

## HEALTH AND HUMAN SERVICES COMMITTEE

### OF THE

## SUFFOLK COUNTY LEGISLATURE

### *Minutes*

A regular meeting of the Health and Human Services Committee of the Suffolk County Legislature was held in the Rose Y. Caracappa Legislative Auditorium of the William H. Rogers Legislature Building, 725 Veterans Memorial Highway, Smithtown, New York on Thursday, June 16, 2011 at 2:00 p.m.

#### **MEMBERS PRESENT:**

Legislator Kate Browning, Chair  
Legislator Vivian Vilorio-Fisher, Vice Chair  
Legislator John Kennedy  
Legislator Sarah Anker

#### **MEMBERS NOT PRESENT:**

Legislator Jack Eddington

#### **ALSO IN ATTENDANCE:**

*Legislator DuWayne Gregory - Legislative District No. 15*  
George Nolan, Counsel to the Legislature  
Barbara LoMoriello, Deputy Clerk/Suffolk County Legislature  
Paul Perillie, Aide to Legislator Cooper  
Marge Acevedo, Aide to Presiding Officer Lindsay  
Ali Nazir, Aide to Legislator Kennedy  
Leslie Kennedy, Aide to Legislator Kennedy  
Kristopher Oliva, Aide to Legislator Anker  
Eric Kopp, Assistant County Executive  
Ken Crannell, County Executive Assistant  
Diane Dono, Budget Review Office  
Craig Freas, Budget Review Office  
Dr. James Tomarken, Commissioner/SC Department of Health Services  
Ed Hernandez, Deputy Commissioner/SC Department of Social Services  
Linda O'Donohoe, Suffolk County Department of Social Services  
Art Flescher, Community Mental Hygiene Services  
Gail Lolis, County Attorney's Office  
Jeff Reynolds, PHD, LI Council on Alcohol and Drug Dependence  
Kathy Ligouri, Vice-Chair/Welfare-to-Work Commission  
Lee Marks, State Government Manager/Reckitt Benckiser Pharmaceuticals  
Dan Ruland, Clinical Liaison/Reckitt Benckiser Pharmaceuticals  
Ed Olsen, Town of Babylon/Drug and Alcohol  
Geri Walsh, SB Health Centers Advisory Board  
Dot Kerrigan, AME 3rd Vice-President  
Rick Brand, Newsday

#### **MINUTES TAKEN BY:**

Alison Mahoney, Court Stenographer

#### **MINUTES TRANSCRIBED BY:**

Kim Castiglione, Legislative Secretary  
Denise Weaver, Legislative Aide

*(The meeting was called to order at 2:09 P.M.)*

**CHAIRPERSON BROWNING:**

Okay. Good afternoon. We will start the Health and Human Services Committee. We'll start with the Pledge of Allegiance led by Legislator Anker.

*(Salutation)*

Okay. I do have two cards, and our first one is Jeff Reynolds.

**MR. REYNOLDS:**

Kate, if it's okay, I asked Kathy Liguori to come on up with me.

**CHAIRPERSON BROWNING:**

Yes. Come on up, have a seat. And yeah, Kathy, you are the second card, so go ahead.

**MR. REYNOLDS:**

I would yield that first place to Kathy.

**CHAIRPERSON BROWNING:**

Okay, we can reverse.

**MS. LIGUORI:**

Good afternoon. My name is Kathy Liguori, I'm the Vice-Chair of the Suffolk County Welfare-to-Work Commission of the Legislature. And first I'd like to offer my regrets that our Chair, Richard Koubek, who is at his granddaughter's kindergarten recital, could not be here today.

**D.P.O. VILORIA-FISHER:**

Aw, that's great.

**MS. LIGUORI:**

We're here to talk about the resolution for the sober homes, IR 1543, the Oversight Board. And it was two years ago today -- well, not today, but two years ago that the Welfare-to-Work Commission began a study of the Suffolk County sober home problem, and it was one year ago that we submitted our report to the Legislature which was titled, "Recovery for Whom."

We found that sober homes are virtually unregulated by any government body. The New York State Office of Alcohol and Substance Abuse Services, OASIS, claims no responsibility for them. Suffolk County has received no funding from OASIS to regulate these homes, and town code enforcement officials are limited in their ability to regulate these homes. We had hoped that our report would be welcomed by OASIS and that they would have assumed some responsibility for the sober homes, but this did not happen.

Meanwhile, possibly hundreds of these unregulated Suffolk County sober homes continue to collect government funds and to housing recovering alcoholics and drug addicts in situations where there is serious overcrowding, open use of alcohol and drugs, no professional supervision, there are shabby living conditions and properties that are an offense to both the residents and their neighbors, and most importantly, the undermining of the recovery of these fragile substance abusers.

Thanks to the leadership of Legislator Browning and the full Legislature, a resolution was unanimously adopted last year which would create the Suffolk County Department of Social Services to establish guidelines to professionalize sober homes in return for receiving enhanced rates to the residents. The Welfare-to-Work Commission supported this resolution but recognized that absent support from OASIS that it required some form of oversight to make certain that DSS-approved

sober homes are complying with the new criteria. And for this reason, our Commission's Sober Home Committee convened this year, and with the help of a number of consultants from the recovery profession, as well as representatives from the Department of Social Services in Suffolk County, they recommended creation of a Suffolk County Sober Homes Oversight Board.

These recommendations have been incorporated in IR 1543, and it is our hope that this Oversight Board will recommend the procedures to the Department of Social Services to monitor compliance with the criteria that's been established for decent and professional sober homes. And ultimately our hope is that the Board will encourage the creation of a network of approved sober homes that will drive the bad sober homes out of business, and therefore we really urge your support to this resolution. Thank you. And Jeff?

**CHAIRPERSON BROWNING:**

Thank you, Kathy. Go ahead, Jeff.

**MR. REYNOLDS:**

Kathy has done a great job, I think, of giving the overview as to where we are just to, I think, amplify the need for this. Over time, if anything, OASIS has become a little less involved in our region.

They've suffered significant budget cuts, and at the same time we have record numbers of young people, largely due to the County's opiate crisis, going through the treatment process, in many cases using taxpayer dollars to go through that process, finally find the miracle of recovery, only to wind up in an unsafe, unhealthy environment that doesn't support their recovery. Then we wonder why they relapse. So as we talk about relapse rates that are upwards of 80% in some populations, this is a key component of that. I think the long-term goal is to create an understanding that safe, secure sober housing is part of the treatment continuum.

In the meantime, I congratulate this County for stepping forward and saying "Look, at the very least we control the dollars and we control how they are spent." And I think that approach, in combination with a community approach that begins to say this is not acceptable anymore as a treatment community, I think that'll ultimately get us to where we need to be.

Certainly we recognize the limitations in that five responders to the RFQ only covers a fraction of the beds that are out there, and in many regards the five entities who responded are the good guys. But part of dealing with the bad guys is ensuring that the good guys have the resources they need to continue to do a good job; we've got to find a way to get some of those bad guys. But more importantly, there's a whole middle segment that's on the fence that's doing an okay job but not a great job. We can help those guys do better and make sure that they wind up in that good guy column really fast. We need the beds more than ever before.

So thank you for putting this forward, thank you for seeing through this process. I know that it's been a long process, but I think we have all the makings of a very dynamic and effective oversight board and we're anxious to get to work.

**CHAIRPERSON BROWNING:**

Thank you, Jeff. And I did speak with Dr. Tomarken and he did ask that I table it this cycle because he has yet to have a meeting with DSS to see how they're going to coordinate with DSS in doing this, and I'm receptive to his request. I think he's been very cooperative and certainly wanting to work with us and make this a reality. So I may consider the tabling for this cycle, and we'll be back in August.

But I want to say thank you to you guys, because I know like two years ago I came and I got some resistance, and I think that over the past couple of years, with the many meetings and the public hearings that we had, I think you're all understanding where I'm coming from now. And again,

there are too many kids that are -- you know, too many of our children who are getting hooked on heroin and we know that sometimes they can't go back home and they need somewhere to go. And just this week Outreach had their luncheon event and places like them, they do a fantastic job with our young people, but there's not enough places like this here on Long Island.

I think we have a major crisis going on and nobody seems to want to address it. And I'm glad that my colleagues here at the Legislature are seeing that this is an important issue. We have to take care of our children. We need to make sure that they get the rehabilitation that they need and, you know, get their lives back on track.

So, Jeff, I appreciate everything, your expertise. I know you're going to be on the Oversight Board, I certainly appreciate your input. And, you know, with that, does anyone else have questions?  
Vivian.

**D.P.O. VILORIA-FISHER:**

Well, I just want to thank both of you again. You know, Kathy, you have been on the Welfare-to-Work Commission for so many years and have really made some important changes and you're making a difference. And Jeff, we know how you extend yourself to the most vulnerable.

You know, one of the saddest things about the abuse of the sober home system is that when people see that a sober home is someplace where people are hanging around outside, breaking into fights, turning tricks, being drunk and disorderly, then they paint all sober homes with that brush and don't want them anywhere in their neighborhoods. Because that's what we were hearing for years and years, people coming in, it was heartbreaking, it was really hurting people's quality of life.

