting it. Our County employees do an outstanding job there, I also do believe that there is a roll for public health care, for those who cannot find care elsewhere, other than to be shipped to some remote jurisdiction far from their loved ones or family, and I believe that's probably what would happen to the lion's share of the patients in John J.

So at the very least, what I'll ask you to do is -- and I intend to vote yes for your confirmation. I'm going to ask you to at least look at that patient population, look at the degree of care, and also be open to the way that the administration has chosen to characterize some of the costs that are hung on John J that may not necessarily be attributable to them specifically as a facility. That's all. Thank you.

CHAIRPERSON BROWNING:

Thank you. So I think we had a motion and a second. All in favor? Opposed? Abstentions? Okay, it is ***approved (VOTE: 6-0-0-0 - including Presiding Officer Lindsay)***.

I don't -- I know Monday -- sorry, next Tuesday, our General Session, we don't start until four o'clock. But also a reminder, that there will be an FQHC presentation.

D.P.O, VILORIA-FISHER:

At two o'clock.

CHAIRPERSON BROWNING:

At two o'clock, so you might want to keep that in mind also. Does he need to come back on Tuesday? I mean, obviously we invite you to come back at two o'clock and we'll go from there. Thank you. So we will see you Tuesday, I guess.

DR. TOMARKEN:

Thank you.

CHAIRPERSON BROWNING:

Does anyone have any questions about the EMR?

D.P.O. VILORIA-FISHER:

No.

CHAIRPERSON BROWNING:

None? Okay.

ACTING COMMISSIONER MERMELSTEIN:

Can I make one --

CHAIRPERSON BROWNING:

Because I know that was tabled, there were some questions about the electronic medical records program, I believe that was tabled.

ACTING COMMISSIONER MERMELSTEIN:

The part I think that didn't pass was the Bond Resolution, and so I prepared a handout that I gave to you, all of you, that provides information about cost savings. And basically it's going to pay for itself over the course of a couple of years, so I really wanted to put that forward. For us it's a very important priority in the department, we think it will improve patient care, and the first page of the handout goes into all of those details. But I hope you'll take a look at that and see if it could be -- or if I could request if it could be reactivated or reinstated somehow in the full Legislature.

D.P.O. VILORIA-FISHER:

Or reconsidered, yeah.

ACTING COMMISSIONER MERMELSTEIN:

Reconsidered; that was the word I was trying to look for.

CHAIRPERSON BROWNING:

Reconsidered next week.

P.O. LINDSAY:

It was tabled on the floor.

CHAIRPERSON BROWNING:

Actually, yeah, it was tabled on the floor, but the Bond failed.

ACTING COMMISSIONER MERMELSTEIN:

I thought the resolution passed but the Bond failed.

CHAIRPERSON BROWNING:

So we -- it's up again next week. Now, actually --

D.P.O. VILORIA-FISHER:

It could be.

MR. NOLAN:

(Inaudible).

D.P.O. VILORIA-FISHER:

What do you mean by that, George? I'm sorry.

CHAIRPERSON BROWNING:

Go ahead.

D.P.O. VILORIA-FISHER:

Once it fails, Bond Counsel has to start all over again?

MR. NOLAN:

No, no, it's just that when Bonds have failed in the past, sometimes they have to come back at the next meeting, a new Bond Resolution, sometimes no. It's not determined yet if we're going to have a new Bond before us,

D.P.O. VILORIA-FISHER:

Can we ask the County Executive's people?

MR. NOLAN:

We can ask them if that's their intension, I don't know.

CHAIRPERSON BROWNING:

Is there anyone here that can answer that question? Not at this time?

P.O, LINDSAY:

Yeah, over there.

CHAIRPERSON BROWNING:

Okay, Allen is here.

MR. KOVESDY:

Yeah, we fully support the EMR, so we'll do all the paperwork necessary before the next meeting.

CHAIRPERSON BROWNING:

Okay, thank you. And actually, there was one thing I did want -- I know we had a conversation, because with the storm you had some problems out east with the building and we had a conversation about now you're having to reschedule patients because of the condition and what EMR would have done if we had it today.

ACTING COMMISSIONER MERMELSTEIN:

Yes, we lost the roof on the Southampton Health Center, so patients who came in -- who would have wanted to come in the following day were not able to be seen at the health center. And had we had an EMR, they could have had their visits at the Riverhead Health Center or East Hampton and the providers would have had all their information at their fingertips and been able to effectively treat them. What ended up happening is we had to basically reschedule patients for the following day and fit them in to an already busy schedule, so it really would have been helpful.