So what Katy's doing with this is exactly where we should be going. We've been trying to do it for years. You know, your predecessor had legislation, the predecessor before him had legislation, but we were always knocked down by OASIS, by the State; they tied our hands to be able to do anything. So this is another way we're trying to get it done, let's hope it sticks. Thank you for all the work you do.

**MS. LIGUORI:**

Thank you.

**MR. REYNOLDS:**

Thank you.

**CHAIRPERSON BROWNING:**

I think, too, it's those trips to Albany that have hopefully helped. And again, we still need to push on the State level, that they have to recognize that we have a problem and they need to do something.

So anyway, I appreciate everything you've done, and we'll keep working. Thank you.

**MR. REYNOLDS:**

Kate, I wanted to speak on 1485 as well. Should I stay here or do we do it in a different way?

**CHAIRPERSON BROWNING:**

Yeah, there's nobody else here to speak. 1485, which one is that?

**D.P.O. VILORIA-FISHER:**

Just to the extend the deadline on the panel.

**CHAIRPERSON BROWNING:**

Oh, to extend the deadline. Okay.

**MR. REYNOLDS:**

Yeah, I wanted to say just a couple of words on that, if I might?

**CHAIRPERSON BROWNING:**

Sure, go ahead.

**MR. REYNOLDS:**

As you know, we were constituted about this time last year with a primary mission to make a series of recommendations as it relates to prevention, access to treatment and recovery services, specifically as it relates to heroin and opiate addiction here in this County. We did that and made 48 separate recommendations about how to improve that system. We finished that in December, well within the established time frame, and have continued to meet and would like to continue to meet to move towards implementation of some of those key recommendations.

I think all of us of said, you know, this has been a really good process, and to simply publish a list of recommendations and be done with it and go on with our day-to-day lives probably wasn't the thing to do. And we've got some great ideas, I think, about how to implement some of the recommendations. And so we've accomplished our mission, it's not an extension because we did an extension because I think we've generated some interest, some chemistry, and have some great ideas about how to move forward with implementation beyond simply publishing the required report.

**CHAIRPERSON BROWNING:**

Okay. Thank you.

**MR. REYNOLDS:**

Thank you.

**CHAIRPERSON BROWNING:**

Okay. I will say, Legislator Viloría-Fisher has a committee meeting that she has to attend, so we will go on with the agenda which will be very quick, and we'll have Mr. Marks and Ruland will come up and speak after that. So we have tabled resolutions.

**Tabled Resolutions**

***2254, Authorizing not-for-profit agencies to utilize funding for extra-contractual social services delivered to the County and its residents (County Executive).*** Motion to table.

**D.P.O. VILORIA-FISHER:**

I'll second it.

**CHAIRPERSON BROWNING:**

Second, Legislator Viloría-Fisher. All in favor? Opposed? Abstentions? It's ***tabled (VOTE: 4-0-0-1 Not Present: Legislator Eddington).***

***1100, Adopting Local Law No. -2011, A Local Law to increase awareness of the harmful effects of tobacco use (Cooper).***

**D.P.O. VILORIA-FISHER:**

Motion to table at the request of the sponsor.

**CHAIRPERSON BROWNING:**

Right, table has requested a table -- the sponsor has requested a table.

*(\*Laughter\*)*

So it's tabled; Legislator Viloría-Fisher, I'll second. All in favor? Opposed? Abstentions?  
It's **tabled (VOTE: 4-0-0-1 Not Present: Legislator Eddington)**.

**1470, Establishing a policy of fair and equitable budget reductions at County Health Centers (Browning).** I will say, Mr. Kopp and Mr. Crannell are here, I would like to pass this out of committee. So I'm going to make a motion to approve.

**D.P.O. VILORIA-FISHER:**

I'll second that.

**CHAIRPERSON BROWNING:**

And we'll have a second from Legislator Viloría-Fisher. However, I know that you have a meeting, a conference call tomorrow at eleven, and I have to say that the committee, we have worked very well together on this issue. I appreciate everything that you guys have done as far as going up to Albany, the negotiations that you've done. Also, our Budget Review, Craig Freas, what you have done. So I would like to get this out to the floor for next Tuesday. We don't know what kind of money we're going to get, if we're getting any money, but in the event that we might get money and there'll be a decision, I'd like to at least get this on the floor and hopefully we can work out some kind of an arrangement.

So with that, I made the motion; we had a second. All in favor? Opposed? Abstentions?  
And it is **approved (VOTE: 4-0-0-1 Not Present: Legislator Eddington)**.

**1474, Terminating a consultant contract (Degere Physical Therapy Services, P.C.) (Kennedy).**

**LEG. KENNEDY:**

Madam Chair, I'll make a motion again to table for this cycle, but I want to just give a message, I guess, to the Health Department.

My understanding is that our full-time physical therapist is back and that he is fully engaged. So my expectation is, Doctor, that in August I'm going to be looking to move this resolution. Assuming that everything goes forward in a proper fashion and we have another month to have, you know, things kind of get resettled and engaged with our full-time staff, then I'm going to look to move this in August.

**CHAIRPERSON BROWNING:**

Okay.

**D.P.O. VILORIA-FISHER:**

I'll second it to table.

**CHAIRPERSON BROWNING:**

Second for a table is Legislator Viloría-Fisher. All in favor? Opposed? Abstentions?  
It's **tabled (VOTE: 4-0-0-1 Not Present: Legislator Eddington)**.

**1475, Directing the Department of Social Services to close the sex offender trailer in Westhampton, Town Of Southampton (Schneiderman).** I'll make the motion to table.

**D.P.O. VILORIA-FISHER:**

Second.

**CHAIRPERSON BROWNING:**

Second, Legislator Viloría-Fisher. All in favor? Opposed? Abstentions? It's *tabled* (**VOTE: 4-0-0-1 Not Present: Legislator Eddington**).

*1476, Directing the Department of Social Services to close the sex offender trailer in Riverside, Town of Southampton (Schneiderman).* Motion to table. Same motion, same second, same vote. **Tabled (VOTE: 4-0-0-1 Not Present: Legislator Eddington).**

**Introductory Resolutions**

*1485, To extend the deadline for the Heroin and Opiate Epidemic Advisory Panel (Nowick).* Motion to approve, Legislator Kennedy. I'll second. All in favor? Opposed? Abstentions? It's *approved* (**VOTE: 4-0-0-1 Not Present: Legislator Eddington**).

*1523, Amending the 2011 Adopted Operating Budget to transfer 100% State Aid funding from Suffolk County Department of Health Services to the Pederson-Krag Center, Inc., and to accept services to Brentwood Union Free School District (County Executive).* I'll make a motion to approve and place on the Consent Calendar. Second, Legislator Viloría-Fisher. All in favor? Opposed? Abstentions? It's *approved and placed on consent calendar* (**VOTE: 4-0-0-1 Not Present: Legislator Eddington**).

*1524, Accepting 100% Federal grant funds from the United States Environmental Protection Agency passed through the New York State Department of Environmental Conservation to the Department of Health Services for the State Pollutant Discharge Elimination System (SPDES) Water Quality Management Planning Program and authorizing the County Executive to execute any related agreements (County Executive).* I guess we'll make same motion, same second, same vote?

**D.P.O. VILORIA-FISHER:**

How much is that for, George?

**CHAIRPERSON BROWNING:**

How much money is that?

**MR. NOLAN:**

One hundred and twenty-five thousand.

**MR. FREAS:**

This is a previously approved contract, I believe it's about \$100,000 a year. Hold on.

**D.P.O. VILORIA-FISHER:**

Yeah, George just said 125.

**MR. FREAS:**

Right. The State now requires us to execute a municipal agreement with them in order to receive the money. We've already received the money. We're already in contract with them, but we have to have the contract in order to get the funding, so this is basically just approving the execution of the municipal services agreement. There's no cost implication really at this point.

**D.P.O. VILORIA-FISHER:**

Okay, but I just have a question. Because when -- so we lay out the money and they give it back us to us, right; is that what you are saying? They reimburse us.

**MR. FREAS:**

I'm saying this bill doesn't -- we are already receiving this money. We've -- but the bill requires -- we're now required to have this contract where we previously were not.

**D.P.O. VILORIA-FISHER:**

So we didn't spend the money and then have it reimbursed?

**MR. FREAS:**

The money is in here only because -- to show that this is what we won't get if we don't execute this agreement.

**D.P.O. VILORIA-FISHER:**

Okay. The reason I'm asking that is because generally this type of program we use 477 money, and I was just curious, is that we had to spend it, it did come out of 477, and if we got the grant money would it go back into 477 or would it go into the General Fund? Because we -- I just spent from 9:30 to ten of two at a Water Quality Review Committee and we -- we have more requests for funds than we have funds.

**MR. FREAS:**

Let me get back to you on that.

**D.P.O. VILORIA-FISHER:**

Thank you.

**CHAIRPERSON BROWNING:**

Okay. We're going to accept it anyway.

**D.P.O. VILORIA-FISHER:**

Oh, we'll accept it. I just want to make sure it goes in the right place.

**CHAIRPERSON BROWNING:**

Sure.

**D.P.O. VILORIA -FISHER:**

I will make a motion to approve. Can we not put it on the Consent Calendar?

**MR. NOLAN:**

You can.

**D.P.O. VILORIA-FISHER:**

No, I'm asking if we cannot put it on the Consent Calendar.

**CHAIRPERSON BROWNING:**

Okay. So --

**D.P.O. VILORIA-FISHER:**

So that if it stays open --

**CHAIRPERSON BROWNING:**

We'll just make a motion to approve, but we'll not put it on the Consent Calendar.

**D.P.O. VILORIA-FISHER:**

Yeah, just so it can come back to me.

**CHAIRPERSON BROWNING:**

Okay?

**MS. LOMORIELLO:**

1524? You've done it already.

**CHAIRPERSON BROWNING:**

1524, don't put it on the Consent Calendar. Okay? So we --

**D.P.O. VILORIA-FISHER:**

You didn't call the vote.

**CHAIRPERSON BROWNING:**

We did have a motion. Well, I was doing same motion.

**D.P.O. VILORIA-FISHER:**

You called the vote?

**MS. LOMORIELLO:**

Yeah, the vote has been called.

**D.P.O. VILORIA-FISHER:**

Oh, for the Consent Calendar. But we can just --

**MS. LOMORIELLO:**

Not for the Consent Calendar.

**MR. NOLAN:**

She wants it off the Consent Calendar.

**D.P.O. VILORIA-FISHER:**

Okay.

**CHAIRPERSON BROWNING:**

Yeah. So we had the motion -- so the vote was called entirely. Okay, that's good.

***Approved (VOTE: 4-0-0-1 - Not Present: Legislator Eddington).***

Okay next one. ***1543, Establishing a Sober Home Oversight Board. (Browning).***

Dr. Tomarken, can I ask you a question?

**D.P.O. VILORIA-FISHER:**

Me, too.

**CHAIRPERSON BROWNING:**

I believe -- I was just looking at the calendar, we meet next Tuesday on the 21st. If we were to pass this out of committee and just put it on the floor next week, and if there's any kind of prior negotiations need to go on between yourself and the Department of Social Services; would that be a problem?

**COMMISSIONER TOMARKEN:**

I'm not sure what exactly the legislation requires of us, that's why I can't answer that definitively.

**CHAIRPERSON BROWNING:**

Okay.

**D.P.O. VILORIA-FISHER:**

I just need to ask him a question. As I read this, Dr. Tomarken, it seemed that it's DSS who has to do an RFQ?

**CHAIRPERSON BROWNING:**

The RFQ was done.

**D.P.O. VILORIA-FISHER:**

The RFQ was done.

**CHAIRPERSON BROWNING:**

It was just (inaudible).

**D.P.O. VILORIA-FISHER:**

Oh, okay.

**CHAIRPERSON BROWNING:**

This is just establishing the oversight board to oversee the homes.

**D.P.O. VILORIA-FISHER:**

I don't see any harm in sending this out.

**CHAIRPERSON BROWNING:**

I know, but --

**D.P.O. VILORIA-FISHER:**

I just don't know what the problem is with our voting yes on this.

**COMMISSIONER TOMARKEN:**

Well, we just haven't had any input into this oversight board and our participation in it and how we would contribute and who would have which responsibility. So that's why I just was asking for it to be tabled so that we could meet first with DSS.

**D.P.O. VILORIA-FISHER:**

You mean as far as staff support and that kind of thing?

**COMMISSIONER TOMARKEN:**

Just exactly what our -- what we're being asked to do and what our participation is. We've had no meetings regarding this.

**D.P.O. VILORIA-FISHER:**

Okay. All right. Okay, thank you.

**CHAIRPERSON BROWNING:**

Okay. So to save any future further discussion, what I'll do is, you know, I think by the August meeting we'll be good to go. So I'll make a motion to table.

**D.P.O. VILORIA-FISHER:**

Second.

**CHAIRPERSON BROWNING:**

And we'll have a second, Legislator Viloría-Fisher. All in favor? Opposed? Abstentions?  
It's *tabled (VOTE: 4-0-0-1 Not Present: Legislator Eddington)*

*1551, Authorizing reformation of contract with Suffolk Y Jewish Community Center (Kennedy).*

**LEG. KENNEDY:**

I'll make a motion to approve.

**CHAIRPERSON BROWNING:**

I'm making a motion to table at this time.

**D.P.O. VILORIA-FISHER:**

On that motion that there's no second on. I understand that Joe Sawicki had recommended that we move forward with it, that it meets his requirements. Is there any representation that he has made, had communication with anybody here that he is okay with this?

**LEG. KENNEDY:**

Yes. As a matter of fact, Legislator, he has worked with the other sponsor on this reso, Legislator Stern, we are cosponsors. And, in fact, I think a lot of Mr. Sawicki's concerns initially were the broader language that was associated with the resolution that we just tabled, 2254. The circumstances that are surrounding the Y, the Suffolk Y, are something that you do find in law sometimes, which is something that's actually called mutual mistake. If you'll recall, the initiative to commence the contractual arrangement with the Suffolk Y predates my time and goes back to one of my colleagues that served with you, Legislator Postal, Maxine Postal.

**D.P.O. VILORIA-FISHER:**

Uh-huh. By the way, I opposed her resolution when she introduced it then, because it was so much money to one agency.

**LEG. KENNEDY:**

I understand, but my purpose in being a sponsor on this resolution is for a variety of reasons. First of all, I think this resolution was somewhat mischaracterized when it first came out and made it appear that we would be, in essence, relinquishing a contract entity from an obligation to go ahead and repay on funding that we had first instanced that somehow they had misappropriated or spent improperly; that's not the case.

**D.P.O. VILORIA-FISHER:**

Well, this just makes Youth Services go back and do another contract.

**LEG. KENNEDY:**

Absolutely, absolutely.

**D.P.O. VILORIA-FISHER:**

George, have you gotten anything from Sawicki on this? I'm sorry to interrupt you, John, I just wanted to --

**MR. NOLAN:**

Yeah, in putting this together I did speak to the Comptroller's Office. He did prefer going this route than the other type of resolution that was broader and that would of encompassed more groups. So he -- I don't want to speak for him, but it was my impression from speaking with him that he preferred that the Legislature go this way, limit it to the one group. He did -- you know, I will recall when they did the audit, they really didn't find fault with the Y. Everybody who has come to testify

has said that there was a misunderstanding as to that term whether or not they had to return money to us, to the County. So I think the Comptroller's Office is okay with this resolution; that's the way I would characterize it.

**LEG. KENNEDY:**  
(Inaudible).

**D.P.O. VILORIA-FISHER:**  
And it's bouncing it back to the administration to fix the contract.

**LEG. KENNEDY:**  
(Nodded head yes).

**D.P.O. VILORIA-FISHER:**  
Which is what we've been asking them to do.

**LEG. KENNEDY:**  
Yes.

**D.P.O. VILORIA-FISHER:**  
Okay. I'm going to second the approval.

**LEG. KENNEDY:**  
Okay.

**CHAIRPERSON BROWNING:**  
I know that, you know, Legislator Lindsay has been going back and forth with the other providers that are kind of in the same position; they provided a service and now they're being told, "You have to pay back". So my fear is are we doing it for one and not for another? But --

**LEG. KENNEDY:**  
Well, Madam Chair --

**CHAIRPERSON BROWNING:**  
If we are going to do it for them, I certainly want to make sure that they're doing it for the other group.

**LEG. KENNEDY:**  
Let me just address that. And, again, you're right that we should always strive to be consistent if we look to go ahead and to accommodate where there's been some kind of a misunderstanding or something to that effect. But I spoke with the Comptroller's Office at length, and I also called the County Attorney and I spoke with the County Attorney as well, and while Legislator Lindsay seems to have wanted to link these two disparate providers; in actuality, if you look at the facts associated with the audits, they are dissimilar, they're not similar.

The shelter providers, the Comptroller's audit, found that, in fact, reimbursement that the shelter providers were seeking for personnel weren't performing as the provider had represented; they're, in fact, sleeping. And there was no provisions in the contract that the provider would be reimbursed for personnel that actually were in a shelter but slept.

So when you -- on the surface they're two providers, but it is a disparate set of circumstances between the two different entities. And so, therefore, I don't know that it really warrants us joining or linking the two for restoration or to make them whole. I think Suffolk Y needs to stand on its own set of circumstances and then I think we would visit what went on with Penantes or any other

shelter provider, because I don't think we have that same circumstance of mutual mistake.

So, you know, at any time I'm always happy to look at what the terms and conditions are, but if you put the Comptroller's audits side-by-side, you'll see a much different set of findings with the two entities.

**CHAIRPERSON BROWNING:**

Okay. You know, I haven't -- usually I do go back and forth with Joe to find out where he is on this because it's been going on for a while. I haven't heard from him, but I guess we can approve it out of committee --

**LEG. KENNEDY:**

Okay.