CHAIRPERSON BROWNING:

Okay. Thank you.

LEG. KENNEDY:

Madam Chair, just one question for Dr. Mermelstein. Doctor, the savings that you lay out for us, and I appreciate that, but in essence the savings basically would be representative of a number of -- I would presume number of hours of staff time that would not be necessary to dedicate to these various functions.

ACTING COMMISSIONER MERMELSTEIN:

Absolutely, and then staff would need to be reallocated to do other things that relate to the electronic medical record. But when you -- we found an article, actually, that was published that described a surgical practice that implements an electronic medical record and they outlined what the costs savings were and they assigned a certain dollar figure to every chart pull, etcetera. We put that information and applied it to our program and those are the potential savings that we have estimated. At the bottom of the handout, it also goes over the questions that came up at the last meeting about the incentive program for Medicaid. So we really feel that there is the potential here for a savings that will offset the costs, or some of the costs of the electronic medical record.

LEG. KENNEDY:

So in other words, Doctor, your statement is or you're saying that if we -- if this project went forward, that we would receive an additional up to \$450,000 a year in Medicare or Medicaid reimbursement?

ACTING COMMISSIONER MERMELSTEIN:

Yes.

LEG. KENNEDY:

Do we have that just because we know that's what the parameters of this grant program are, or we've actually gotten notification from HHS or some Federal agency that will receive that?

ACTING COMMISSIONER MERMELSTEIN:

Well, we haven't gotten direct notification, but there -- the program is coming into place and when that program is in place, then we would see that savings, we would recognize it. So those are our estimates based on the information that's put out by centers for Medicare and Medicaid services.

LEG. KENNEDY:

Okay. But in other words, as of right now that program is not in place yet.

ACTING COMMISSIONER MERMELSTEIN:

I don't believe it's finalized yet, but it's in a proposal. Actually, Craig, you might know more about this than I do.

MR. FREAS:

The regulation is published --

P.O. LINDSAY:

You're not on.

MR. FREAS:

The final of the final interim regulations will come out June 15th. The release that we used, that the department used to calculate the revenue enhancement is based on March 15th Federal Register with those regs. I can send them to you if you want a separate analysis. I thought that the department's revenue enhancement -- correct me if I'm wrong, I don't have a copy in front of me. Is between 200 and 450,000 --

LEG. KENNEDY:

Yes.

MR. FREAS:

-- per year.

LEG. KENNEDY:

The soft savings, with all due respect -- and I appreciate it, Doctor -- but for nine years we tried to quantify soft savings out in the County Clerk's Office; it never materialized. But enhanced reimbursement, if we can point to the 2011 Federal Fiscal Year or the 2012 Federal Fiscal Year where we're going to have an increased, almost half million dollars worth of reimbursement as a result of implementing this program, then with the dedicated stream to repay we can liquidate the bond in less than three years; that is something that I would be interested in talking about. Thank you.

ACTING COMMISSIONER MERMELSTEIN:

Thank you.

D.P.O. VILORIA-FISHER:

Okay. Oh, I think we're going to have the vote now.

CHAIRPERSON BROWNING:

Okay. I guess we'll go on with the agenda then. Thank you.

IR 1095-10 - Directing the Department of Health Services to make its database of automated external defibrillator locations available to emergency 911 dispatchers (Presiding Officer Lindsay).

P.O. LINDSAY:

Motion to approve.

CHAIRPERSON BROWNING:

Motion to approve, Legislator -- Presiding Officer Lindsay.

D.P.O. VILORIA-FISHER:

Second.

CHAIRPERSON BROWNING:

Okay, I'll second it. All in favor? Opposed? Abstentions? Motion carries, ***approved (VOTE: 6-0-0-0 - including Presiding Officer Lindsay).***

1096-10 - Directing the Department of Health Services to develop signs for locations of automated external defibrillators (Presiding Officer Lindsay).

P.O. LINDSAY:

Motion.

CHAIRPERSON BROWNING:

Presiding Officer Lindsay made the motion to approve.

LEG. EDDINGTON:

Second.

D.P.O. VILORIA-FISHER:

Second.

CHAIRPERSON BROWNING:

Second, Legislator Eddington. All in favor? Opposed? Abstentions? Motion carries. ***Approved (VOTE: 6-0-0-0 including Presiding Officer Lindsay).***

CHAIRPERSON BROWNING:

A Local Law to ensure the integrity of prescription labels in Suffolk County; was that --

MR. NOLAN:

It has to be tabled.

P.O. LINDSAY:

No.

CHAIRPERSON BROWNING:

Okay. For a Public Hearing?

D.P.O. VILORIA-FISHER:

The other one was withdrawn.

P.O. LINDSAY:

It was withdrawn, right?

CHAIRPERSON BROWNING:

1129 is withdrawn?

P.O. LINDSAY:

No, 1103.

D.P.O. VILORIA-FISHER:

No, 1103 was withdrawn.

MR. NOLAN:

It's not on your agenda.

D.P.O. VILORIA-FISHER:

You don't have it there, don't worry.

CHAIRPERSON BROWNING:

Oh. Well, then ***1129-10 - Adopting Local Law No. -2010, A Local Law to ensure the integrity of prescription labels in Suffolk County (Cooper).***

D.P.O. VILORIA-FISHER:

Didn't Cooper want to table?

MR. NOLAN:

No, it's still open to Public Hearing.

D.P.O. VILORIA-FISHER:

It's still open.

CHAIRPERSON BROWNING:

Okay. So --

D.P.O. VILORIA-FISHER:

Motion to table.

CHAIRPERSON BROWNING:

Motion to table for a Public Hearing, Legislator Viloria-Fisher, and I'll second. All in favor? Opposed? Abstentions? ***It's tabled(VOTE: 6-0-0-0 including Presiding Officer Lindsay).***

1199-10 - Establishing a Heroin Epidemic Advisory Panel (Horsley).

I believe the sponsor wishes to have it tabled. I'll make a motion to table.

LEG. KENNEDY:

Second.

CHAIRPERSON BROWNING:

There was a second, Legislator Kennedy. All in favor? Opposed? Abstentions? ***It's tabled (VOTE: 6-0-0-0 - including Presiding Officer Lindsay).***

IR 1229-10 - Adopting Local Law No. -2010, A Local Law prohibiting the sale of aerosol dusting products to minors (Horsley).

D.P.O. VILORIA-FISHER:

Motion to table.

CHAIRPERSON BROWNING:

Motion to table by Legislator Viloría-Fisher for Public Hearing.

I'll second. All in favor? Opposed? Abstentions? ***It's tabled (VOTE: 6-0-0-0 - including Presiding Officer Lindsay).***

1230-10 - Adopting Local Law No. - 2010, A Local Law banning the sale of drinking games to minors (Cilmi). I believe we have a Public Hearing still?

D.P.O. VILORIA-FISHER:

Yes.

CHAIRPERSON BROWNING:

I'll make a motion to table for Public Hearing. Second, Legislator Viloría-Fisher. All in favor? Opposed? Abstentions? ***It is tabled (VOTE: 6-0-0-0 - including Presiding Officer Lindsay).***

1249-10 - Accepting and appropriating 100% grant funding from the New York State Office of Temporary and Disability Assistance to the Suffolk County Department of Social Services for the continuation of the Safety Net Assistance Program(SNAP) and authorize the County Executive and the Commissioner of Social Services to execute a contract (County Executive).

D.P.O. VILORIA-FISHER:

Can we put that on the Consent Calendar?

MR. NOLAN:

You may.

CHAIRPERSON BROWNING:

We can. So motion to approve, Legislator Viloría-Fisher, and to place on the Consent Calendar. I'll second. All in favor? Opposed? Abstentions? ***It's carried (VOTE: 6-0-0-0 - including Presiding Officer Lindsay).***

1259-10 - Creating a Suffolk County Emergency Housing Assistance Task Force to locate suitable housing equitably throughout Suffolk County for individuals registered with the State Division of Criminal Justice Services pursuant to the provisions of Article 6-C of the New York Correction Law (County Executive).

D.P.O. VILORIA-FISHER:

Otherwise known as punt.

(*Laughter*)

LEG. KENNEDY:

I will make a motion to table.

LEG. EDDINGTON:

Second.

D.P.O. VILORIA-FISHER:

Second.

CHAIRPERSON BROWNING:

Okay, we had a motion to table.

D.P.O. VILORIA-FISHER:

Subject to call is good, so it's not hanging around in front of us.

LEG. KENNEDY:

I'll amend the motion to table subject to call.

CHAIRPERSON BROWNING:

Okay, I guess we had a motion to table subject to call by Legislator Kennedy. Second, Legislator Viloría-Fisher. All in favor? Opposed? Abstentions? *I guess it's tabled subject to call (VOTE: 5-0-0-0).*

1260-10 - Amending the 2010 Adopted Operating Budget to accept and appropriate 100% additional State Aid from the New York State Office of Alcoholism and Substance Abuse Services for Eastern Suffolk BOCES to support the implementation of youth development surveys throughout Suffolk County School Districts (County Executive).