**CHAIRPERSON BROWNING:**

-- and get an answer back from him by Tuesday.

**LEG. KENNEDY:**

Okay.

**CHAIRPERSON BROWNING:**

So we had a motion and a second. So all in favor? Opposed? Abstentions? It is *approved*  
**(VOTE: 4-0-0-1 Not Present: Legislator Eddington)**

**LEG. KENNEDY:**

Thank you

**CHAIRPERSON BROWNING:**

Okay. So, the next one is, *1565, Establishing a County policy to ensure the full operation of all County Health Centers in 2011 (Montano)*. I'm going to make a motion to table, basically because it's really -- you know, I asked the sponsor about this, I don't know what it's really doing. And if you're going to pass a bill like this to ensure full operation, I'd like to see an offset of money attached to it and there isn't at this time.

**D.P.O. VILORIA-FISHER:**

I also have a question for Counsel about it.

**CHAIRPERSON BROWNING:**

Go ahead.

**D.P.O. VILORIA-FISHER:**

George, according to the Charter, can the County Executive provide a directive to the Health Commissioner and the Legislature prohibit that directive regarding a budgetary issue? Doesn't the County Executive have the administrative prerogative as the Chief Budget Officer?

**MR. NOLAN:**

Yeah. Well, I think there is some inherent conflict between this and what's in the Charter. In a deficit situation, the County Executive does have certain authority to hold off on spending, items that are budgeted up to a certain amount. This resolution says don't make any reductions. I think Legislator Montano, in light of what the County Executive proposed which were deep cuts to certain centers and cuts to all the centers, was anxious to make a policy statement about what he felt and this is what he proposed. But, yeah, there is some tension, for sure, between this resolution and what the Charter allows the County Executive to do in a deficit situation.

**D.P.O. VILORIA-FISHER:**

That's my hazard; I see it as being counter to the charter provision. Okay. I second the motion to table.

**CHAIRPERSON BROWNING:**

Okay. So we have a motion to table and a second. All in favor? Opposed? Abstentions? It's **tabled (VOTE: 4-0-0-1 Not Present: Legislator Eddington)**

**1566, Adopting Local Law No. -2011, A Local Law to require legislative approval of Major Water Management Policy Initiatives (Cilmi).** And I hate to tell you, I have no idea what this is about because I haven't had a chance.

**D.P.O. VILORIA-FISHER:**

We have to table it for a public hearing.

**CHAIRPERSON BROWNING:**

Oh, yeah. So, thank God, I've got time to look at it then.

**D.P.O. VILORIA-FISHER:**

There's a study, there are letters supporting it.

**CHAIRPERSON BROWNING:**

Yeah, okay. So, anyway, we made a motion to table for public hearing; Legislator Viloría-Fisher, I guess, made that motion.

**D.P.O. VILORIA-FISHER:**

Yes.

**CHAIRPERSON BROWNING:**

Second, Legislator Anker. All in favor? Opposed? Abstentions? It is **tabled (VOTE: 4-0-0-1 Not Present: Legislator Eddington).**

**D.P.O. VILORIA-FISHER:**

Thank you for the courtesy, Madam Chair. I had, as I said, that Water Quality Review Commission that started at 9:30, ended at ten to two -- no, it ended, I was able to get here. But now I have to head out to the Soil & Water Commission meeting in Riverhead, so I'm gone.

**CHAIRPERSON BROWNING:**

Thank you. And with that -- actually, I don't know if, Dr. Tomarken, if you have time to stick around. I would like for our presentation to happen, but I have a few questions about some of the positions for the John J. Foley Nursing Home. But I would like to have Mr. Lee Marks and Daniel Ruland from Reckitt Benckiser Pharmaceutical to talk about the Suboxone Program.

Okay, thank you for coming. And if you would like to start, introduce yourselves for our stenographer.

**MR. MARKS:**

Thank you very much, Madam Chairwoman.

**CHAIRPERSON BROWNING:**

You've got to keep your finger on the button, I'm sorry, the whole time.

**MR. MARKS:**

The whole time, huh?

**CHAIRPERSON BROWNING:**

The whole time.

**MR. MARKS:**

There you go. Yeah, my name is Lee Marks, State Government Manager for Reckitt Benckiser; very good on the pronunciation, you did that pretty well. And I'm joined by Dan Ruland who is a -- who's like a clinical liaison also for, you know, Reckitt Benckiser. And again, we want to thank you for your time. I want to also thank Representative Kennedy, who was helpful in, you know, bringing this forward and we appreciate his time as well.

Just very briefly about me. I'm actually very pleased to be home. I am a Suffolk County resident for many years, I graduated high school here, so for me it's particularly thrilling to have an opportunity to speak before the Legislature here today and I thank you for that.

Our agenda today, quite briefly, is to discuss the Suboxone, Buprenorphine Program and our open invitation to collaborate more with the County in moving forward on this. We want to share some new developments in terms of the evolution of treatments that we're now seeing and some of the things that Reckitt Benckiser's being working on to advance, you know, treatment in the field of opioid, you know, like dependency, and also share some models of what some other entities and states and localities are doing all across the country that we think could be instructive to the effort that's being undertaken here in Suffolk County as well.

Just some history here. I think you folks have already touched on some of this, but obviously there's been a growing problem of opioid, you know, like dependency in this County. This is not unlike many counties and many states across the country. It's an outgrowth of a tremendous use of, you know, prescription drugs that is, you know, fueling quite a bit of this and, you know, through our mind, probably not, you know, sufficient enough oversight by physicians and others to make sure people don't end up, you know, heading in the wrong direction.

The problem here in Suffolk has obviously been well documented by such papers as Newsday, we know some local papers have also been very much involved. We're aware that there are a good number of public forums out here that were held at schools in which two to 300 parents, students, teachers were showing up and expressing some of the things that they were seeing. We heard that Brookhaven alone was suffering from two deaths per week due to opioid, you know, like overdoses. We met with Representative Kennedy about six months ago where he just anecdotally told us that he knew of ten people in his district that had died in the past two weeks due to overdoses, including people who had worked on his campaign and had been close, you know, friends of his. So, clearly this is an epidemic. I would again say, as bad as it is in Suffolk County, you are not alone. This seems to be, you know, a problem that we're seeing, you know, throughout the entire country.

In February, 2010, the County Executive rightly proposed and attempted to respond to this problem by working on basically like a two or three, you know, prong approach, one of which had to do with treatment, and to bring Buprenorphine and Suboxone, which is the product that we make -- we are the sole manufacturer of that product, you know, in this country -- and to put \$350,000 towards this effort with the notion of treating some 60 patients, adolescents, hiring two caseworkers and a nurse over time. It's been about 18 months since that time and we're frustrated and I believe the County is frustrated as well that at this point in time, to my knowledge, there's only been one patient I was able to enter into that program. We now know that a new protocol has been put in place to help move this process along. I think there were several problems with the previous protocol which was probably a little too tight, it dealt with only adolescents alone, I understand now we're going to start to expand that.

There are many contributing factors to getting a Buprenorphine program like implemented. So it's not entirely like unique that Suffolk is having some difficulty trying to move this along. A couple of the problems. You know, clearly one of the big problems is the stigma that's related to this, you know, disease state. It's a problem in terms of getting, you know, providers to actually treat these patients. Now, Suboxone is a very interesting medication. This is the only medication on the market that requires for a physician to treat opioid dependency, they have to get a special certification; there is no other medication in the market that requires a special certification for physicians to use it. We say that noting the irony that people can write OxyContin and Oxycodone and Vicodin without any kind of special certification, but if you intend to treat somebody, you need to get a special certification to move ahead. That creates, you know, something of a barrier in terms of finding, you know, providers who are willing to go ahead and do this. In fact, they have to affirmatively, by getting the certification, say, "This is something I want to get into." And we can tell you even there that of the 20,000 physicians in our country that have that certification, only half actually write. So finding providers out there is a real difficult problem and we understand that's a problem that the County's been trying to work through as well.

There's also some issues that relate to DATA-2000. This was a drug that came to market with the help of legislation -- it was the last bill signed by Bill Clinton before he left office -- that allowed this medication to come to market. One of the key components in that legislation capped the number of patients that a provider can have. So not only do you have to get a certification, but over time you can only treat up to one hundred patients. That also creates a capacity issue over time which is something that Suffolk, as well as other, you know, like entities have been struggling with as well.

The third piece are protocols that you have to put in place for this very special disease-state for these very special patients. And from our perspective, we're a company that believes very strongly that the medication itself is not the answer. What the medication does, quite frankly, is that it removes withdrawals and cravings. That's what allows the patient to then get engaged with counseling and enables them to work on all the problems that help them get to where they were when they decide to finally come into treatment. And finding protocols that make sure that people stay within this program are very difficult. We're a company that supports appropriate prior authorizations that includes such things as counseling requirements, regular urine drug screens. We want to make sure that there is an opioid, you know, like dependency, you know, I mean, like indication, you know, and we want to make sure that people are staying true to the protocols and to the methods at which they need to undertake in order to reach full recovery. So lots of pieces come into play here. I would say that every entity I've worked with has had some, you know, difficulty in working through those and I understand that Suffolk County has as well.