D.P.O. VILORIA-FISHER:

Motion to approve and place on the Consent Calendar.

CHAIRPERSON BROWNING:

Motion to approve and place on the Consent Calendar, Legislator Viloría-Fisher. I'll second. All in favor? Opposed? Abstentions? *It's approved (& placed on Consent Calendar - VOTE: 5-0-0-0).*

1261-10 - Amending the 2010 Adopted Operating Budget to accept and appropriate 100% Federal grant funds passed through the New York State Department of Health for the ARRA Immunization Program (County Executive). I guess same motion? Same motion, second, same vote. *Approved and placed on Consent Calendar (VOTE: 6-0-0-0 - including Presiding Officer Lindsay).*

1262-10 - Amending the 2010 Adopted Operating Budget to accept and appropriate 100% additional State Aid from the New York State Office of Mental Health for the provision of an additional crisis residence-single room occupancy operated by Concern for Independent Living, Inc. (County Executive). I guess same motion, same second, same vote. *Approved and placed on Consent Calendar (VOTE: 6-0-0-0 - including Presiding Officer Lindsay).*

1271-10 - Amending the 2010 Adopted Operating Budget to adjust current levels of funding and to accept and appropriate 100% additional State Aid from the New York State Office of Mental Health for Personalized Recovery Oriented Services (PROS) Providers (County Executive). Same motion, same second, same vote. *Approved and placed on the Consent Calendar (VOTE: 6-0-0-0 - including Presiding Officer Lindsay).*

IR 1300-10 - Maintaining a common-sense policy for housing sex offenders that protects and safeguards public safety (Stern).

Do we have a motion?

D.P.O. VILORIA-FISHER:

I'm going to make a motion to table.

LEG. EDDINGTON:

Second.

CHAIRPERSON BROWNING:

Okay. Motion by Legislator Viloría-Fisher to table. Second, Legislator Eddington. And I guess there's going to be some discussion. And we have Legislator Stern who is the sponsor of the bill.

LEG. STERN:

Thank you, Madam Chair. Although I am not a member of this committee, I appreciate the opportunity to speak on the resolution.

Look, this continues to be a serious issue and a very, very difficult and emotional issue for all of us and for those that we represent. There is no perfect solution. I have not been -- with all the conversations I have had with so many, I have yet to hear anything that comes to close to a perfect solution. But in a world with imperfect solutions, the one that is before us, one that would simply provide homeless sex offenders with vouchers to then go seek housing of their choice in any community of their choice, to me is absolutely unacceptable. And this proposal is a way to hopefully begin a process of coming up with what could be a more comprehensive and definitive solution. This is not a perfect solution, but it is one that I would hope that we can maintain rather than shifting gears and going to something that, for me anyway, is absolutely unacceptable.

I think we have a system in place that we need to make work. Transportation costs are an issue, but we can do better. Providing amenities to those who require them, to those who need to receive them by State mandate, we need to do better. But I would much prefer a system where we can and should do better rather than shifting gears and going to a system which would be unacceptable to us and certainly to those that we represent.

There was a comment earlier that what this legislation seeks to do is to place homeless sex predators permanently at the site of the County jail and trailers, but that's not what this legislation does. In the last -- actually, yes, in the last WHEREAS clause, and this was important to me to specifically say in this proposal that this would really be a measure that we would take, this would be our policy until a more appropriate, long-term solution is established. And that's what I'm seeking to do here and I think this is an important way to start and then ultimately continue that process. And so I urge all of my colleagues to support this measure because, again, in a world where we have imperfect solutions before us, I maintain that this is the best.

CHAIRPERSON BROWNING:

I know Legislator D'Amaro has some questions, and if we could get maybe the Commissioner to come up and our County Attorney, Christine.

D.P.O. VILORIA-FISHER:

Malafi.

CHAIRPERSON BROWNING:

Yeah, there's some questions possibly for you.

P.O. LINDSAY:

Could I just make --

CHAIRPERSON BROWNING:

Bill? Yeah, go ahead. Go ahead.

P.O. LINDSAY:

-- one comment? I'm going to support the tabling and I'm going to ask all of my colleagues to give me some latitude with this. This is probably one of the most emotional issues that any of us face. And in all due respect to the Executive Branch, I think every solution they've come up with so far is a failure. And I've talked to a few of you, I'm -- I just want a little time. We're working on some ideas and, you know, probably within one cycle we'll be able to flesh out whether we can come up with something that -- I don't think there's any good solutions here at all, but some kind of solution that at least would appear more equitable. So that's my appeal to everybody, to just give us a little time.

CHAIRPERSON BROWNING:

Lou, you have something to say?

LEG. D'AMARO:

Thank you. And although I'm not a member of the committee, I appreciate the Chair recognizing me, giving me an opportunity to ask maybe a couple of questions and make a few comments.

I agree with the Presiding Officer, it's a real tough issue. I was going to ask initially why are we tabling, but the Presiding Officer has already established that he feels at least we need a little more time to talk about solutions. But I just want to go on the record today and stress a couple of points. Number one, I've received many, many e-mails from constituents firmly in support of this resolution basically saying to me, "Legislator D'Amaro, don't allow homeless sex offenders to come back into our neighborhoods overnight. It is the wrong policy decision." And I can tell you, I have not received any e-mails or communications in favor of a voucher policy that hands them 90 bucks to go and find their own accommodations overnight. So I would strongly urge passing this bill, although I do understand there may be a need for a little more time.

And I just want to put on the record, you know, another story. A few years back, when I believe the County was giving homeless sex offenders funding to go out and get their own accommodations, we have a motel in Babylon, in part of my district, called the Brook Motel where that exact -- that -- the resident got the voucher, went to the Brook Motel and took up residency there; at least overnight, I don't know if it was residency. And I have to tell you, the town mobilized and it wasn't -- I'm not talking about the town officials, I'm talking about the people mobilized. And I can recall going to a meeting that happened to take place in a town board meeting room where there was over a thousand residents present in opposition to the voucher system. So I think we've been down that road. There's no perfect solution, Legislator Stern is absolutely correct, but this is a better solution to try and make these trailers work than to hand homeless sex offenders funding to go back into our neighborhoods and sleep comfortably in a motel overnight. I think it's the wrong direction to go.

So ultimately, I am going to, you know, support this bill. I do understand there may be a need for a little more time to flesh out some solutions, but I wouldn't also object to just moving it to the floor of the Legislature so we can keep it moving. So of course that's up to this committee to make that decision. Thank you.

CHAIRPERSON BROWNING:

John?

LEG. KENNEDY:

Thank you, Madam Chair. And I concur with my colleagues that there are no perfect solutions here. And I give them credit for trying to bring forward a proposal, but I also think that the Presiding Officer -- I trust his guidance in his effort to try to establish something that may be workable. But I also know that I think -- two things. One, my recollection, following the last meeting when we debated this at length, was that the administration now envisions operating the trailers through at

least June or July. And I guess through the Chair, I'm going to ask the Commissioner what is the present stance of the administration now regarding these trailers?

COMMISSIONER BLASS:

In general, Legislator Kennedy, we are complying with the recent Fair Hearings decision and we are continuing gradually with the voucher system, but we have very limited ability to do much more than the three or four that are part of the voucher system. And we are exploring -- we are implementing a short-term and long-term plan to provide for what the Fair Hearing decision mandated we do.

LEG. KENNEDY:

Okay. And now through the Chair, the Fair Hearing decision is actually just the first step in an administrative appeals process that occurs for a whole gamut of benefits through the Department of Social Services. And I believe not only does the recipient party have the ability to seek a Fair Hearing, but the department also has the ability to dispute what an Administrative Law Judge may find. So without getting into any specifics or any merits at all, I'd like to ask, A, if the Fair Hearing decision itself is within the public realm, I'd be interested to see it. If it's not, then did the department dispute or appeal what the Fair Hearing decision is?

COMMISSIONER BLASS:

The department will not be doing that because the decision really conforms to what we think the general shelter provisions for any homeless population would require; namely shower facilities; we think appealing that would not be -- would be futile.

LEG. KENNEDY:

My purpose is not to get into something that's sensitive in nature here. However, I'm going to continue just a little bit more procedurally. Then can you tell me what was the date of the decision and how many days does the department have to appeal?

MS. MALAFI:

By Counsel, I'll answer, if that's okay.

LEG. KENNEDY:

Certainly.

MS. MALAFI:

The decision was almost 30 days ago, February 18th, 2010; we can get you a copy of the decision, we believe that we -- to appeal it would be an Article 78 proceeding which would be a four-month time period from that date. The department and the county executive have no intention of bringing an Article 78.

LEG. KENNEDY:

Again through the Chair. Counsel, I appreciate this information, but I'm going to go to my specific. At what point would we be time-barred from appealing? How many days left do we have to appeal should we choose to appeal?

MS. MALAFI:

I believe that it would be subject to the four-month statute of limitations to bring an Article 78, so it would be four months from February 18th, 2010.