Over the past 18 months, we haven't stood still either. We have seen the need to move the evolution of treatment along in terms of this medication. I'm going to turn the mic over very briefly to, you know, Dan Ruland who will tell you some of the things that we've been doing as a company to try to move this entire process along, and then I'll come back and talk a little bit, you know, what we're doing in other places.

**MR. RULAND:**

Well, basically our company, Reckitt Benckiser, which has been a very patient focus company since its inception, saw some needs in Suboxone. Some of you obviously know, made notes, some people are successful in Suboxone and we've had huge success with Suboxone. So some of you might be thinking why would we have to do anything to it; why not just keep it as is? Well, what the company noticed four years ago was that there's a few concerns with Suboxone that they wanted to address to make it even better.

Two of the major concerns was the dissolve time, and the second one was taste. Now, I don't know how familiar you guys are with this medication, but it's a sublingual medication, So if it doesn't taste well, the people may not want to sit still long enough to get it to absorb fully through the mouth.

Anything they swallow, the medication is lost due to the acidity of the stomach. So I don't want to get into it much further than that.

So what the company decided to do, and also because the goal of the DEA now is to prevent unintended pediatric exposure which is a big push of the Federal Government, what my company basically was in the works of doing for four years prior to last April of the Federal -- the DEA changing their risk evaluation mitigation strategy for controlled substances is we put this product into research and development. Basically it's Suboxone film, each Suboxone film is prepackaged individually, comes 30 in a box. Each package is child resistant, so if a patient manages to get into this, they've only got access to one dose rather than getting into a bottle of 30 or 60, let's say, where they have a potential to possibly overdose; so that's a positive. It taste's better; 70% of the patients said it tastes better. And also, because it's a sublingual film that you put under your tongue, it dissolves in almost half the time, so most patients are more likely to get the full dose that they're supposed to get.

The other additional benefits to the film is each one has a ten-digit code on it. If you get a box of 30, each tab within that box has a ten-digit code on it which will all be the same. If somebody on -- well, not really out here in Suffolk County because pharmacies do not have to enter the lot numbers when a prescription is filled out here in Suffolk County, as in other areas of the State and other states throughout the country. If that was the case, if somebody got arrested with this, my company knows what lot number it came from and could find out who it was initially dispensed to to bring them in on the whole investigation. So it's a world of difference.

There's also a UPC symbol on each dose which is going to be utilized in the next year-and-a-half to two years when the Federal Government puts a prescription monitoring program in place called Pedigree, which is designed to monitor controlled substances from the manufacturer down the supply chain, and it's going to be scanned along the way so if it disappears, they're going to know exactly where it disappears.

So that's everything we've put in place to help this not only meet the patients' needs, meet the public health needs, but also the needs of our physicians to give them peace of mind to know that it's less likely to end up in the wrong hands.

**MR. MARKS:**

So what are the other, you know, localities and states doing? Well, you know, we take a look -- you know, we work very closely with a good number of State/County entities, and we look at the kind of programs that they're putting together and there's two that we would point to for this, you know, like for Suffolk County. You know, one is in Baltimore, which has been extremely successful, which was moved by the then Health Chairman who's now over at the FDA, largely moved to the FDA because then President Obama was so impressed with the work that he did with Suboxone and the reduction in terms of overdoses and the reduction in terms of Opioid abuse that they saw there, that they actually moved him along.

And what Baltimore did, is that they came up with a program where they put together a, like, induction center, a single center in which inductions would take place; this is the process by which you bring patients in and you start the administration of the medication. And it's a process that is, you know, time consuming for most and really requires, I think, a fairly good level of understanding about how the medication works.

Those entities would actually -- those induction centers would actually hold these patients for between six and nine months until they were stabilized, and for them that meant very intensive oversight. That meant staying on top of patients with urine drug screenings, keeping them coming to the physicians on a fairly regular basis. And from Baltimore's view, it was important then that if they were going to discharge this patient; that patient should be well along the road of recovery so

when the local physicians got them, who weren't typically enured to using, you know, Suboxone, they would feel more comfortable about having a patient who was very stable and that they were able to treat on like a monthly basis, come in, have a discussion about, you know, how they're doing and then be able to write a, you know, script for them and to, you know, move them along.

This has worked remarkably well for the City of Baltimore. And I think it's the kind of model that I think that -- you know, that I think Suffolk was initially. You know, I mean, kind of walking down towards, I think they're kind of still there, but I think there are some pieces that maybe need to be filled in. One of the things that Reckitt Benckiser uses -- is prepared to do is to bring the people from Baltimore here to Suffolk County so you can talk to them directly and find out what worked for them and what didn't. Again, this is a fairly complicated medication and it's not very easy always to put the type of program in place that's going to work effectively.

I think the second place you might want to look at is the City of Boston, which has taken on also a somewhat different type of model where they have really worked very hard with their nurses and their Federally Qualified Health Clinics. Federally Qualified Health Clinics really have a special role here, because unlike some of the other, you know, reimbursement rates, they get a very good rate in terms of what they provide and in terms of their patient encounters, and they could actually build a business model that makes a lot of sense for them.

So in Boston what they've done is that they have pulled together some 14 centers throughout the entire State. They have a centralized induction center as well. They work very closely. They don't keep them nearly as long, not the six to nine months, but maybe closer to two or three, and they have worked out really good arrangements with their local, you know, providers, the Federally Qualified Health Clinics to allow those patients to be able to move out of induction and make a warm handoff into those centers where people can continue to get their care and to move effectively. Their results have been fairly compelling. They are now claiming that they are getting around a 75 to 80% success rate, success for them being the person is clean of opioids for over a year and they've had several people now three, four years out and they're well into the 70 or 80% where they're getting real success.

So I would say overall, like you, we really want this to succeed. Failure's not an option. We have a real problem here out in Suffolk County. We want to continue to offer our assistance in every way that we can. We could bring a lot to table in terms of education, we can bring players here who have had success with this in the past. I would say that I think the Legislature needs to be aggressive in terms of oversight to ensure this moves along. I don't think anybody is satisfied with waiting 18 months to get this moving; I don't think the County's satisfied, I don't think the Legislature's satisfied, certainly we're not, you know, satisfied. I don't think it's due to any sort of malfeasance or, you know, lack of effort by any means. It's a complicated process. And what I would say to all of you is that we really need to work collaboratively to try to work this through because the need has never been more severe.

So I will stop there. And I heard I was the last, you know, committee meeting, you know, for like the entire week, so I don't want it to be me holding us up between, you know, recess and not, so I'll stop right there. Thank you.

**CHAIRPERSON BROWNING:**

I'd like to ask you a couple of questions.

**MR. MARKS:**

Sure.

**CHAIRPERSON BROWNING:**

More my concern is, you know, we have methadone and it was supposed to be the cure to take care

of people that have drug problems; it's not working. It doesn't work. You know, no offense to what you do, but I'm not a big medication person. And one of my biggest fears is, you know, we have OxyContin, Vicodin the kids are getting hooked on and then they're doing the heroin. And so now to treat their heroin addiction, they're getting another drug, which is Suboxone, which is addictive. So how do you make sure that you're treating somebody with Suboxone and at some point in time they're not going to need it, they're going to be able to stop and they're not going to get addicted to it?

**MR. MARKS:**

Well, Suboxone is like an addictive medication. It is an easier medication to get off than both methadone and OxyContin. We would say that if people are functioning well, even with a small dose, and some people ask for nothing more than two milligrams which hardly covers their receptors, but they're not doing all the other things that got them to where they are, they're not exhibiting drug-seeking behavior, they're not performing illegal activities, that they're, in fact, contributing to society as opposed to taking, then we would say that's probably a pretty good, you know, trade-off. Would we like everybody to be free of drugs? Yeah, we really would, I think that would be best, you know, outcome.

But I think what you do with Suboxone and what it buys you at the end of the day is the ability for somebody to be able to engage in the counseling they need to engage. Think about someone who is doing nothing but craving, nothing but desiring drugs, trying to sit down with like a social worker or like a psychiatrist and have a dialogue; they're not thinking about what they're saying, they're thinking about where they're getting their next high. That's the problem. Until we can get them to engage, you're never going to get to the end of the problem.

Now some people are very fortunate and some people can do this cold turkey, abstinence-based, never see another drug. That's not the case for all. One thing we've learned throughout -- in terms of treating, you know, like addiction is that one size does not fit all. And what I would say to you is that you need every single tool that you can possibly get your hands on, and for some people that's methadone, for others that's Suboxone. Some people need some sort of abstinence program. But I can tell you that the science is very compelling. Those who just get, you know, counseling, don't do as well as those who get counseling and the drug; those who just get the drug don't do as well those who get counseling and the drug. It's the two pieces together is your best chance of success in terms of breaking people from the drug-seeking behavior that they're under.

**CHAIRPERSON BROWNING:**

But you can be weaned off of the Suboxone at some point in time, it's not something that you have to take for the rest of your life.