LEG. KENNEDY:

So were the County Attorney's Office, directed by resolution at this point, to perfect an appeal, we would still be timely.

MS. MALAFI:

Yes. But I also believe that we are the prevailing party, so I do not believe we would have an actual basis for an Article 78.

LEG. KENNEDY:

Then I guess I need to see the decision --

MS. MALAFI:

But we could talk about that in Executive Session.

LEG. KENNEDY:

-- but the Commissioner indicated that we're commencing the policy of moving residents out of the trailers subject to the decision, hence my confusion.

MS. MALAFI:

I think that they had -- before the Fair Hearing decision was received, the voucher system had begun to be implemented and that system -- they have not continued to add people to that voucher system, that's what the Commissioner meant by that.

COMMISSIONER BLASS:

Right.

LEG. KENNEDY:

Okay. Then I will ask, Commissioner, if I could get a look at the decision.

COMMISSIONER BLASS:

Absolutely.

LEG. KENNEDY:

Thank you very much. Thank you, Madam Chair.

CHAIRPERSON BROWNING:

Legislator Eddington.

LEG. EDDINGTON:

Yes. Thank you for coming to my office last week, I appreciated it, the Commissioner and Deputy Commissioner. And I just want to let you know that if you have been like me saying the "sex offender trailers", you are inaccurate, because other people are put in there other than just sex offenders. And that what's been happening is non-sex offenders are there, but sex offenders are being put under the voucher program out of the trailers. Luckily, they found a nice area I think in Bohemia and not in Patchogue, but I thought -- I was under the mistaken belief that those were sex offenders there, and if we had homeless people other than sex offenders they would get the vouchers, and that's not what's been happening, and I'm not even going to try to get in to the motivation or the why. But I do have a couple of concerns with the legislation.

First of all, I want to thank Legislator Stern for taking the initiative, because this is a problem that's been dumped on us. And some people, like him and myself with the GPS system, are trying to look at how can we make a bad thing better? And I almost kind of think the combination of the two where we had GPS and they could be in the trailers, because that's been the biggest concern of the east end Legislators -- and I hate when it's east against west or north against south -- and I think that would alleviate some of that concern.

I also was talking to Laura Ahearn, she couldn't stay but she was here earlier, and she told me that she was under the impression there was going to be an amendment, because Legislator Schneiderman said that there is a park being built at this moment that will --

D.P.O. VILORIA-FISHER:

Uh-huh.

LEG. EDDINGTON:

-- basically throw this law out.

LEG. D'AMARO:

It's not a park.

LEG. EDDINGTON:

And I just -- isn't it a sad situation where we have Legislators kind of fighting against each other and we've lost what the problem really is?

They have concerns out there about residents loitering in Riverhead; whether it's true or not, there's concerns and we have to deal with the perception. And giving a voucher system and sending them out into residential areas I think, as Legislator Lou D'Amaro said, of their choice is not something that I can live with.

So right now I'm just basically looking at the status quo until we can put some GPS bracelets on and then know where they are, whether it's at the trailers or in our communities. So that's why I supported the tabling.

LEG. D'AMARO:

Kate, can I ask a question?

CHAIRPERSON BROWNING:

Sure. I mean, while I'm listening to this, I have to tell you, this is an issue that I get beat up on every campaign season.

You know, to start, I had printed out a number of the Megan's Law list of sex offenders. And while I've said before, is Parole is not being very helpful in this issue. They actually called me to sit down and talk to me; I wonder why. But New York State Division of Parole, a sex offender, it says, "The arresting agency, Nassau County." I have a number of them here; arresting agencies, Nassau County, Monroe County, Orange County, New York City. And how come -- in fact, there's one from the Virgin Islands. And I'm looking at them and saying "Wow in the name of God do they wind up in Suffolk County?" And that's what's aggravating. I mean, nobody knows more than I do, I know a few of my other colleagues do, about the saturation of sex offenders in certain communities, and I am getting really tired. And I think that the purpose of this legislation and all of the sex offender legislation was created because it's become a political issue, it's used in campaigns against people, and it's not really an issue that any of us can fix. You know, they're choosing to live where they want to live, and yet I get beat up every campaign season that I'm allowing sex offenders to move to my community, I'm bringing them to my community. And, you know, they seem to forget, I'm a mother with three kids, I have a 14 year-old, the last thing I want is a sex offender in my community, and it's really limited to what I can do to fix that problem.

And so I really think it's time for Republicans, Democrats, working Families, Independents, to realize it's not a political issue, it shouldn't be used on campaign lit, and we all care about this issue.