**MR. MARKS:**

We view that -- yes, that's absolutely true, but we view that as a decision that the patient and their physician have to make together, And that's something that they have to move towards. Our average length of treatment is between nine and eleven months, that's our average length of treatment. So like can people get off? Absolutely. Do some people need to take this, you know, for like an indefinite time? Absolutely. If they're not robbing, stealing and cheating; is that better? We would say absolutely.

**CHAIRPERSON BROWNING:**

John?

**LEG. KENNEDY:**

Yes. Thank you for coming forward and, as a matter of fact, we've spoken many, many times and I appreciate the commitment on your part and on your firm's part to in -- 18 months is a long time, but then again sometimes it's a short time. When we first started this dialogue you were still

administering in pill form and we were hearing about some of the issues that were out there where individuals were cheating, there was a black market developing, there was a variety of different things to go towards some of the stigma that you spoke about that may have been out there. I'm hoping that that's something that's much less of an incident with the film. But I also know that we have five or six other folks in the audience here who have made it their life's work to go ahead and study on addiction prevention and I'm eager to hear from them.

But going to you specifically, I was the sponsor of the resolution last year to go ahead and put this program into place. I've shared with the Health Department before my frustration, the fact that I thought that we clearly weren't doing something right and that we had to change. I know that Dr. Tomarken is going to speak to us a little bit, because at a time where we're contemplating closing clinics, bringing \$300,000 to bear to assemble staff to administer to our adolescents that are becoming addicted is a significant commitment of funding and resources. I still remain somewhat mystified as to why we weren't able to go ahead and get this out to more patients. I think the numbers on age may be somewhat arbitrary, but then the State Health Department and the Federal agencies sometimes get caught up in chronology .

You know, today, you know, you look at 27, 28 sometimes as adolescence. Back in my time, you know, there were people that were 17 and 18 that were living pretty much self-sufficient. So I don't know if it's part of our societal differences or cultural differences.

The other thing that I'd say, and I'm eager to look at the studies in both Boston and Baltimore, but it occurs to me each of those places are highly urbanized centers with mass transportation, infrastructure in proximity to clinic settings. Here in Suffolk County we are the largest County in the State of New York, we have a woefully inadequate transportation system. And I'm thinking that -- or I'm hoping that our Health Department folks are going to talk to us about how here where we have a methadone program literally within walking distance and another one on Wireless, how are we working with the 23 year-old addict in Cutchogue who doesn't drive and whose family may work day and night; how are we engaging them? Because they're just as much our residents as any place else.

The last thing that I'll ask you, and it's no secret, I -- both my wife and I are involved in CASAC training, so I've had the benefit of having some of the science associated with brain changes that do occur associated with opiate addiction. But if you guys have a thumbnail for us, I think it's important sometimes that we have that so that we can be mindful of the fact that the people that we're trying to help really are suffering from a disease as a result of the damage that they've done. Now, granted it's self-inflicted, but over time their systems have changed. It is not just malingering. It is not just, you know, if you pulled yourself up by your bootstraps and flew straight; you'd lead a better life; that's not it. So the science associated with the drug and how it interferes with the euphoria associated with the opiate, I think, is important. And then the ability to tight trade-off.

The Chairwoman is right, methadone back in the 60's was the panacea. The fact that we're still using that drug today and prescribing 50 years later is crazy. We don't drive Model T's. It worked well back then when there was nothing else. I remain -- I don't know, unconvinced, that it's still prescribed to the degree that it is. I'll yield, Madam Chair, but I'm hoping that Dr. Tomarken will be speaking to us about this.

**CHAIRPERSON BROWNING:**

I'm sure he will. Sarah?

**LEG. ANKER:**

Hi. Welcome and thank you for your presentation. I'm new here on the Legislature and I would like to hear more about your product. It's an intense problem, not only in Suffolk County but throughout the country.

I would like to say you may have given the Legislature facts and figures, but I would like to see more facts and figures on your product. And again, like Legislator Browning said, I'd like to hear also about the people in our audience that will be speaking. But would you be able to provide those figures for us?

**MR. MARKS:**

Yeah, I would love to and I'd be happy to stop by your office and we can have a more extended discussion at your leisure. So, certainly, yeah.

**LEG. ANKER:**

Okay. This -- I'm just curious, though, right off the bat; what is the percentage of your product versus -- so there's no other product like your product?

**MR. MARKS:**

We're one-of-a-kind, basically. I mean, up until now it was largely treated through like methadone, which is a clinic-driven, you know, has to be dispensed. You know, it turned out that Suboxone has such special qualities in terms of safety that the need to dispense it out of a clinic was no longer necessary. So the notion was now let's get this out of the clinics and let's treat this chronic condition like any other chronic condition in the office of the primary care physician. And that way we eliminate the stigma around the disease state and we allow people to have a lot more freedom, because if you don't have to go to the clinic every day, the possibility of holding a job or doing other things that you want to be doing become a lot more -- you know, I mean, like apparent.

So that was the promise of the medication, and that's why the Federal Government wanted to bring this to market. We shared our efforts with the Federal Government, we partnered to bring this medication to the market and that's how it came about. And largely because of the safety profile that it has, that it really allowed us to do a whole bunch of new things that heretofore wasn't there.

In picking up, you know, like where, Mr. Kennedy was, you know, I would say that if our medication was out before, you know, methadone, you would never build a methadone clinic; that's how I would put it. I mean, but with that said, certain people need that daily visit, that -- they need that structure in their life and it works for them. We don't want to disparage that. We need every tool in the toolbox to make this thing work.

**LEG. ANKER:**

Okay. I have a question as far you partnered with the Federal Government; what department or what part of the Federal Government did you partner with?

**MR. MARKS:**

Yeah, SAMHSA and also NIDA. This was the result of a law called DATA 2000, the last bill signed by Bill Clinton that brought this product, which is actually like an orphan drug, to a market in partnership with us with all those other conditions that physicians would have to get certified, they're limited to the number of patients that they can provide. The wanted to put in the kind of safeguards to make sure that if this was going out into the community, people were still going to have the appropriate oversight to be able to do it.

**LEG. ANKER:**

Thank you.

**MR. MARKS:**

Thank you.

**CHAIRPERSON BROWNING:**

Okay. You know, I'm thinking there was a medical building open up in my district and I've been back and forth with the Health Department. Because a methadone clinic, you have to get a state approval, right, to open up a methadone clinic; am I correct? So in order to dispense Suboxone, you don't have to have a clinic but your doctor has to have a special certification?

**MR. MARKS:**

Right, and I think you have to be careful about the terms you use. So dispense is what you do at a clinic, but prescribe is what a private physician does. So this medication can be prescribed, just like any other medication that gets prescribed. You go to your drugstore, you pick it up, you go home and you administer it as you see fit.

**CHAIRPERSON BROWNING:**

But not every doctor is going to be able to do that.

**MR. MARKS:**

Very few, in fact, do that. As I said, we have 20,000, you know, nationwide, only half actively write.

**CHAIRPERSON BROWNING:**

Okay.

**MR. MARKS:**

And that's attached to the stigma of the disease -- I mean, the reality is that most of these doctors have these patients in their office, they just refuse to recognize them and they leave it to somebody else to do, you know, like, I guess, the dirty work. So, that's unfortunate, but that's the way it works.

We don't feel bad about the fact about the certification that's required, we think it's probably appropriate that there's a higher level of education around. But we also think that there should be more education on opioid use in general, and we'd like to see that increase for all opioids and that's what's critical.

We're a company that is very responsible in this. We are one of the few companies that support a prior authorization around our medication. We want to see urine drug screens, we want to see counseling. We want to make sure that the physician has that "X" number, that they got the appropriate certification out of the DEA. These are all important protocols that we believe need to be part of the mix in order to make sure it's successful.

**MR. RULAND:**

One other -- one additional benefit I want to mention with the film, which a lot of our doctors are utilizing which helps big time, is everybody uses pill counts. Some doctors will call patients randomly, have them come into the office and do pill counts. Using the film, if the doctor instructs the patients to save all of their packages, they could just come in with their empty packages and very easily do a pill count, and also the doctor could also check in case they sold some of it. And also when the doctor calls in and they're like scrambling around to get these, each -- all 30 films in that box all have the same ten-digit code. So if somebody threw out their films over the course of a week and now they have to scramble to get 30 numbers that match, it ain't going to happen.

**CHAIRPERSON BROWNING:**

Go ahead.

**LEG. KENNEDY:**

One of the things that is always -- one of the things, there's many things that are difficult to try to address in this, but building a reimbursement for the service that we provide is important. And I don't want to compare and contrast Suboxone and methadone; methadone basically is a Federal model, I think, that drives down. And as you said, it's built on physical structures and staff and coming to a certain point and I was very familiar with it when I worked out in Riverhead.

And I don't know if you guys can answer this question or not, but the reimbursement component that's associated when a patient first has to start on the detox process, there's got to be some methodology that whether it's the physician or the patient themselves accesses the medication and gets the basic treatment pieces. What has your experience been with the docs? Your docs are getting certified; are they getting reimbursed through Medicaid or -- because the likelihood that, you know, a 22 or 23 or 24 year-old addict is going to have GHI or Blue Cross/Blue Shield through some employment is slim to none. What's the money mechanism?