There's nobody that doesn't care about the issue. We're all parents, grandparents, and it's really -- and this is why we have this problem. And now we have two Legislators on the east end who are complaining about the trailer being shoved out there because of a lot of the things that have occurred in the past and it really -- it's time to stop. And it's time for every single one of us here, you know, Republicans, Democrats, Independents and Working Family party, to work together to resolve the issue. And it's not going to get better while we continue to read it and campaign.

We just had a Council District race in my district and sex offenders, they're going to stop sex offenders from coming to the community; I'd love to know how the hell they're going to do it, because if I could have done it, it would be done already. So with that, I'm sorry, I got on my soap box, but I'm really getting tired of how one community doesn't want it over another, one community is saturated and we all have to come up with the solution. And I think our Presiding Officer said it well, you know, we have to come up with something and we all need to work together on this. So Lou, go ahead.

LEG. D'AMARO:

Okay, just two quick points. One, I think -- I want to commend Legislator Eddington on your bill with the GPS tracking. I think while we're having this debate, if the Executive is going to go forward with the voucher system, even on a limited basis, I think we should get that in place as soon as possible, I think it's a great tool for us to have.

And the other point I just want to reiterate very quickly is that, Legislator Browning, you're absolutely right and that was very well said and I appreciate that, because this should not be a political issue. But I can assure you that the folks that I'm hearing from my community are not thinking politics, they're thinking about the safety of their children, and that's what I'm trying to be responsive to. You know, I've said time and time again that the trailers may not be the ultimate perfect solution, but at least I know where homeless sex offenders will be housed overnight in a facility that is, if not guarded, at least has some security there, and I think that is the lesser of two evils. Rather than getting into all of the -- and there are many, many, many small motels scattered throughout Suffolk County, I'd rather not have those homeless sex offenders scattered throughout neighborhoods within our -- within those motels.

So just to reiterate those points. But I do appreciate all the comments that were made here today, and I think we need to stay focused on this issue. Thank you.

CHAIRPERSON BROWNING:

Well, on that subject, I'd like to add, yes, we know about the sex offenders today because of Megan's Law. And sex offenders are not something new, they've been going around for years. In fact, we're looking at what's going on at the Vatican and sex offenders and pedophiles priests and it's nothing new. It's because of Megan's Law today that we know about sex offenders. The sex offenders were are in our communities before Megan's Law, before notification and, you know -- and that's the shame of it, because there wasn't the outrage 20 years ago when there was no notification because nobody really knew about it, but they were there. Legislator Stern.

LEG. STERN:

Thank you, Madam Chair. Commissioner, or maybe Madam County Attorney, I have a question on some of the discussion from before about the Fair Hearing decision and now our procedure going forward.

You had started to implement the voucher system, little by little, prior to the Fair Hearing decision. The Fair Hearing decision was rendered and now, going forward, I didn't quite understand; did you say that those were -- that were utilizing the voucher system prior to the Fair Hearing decision are still utilizing the voucher system but nobody else afterwards, or are you still going through the process of implementing the voucher system for even those who are not in the voucher system prior to the Fair Hearing decision?

COMMISSIONER BLASS:

The Fair Hearing decision does not prevent us from going ahead with the voucher system. But for all practical purposes, we're having a very hard time putting people on the voucher system because of limited funds and because of limited places that they can go. The trouble with the resolution that's being tabled is that it suggests that there is no oversight when, in fact, there's oversight because most of them are on parole and there's oversight in that their receipts that they provide the next day show where they have been. But as I said, we only have four or five, not even, on the

voucher system and it's going to be probably quite a while before we can get another one on.

The Fair Hearing decision, in response to your question, doesn't conflict with the voucher system. It governs what we are required to do when we maintain a facility for them.

LEG. STERN:

Which -- from what I'm gleaning here, the administration agrees with the decision of the Fair Hearing and what it is we are mandated to provide; that's correct?

MS. MALAFI:

The voucher system was started for them to be put in place in preparation for an adverse decision on the Fair Hearing case.

LEG. STERN:

Would you characterize the decision as adverse?

MS. MALAFI:

No.

LEG. STERN:

It was not an adverse decision and, in fact, it's one that the administration agrees with and as of right now, anyway, has no intention of appealing in an Article 78.

MS. MALAFI:

Yes.

LEG. STERN:

So the talk that we had had prior about a court decision, you know, having an impact on whether or not we continue utilizing the trailer system, as of right now anyway, has not come to be?

MS. MALAFI:

There are four litigations that would impact this decision and this resolution which should be spoken about in executive session only.

LEG. STERN:

All right. Thank you. Thank you for that.

P.O. LINDSAY:

Just when you're done, I just --

LEG. STERN:

Okay. Just one more question, unless you --

P.O. LINDSAY:

No, no, go ahead.

LEG. STERN:

Okay. The -- if it is a New York State requirement that we provide amenities such as showers to homeless sex offenders, trailers or otherwise, if we're able to provide those services, that is not -- that is something that can be done. We can theoretically provide those amenities and not rely on a voucher system to be able to provide those amenities; correct?

MS. MALAFI:

Yes. But just to clear up the record, it wasn't that we weren't providing showers to the homeless sex offenders in the trailers, we weren't providing them enough and in the way that the homeless sex offenders wanted us to provide them.

LEG. STERN:

Well, a much different issue.

MS. MALAFI:

So that's really -- I just don't want -- the issue wasn't did we have to provide them showers, we were providing them with showers, but just the frequency and the location was one of the things that they were arguing about, just one.

LEG. STERN:

And cut me off if I'm going too far, but the argument was made that the showers were not being provided in the way they would want them to be provided and a Fair Hearing decision was rendered and we do not consider the Fair Hearing decision that was rendered to be an adverse decision.

MS. MALAFI:

Correct. We do have to make a change in how we were providing the showers to those living in the trailers, but it was not what any of us would consider an adverse decision.

LEG. STERN:

All right, very good. So whether it's the issue of showers, the issue of transportation or any other amenities, there is a way to provide those services. Are we providing them satisfactorily now? I mean, that's something that we need to take a good hard look at as we come up with a more comprehensive, systematic approach here. But I don't see any reason at this point, legal or otherwise, to go down a road of providing a \$90 a night voucher system when there has been no mandate that we do so. And in fact, we do have options available that can make a system that, although not ideal, can certainly be improved upon.

Let me make a couple of other points, and I pick up on something that the Chairwoman had said and my colleague Legislator D'Amaro. I don't care what you hear about on TV or in a maiming or otherwise, I have always maintained that I approach every decision that I make around this horseshoe most importantly as a parent, a parent of young children. And there is no place for this decision-making process on this critically important issue for really any other approach, geographic, political or otherwise. This is about the safety of our neighborhoods and our most precious resource, our children, and I know that everybody sitting around this horseshoe agrees with that.

I don't believe that this issue on where homeless sex offenders are housed overnight is a mutually-exclusive issue of the GPS. I strongly support Legislator Eddington's efforts, I think that it's a common sense approach, it's something that we need to take a good, hard look at and implement. But there is GPS and then there is location and where homeless sex offenders are spending their evenings, and it's absolutely unacceptable that they're spending their evenings in our neighborhoods.

Let me make one other point, because there has been this suggestion that if, indeed, this legislation goes forward, that there will be some type of response from the town in the form of -- I don't think a park, but a playground. I think the only word that I could probably use on the record to describe that would be disappointing. Thank you.

CHAIRPERSON BROWNING:

Go ahead, Bill.

P.O. LINDSAY:

Hopefully we'll end the debate with my comments, but I want to end it where I really started it. I couldn't agree more with Legislator Stern about the voucher system is a failed system; I don't believe it works and I don't think it's the proper thing to do. And really up to this time, we -- you know, the administration has come up with one plan after another and we've picked it apart. We haven't been proactive because nobody wants to touch this problem, nobody wants it, you know.

Because the solutions are -- there aren't that many solutions out there. You know, I had a long discussion with Commissioner Blass last week about this issue and I'm convinced that we have to be more proactive in trying to find a solution instead of just picking apart everything that they come up with because I haven't seen anything yet that I can live with. And again, I just ask for your permission to give us a little time. I have a meeting with Commissioner Blass on Monday and some other people that are involved in the field and we'll know pretty quickly whether we have the makings of some kind of more global solution. And I promise everybody that -- I know a number of you's are concerned and have been concerned, that we'll -- you know, if we do come up with something, we'll talk about it and see if it suits the bill, and if not we'll go back to your bill, you know, because I agree with you, vouchers are not a solution.

CHAIRPERSON BROWNING:

Okay. So we had a motion to table, I think you tabled it, and me the second. All in favor? Opposed? Abstentions? Okay, it is ***tabled for this session (VOTE: 6-0-0-0 - including Presiding Officer Lindsay)***.

With that, again, I don't think there's any other business, but for all Legislators remember to 2 PM on Tuesday, an FQHC presentation, the Federally Qualified Health Centers. Motion to adjourn, Legislator Vilorio-Fisher, I'll second. We're adjourned.

(*The meeting was adjourned at 4:17 P.M. *)