**MR. MARKS:**

I think it's a good news/bad news type of scenario. The good news is is that the medication itself is covered by Medicaid --

**LEG. KENNEDY:**

Okay.

**MR. MARKS:**

-- and it's fully covered and the film is covered, everything is available to them. What's not adequately reimbursed are the physician services. For instance, an induction can take a physician several hours. It basically requires that the patient come in, they have to be observed because you have to be in a low state of withdrawal when you take this, you get dosed, you get put in the waiting room, you wait an hour or two, you bring them back, you see how they're feeling, you up that dose, you down that dose; it could be several hours before you do it.

Medicaid in New York views that as a well visit. A doctor will get 12 to \$15 for that. Now, that is not great equation. The result has been, and it's a very unfortunate result -- and again, it's like one of the things that keeps this disease state in the dark corners -- is that many physicians will hand out a Medicaid -- will write a Medicaid script, but require their services to be paid for by cash. To a patient typically who doesn't have a lot of cash at their hand, in fact, to a patient who might be, you know, I mean, like in order to find that cash, might go back into practices that they were doing previous to their addiction or while they were going through their addiction.

We've been working very hard with the State who have now put forward like the APG's. We think we're moving in a better direction in terms of doing that, but this is to my mind the only disease state where cash plays a tremendous role in terms of how physicians get reimbursed. And it's for a group of patients that I think are probably least able to be able to do that and it's counterproductive to where we want to be going.

It's one of the things that keeps me up at night as a State government manager to move states along in the right direction on this. I would say one of the places where we've been tremendously successful has been in the methadone clinics. We've actually got the State to integrate this medication into methadone clinics and to charge a higher wrap-around rate to cover the cost of the medication to allow this medication to be used at least, you know, in terms of like a business model, of being no less cost to them than they are administering, you know, methadone.

**LEG. KENNEDY:**

But again, I'm going to defer to the dialogue, because one of the things that I think our Health Department attempted to try to effectuate when they put the model together was to intentionally

not comingle a Suboxone and a methadone population, because a methadone population by definition is addicted for life and is buying in to a lifestyle of consumption. And the hope with Suboxone is that it's a bridge to take an individual out of a chemically dependant life to a chemically free life. And the behavior that you talked about, if, you know, one models the other they'll buy into it forever.

**MR. MARKS:**

One way methadone clinics have worked around that is frankly they just add different hours for Suboxone folks. So methadone folks typically come early in the morning and they say, "Okay, afternoon, then we come and we'll do the Suboxone guys." They never really comingle. So that's one way some entities have been able to work around that issue, because they have the same concerns.

And frankly, there's a lot of concern out there that, you know, for the methadone clinic that they're kind of selling against themselves. If you have an option of either coming in every day and like getting methadone versus, you know, getting a prescription and not having to come in every day, well, you know, they're going to see a lot of their patients start to fade away and go to something that might be more attractive for them as an individual.

**LEG. KENNEDY:**

Okay. Well, again, gentlemen, you know where my office is. We'll keep the dialogue up. I want to see success with this venture and I do believe that there's a role for us, you know, on the Health Department side helping, you know, the community succeed with this.

**MR. MARKS:**

We just want to be clear that we're here to collaborate. And we're here to help the County make this happen and we appreciate that you're here for the same reasons.

**LEG. KENNEDY:**

Okay, thank you.

**MR. MARKS:**

So, you know, I don't want to throw any disparagement towards the County. I think the County Executive was well founded when he put this together and we're just really interested in working with them to bring it to fruition.

**CHAIRPERSON BROWNING:**

Thank you, both of you. Any other questions? No? Okay. Well, thank you for your information, and I guess we'll continue to be in touch with you for any future information.

**MR. MARKS:**

Thank you. I appreciate it.

**CHAIRPERSON BROWNING:**

With that, Dr. Tomarken. I see Mr. Kopp is still here. I'd like to find out, are we getting the CN for the EMR's? Are we getting a CN for electronic medical records? I know that we had -- at our committee meeting the other day, we continued --

**MR. KOPP:**

I came before the committee yesterday, I didn't talk to Ken after committee and see what had happened on that, but I'll --

**CHAIRPERSON BROWNING:**

Come up. Okay. I know we talked about getting the bond resolution for the electronic medical records. Are we --

**MR. KOPP:**

Right, but I've been over here for most of the last two days, ever since that meeting. I'll have to double-check with Ken because he continued after the meeting yesterday --

**CHAIRPERSON BROWNING:**

Okay.

**MR. KOPP:**

-- and I didn't follow-up with Mr. Crannell since then because we've had like six committee meetings since then, and I've been here for all of them.

**CHAIRPERSON BROWNING:**

Overworked and underpaid?

**MR. KOPP:**

No, no complaints.

**LEG. KENNEDY:**

We appreciate it.

*(\*Laughter\*)*

**CHAIRPERSON BROWNING:**

Dr. Tomarken? Did you want --

**LEG. KENNEDY:**

I do, I do.

**CHAIRPERSON BROWNING:**

Art, Mr. Flescher also?

**LEG. KENNEDY:**

Dr. Tomarken, could you and Art talk to us a little bit about --

**CHAIRPERSON BROWNING:**

I wanted to know about the decisions at John J. Foley, too.

**LEG. KENNEDY:**

Okay. I'm preempting the Chair as usual.

**CHAIRPERSON BROWNING:**

Yeah, really.

**LEG. KENNEDY:**

What can I tell you? Give the kid a mic and, you know, he's off to the races. What's your pleasure?

**CHAIRPERSON BROWNING:**

Do you want to talk about Suboxone?

**COMMISSIONER TOMARKEN:**

Thank you. I'd like to start with a little overview of this whole world of addiction. There's a lot of misconceptions about patients that have addiction issues and problems.

First of all, there's a very high, what's called comorbidity, meaning that many of these patients have concomitant mental illness conditions, so they're at a very high-risk, vulnerable population. The drugs methadone and Suboxone and others like that are not a cure-all and they're not magic bullets. And I equate and use as an example these conditions being chronic conditions, very similar to a diabetic. Some diabetics need insulin and pills all their life, never can get away from it. Some, with diet, exercise, weight control, can get off all the medications and just monitor themselves. And I think that's the same analogy I would draw for patients with addiction and substance abuse problems; they're a mixed bag, if you will. Some will be able to get off Suboxone, some will be able to get off methadone, some will not be able to get off either. And so I think we need to have realistic expectations.

And one of the problems that whenever -- since the beginning of the war on drugs back in the 60's, was misapprehension and misunderstanding of who this patient population was and what the actual goals were. And the success of a methadone treatment program is marked by people being productive, paying their taxes and not engaging in crime and other illicit activity, and that may be the best we can get and that's nothing to be ashamed of or to think less of. And if somebody has to take come every day and take their drink of methadone or take their Suboxone but they're a productive member of society, and I've had programs where I've had bankers and all kinds of professionals on this.

So I think we have to appreciate the scope of people. We have people who don't know where their next meal is coming from and we have people who can buy and sell us ten times over in this group. So I think we need to have a realistic expectation that this is not a magic bullet; there's no magic bullet for diabetes and there's no magic bullet for the addiction population.

That's all that I would say. I'll let Art talk about the actual program.

**MR. FLESCHER:**

Good afternoon. As mentioned, the original program we had set up was geared towards adolescents, and we were looking towards addressing the needs of adolescents between the ages of 16 and 19 with the idea that we would have a comprehensive program in which the families would be involved. Because one of the issues we had was who are we dispensing the medication to, we wanted the families to take responsibility.

As mentioned, we tried a variety of different ways of publicizing the program, and ultimately what we learned, and you can speculate as to why that age group maybe was too restrictive, but the idea was that there wasn't a whole lot of demand among that age group; that was pretty clear to us. And I think a large part of it has to do with parents will choose other types of services when kids are that young. They may choose abstinence-oriented counseling, they may choose a variety of inpatient settings, but they won't necessarily choose out-patient care using medication assistance.

So at any rate, what we did was we looked at this whole situation, we said, well, what is really the needs. And so we met with all of our community providers and we looked at what the options were and we realized that really the greatest barrier to Suboxone care for a lot of people, Mr. Kennedy mentioned the expense attached to it, involved the induction of stabilization period. And during that time, as mentioned, a physician needs to have very close monitoring of the individual, because what they're doing is they're increasing the dosage and titrating things and kind of helping that person get comfortable; it requires several hours of monitoring, generally over a few days. And we decided that in working with our partner community-based agencies, that was the best way to approach things.

So what we've done is we've identified at this point six providers in the community which also addresses some of the geographic issues you mentioned in that they're geographically dispersed throughout the County, and the plan is that we would basically serve as providing a service for them. So a community-based agency, let's say Alternatives Counseling out in Southampton, would do an assessment on an individual, and we no longer are going to be concerned about the age range, by the way. They'll do an assessment on the individual, they'll determine that they are appropriate and eligible to receive Suboxone care based upon their opiate history and what's going on in their life. They'll have done their level of care determination and they'll do a comprehensive assessment at that point. They'll refer to us where we'll proceed to see that individual in our Hauppauge office for very few days -- like I said, generally three to five days on average -- and during that time we'll adjust the dosage, we'll work with that individual, we will, of course, have done some of our initial laboratory tests and things like that. But overall, we'll stabilize that person and give them back to the agency in conjunction with the physician who will provide that care, who will provide the ongoing care at that point.

From there, they'll, of course, work in the community, in the community they live in, and at some point they'll make decisions as, Dr. Tomarken mentioned, as to their long-term goals and working with that provider. There may be people that will choose ongoing, maybe indefinite use of Suboxone, and chances are that treatment provider will complete them from care at some point and they'll be referred to a community physician for maintenance of Suboxone. Again, that's a personal choice they'll make. It's our view that, where possible, people will be on Suboxone for a period of time and move towards abstinence. That's certainly the goal for many folks.

But at any rate, it was our view that because of our experience with methadone and the medical side of it, if we can be involved in the induction part only and work with our partner agencies, that would work well. You should know, by the way, there are about 275 people currently on Suboxone that are in our community agencies receiving counseling. So certainly that system is in place. Many of them are already doing this and they all say that the expense of induction as well as the medical expertise, they feel uncomfortable being involved with. So we think that's the niche that will work for us and we think it's an excellent utilization of our resources.

**COMMISSIONER TOMARKEN:**

I've just been advised there are a hundred physicians currently certified to prescribe Suboxone in Suffolk County.

**LEG. KENNEDY:**

The certification, Doctor, that's done by the provider, by the company, or is that something that's done through us?

**MR. FLESCHER:**

They have to go through a course, I believe, through the FDA or through the AMA, I'm not sure which.

**LEG. KENNEDY:**

So the proprietor trains them, they get some kind of acknowledgment, that's an acknowledgment that obviously is forwarded to the State. But have we at our level -- in other words, have you assembled all one hundred of these physicians at any time? Hey, Tom, how are you?

**MR. MARKS:**

Can I say something? The way it works --

**MS. MAHONEY:**

No, no, no.

**CHAIRPERSON BROWNING:**

Come on up.

**MR. MARKS:**

This is a Federal certification. The State does not track this.

**CHAIRPERSON BROWNING:**

We need you on the mic. We need you on the mic.

**MR. MARKS:**

It's a Federal certification and it's based on the DEA's agreement to do this. The doctor has to complete eight hours of training and they can do that on the Internet, they can go to, you know, an eight-hour class somewhere. I know the company at one point did sponsor some trainings for folks. But it is a Federal certification. What that means is now the doctor has a waiver that allows them to prescribe narcotics for the treatment of narcotics dependence, specifically Buprenorphine. Methadone can only be prescribed through a licensed drug treatment program for the treatment of drug addiction. Any doctor can write a prescription for methadone.

So on your point earlier, there's more methadone being prescribed today than ever in history. Okay? Mostly through pain management physicians, okay. In the last nine years there's been a ten-fold increase in the number of prescriptions being written for methadone in this country.

**LEG. KENNEDY:**

Well, that was a question I was going to try to approach with one of you, whoever wanted to do speak to it. Is it still something where a physician may elect to go ahead and prescribe either/or only in the area of addiction? I was aware of methadone through the VA for pain, but not elsewhere.

**MR. MARKS:**

No, no. Only -- methadone can only be prescribed for the treatment of opioid dependence through a licensed methadone treatment program. A doctor in private practice is breaking the law if they write a methadone prescription for the treatment of opioid dependence per se. It's against the law to do that. Only a certificated physician who has a DEA waiver can prescribe Suboxone or Buprenorphine, Subutex or generic --

**LEG. KENNEDY:**

If a patient presents to one of our clinics, you know, and it's a 22 or 23 year-old, you know, opioid addict; what is the likelihood that that individual will be prescribed methadone or Suboxone?

**MR. MARKS:**

We only use methadone in our clinics.

**LEG. KENNEDY:**

You do.

**MR. MARKS:**

Right.

**LEG. KENNEDY:**

Okay.

**COMMISSIONER TOMARKEN:**

I think the question is would they get the option? Would they be able to access Suboxone if they were appropriate for it; is that fair?

**LEG. KENNEDY:**

Absolutely, Doctor. I don't want to make it seem like I have an agenda here, but I have to tell you, as a layman, not a medical person, what it appears to me is is that if an individual is prescribed methadone -- and I know you did mention, Doctor, that some people get off of methadone, but the reading that I've done is is it's almost negligible.

**MR. MARKS:**

Can I -- I'm sorry.

**LEG. KENNEDY:**

Yeah, sure. No, go ahead.

**MR. MARKS:**

Your reading is inaccurate.

**LEG. KENNEDY:**

Okay.

**MR. MARKS:**

The average of duration of treatment for our population is four to five years on methadone. There's a small percentage of the population that remains on methadone for indefinite periods of time, but the majority of individuals on methadone don't stay for more than four to five years, and that's true for us and it's true across the country.

**LEG. KENNEDY:**

How does that compare with the average, or is the drug too new with Suboxone? What's --

**MR. MARKS:**

Well, the thing I'd say about Suboxone is other than research --

**LEG. KENNEDY:**

Yes.

**MR. MARKS:**

-- and whatever informal work the company does, nobody keeps track of this information. Doctors who prescribe the drug don't have to report statistics to anybody. There's no outcome measurement of individual providers. Other than that eight hours of certification, there's no other regulations imposed upon their behavior.

**LEG. KENNEDY:**

Really?

**MR. MARKS:**

Absolutely.

**LEG. KENNEDY:**

So even if we wanted to say, "Okay, we think that it's an important tool to have but here in Suffolk County we think that physicians maybe should have another four or five hours of local based training and a little connection; we don't have the ability to do that, we're preempted by the Feds?"

**MR. MARKS:**

I have no idea what the law is with regard to that. All I'm saying is right now they don't have to do that.

**LEG. KENNEDY:**

Okay.

**MR. FLESCHER:**

If I could just add to that. I think what you're touching on is the goal of our initiative, which is by working with the community-based agencies who have certified docs in Suboxone that we're going to be working with, we will be building in the treatment infrastructure and the accountability that you're talking about. The truth is of those hundred or so docs that are certified, we don't have a whole lot of control over a lot of these things, and some of them are doing quite a good job out there and others perhaps not. But certainly if we can develop a system where we get the people started and work with our system and have regular meetings with those doctors and kind of keep some quality control, that's part of our goal.

**LEG. KENNEDY:**

Well, and -- I'll relinquish, I could do this all day; I'll relinquish, it's not fair. But we are offering value to the medical community by agreeing to perform the induction function, which all appear to agree has to happen and yet nobody wants to pay for. Is that -- that's pretty much it in a nutshell?

**MR. FLESCHER:**

I think that's the idea. But what I would also add to that is we are offering to the medical community a package, which is we will provide the induction, but it's built into a treatment process. It's not -- you know, because some doctors -- there are people out there that are seeing doctors that maybe the individual is also taking other benzodiazepine medications and things like that.

**LEG. KENNEDY:**

Sure.

**MR. FLESCHER:**

We don't support that.

**LEG. KENNEDY:**

Okay.

**MR. FLESCHER:**

So we're going to have a program that we think is kind of cohesive.

**LEG. KENNEDY:**

Okay. All right. Let me give up the mic here.

**CHAIRPERSON BROWNING:**

Sarah?

**LEG. ANKER:**

Okay. Now, bear with me because I'm a new Legislator. This is something that you have researched this product and you feel very comfortable with it?

**COMMISSIONER TOMARKEN:**

Yeah, the product has been around for many, many years in different formats, and now it's in a much more convenient format. We used it in Toronto many, many years ago in a limited amount because it wasn't convenient. But, yes, this is a well-known product. It's been on the market -- and I don't want to speak for the company -- but in one form or another for at least probably 25 years, in that neighborhood.

**LEG. ANKER:**

Okay. Now, as far as this product, you only have one that you're working with right now, the methadone. My question is what's the price difference?

**MR. FLESCHER:**

Just to correct, at this point the adolescent program, that one person has moved on, has completed that program. So now we're moving into this new program that I'm alluding to before, the induction part of it. So we're in the process of -- to the contract process, completing those agreements, they're all at the point of signature by the County Executive, so that should be starting very soon. So there'll be six agencies that will be -- as part of that network, so that's very new.

The medication is, I believe, still on patent and it's quite a bit more expensive than, for example, methadone, which is a generic medication. But I'm sure the gentleman from the pharmaceutical firm could give you more specifics in terms of the cost.

**LEG. ANKER:**

And one other question. Are you working with other clinics or hospitals, like North Shore Jewish or Brookhaven National Lab, with some of their treatment programs that are, I think, excelling in understanding the addiction issue?

**MR. FLESCHER:**

Well, what I was going to say is certainly we're in contact with them we're aware of them, you know, and certainly follow-up on. As you noted, Dr. Schmidt is very well versed in this, he's in charge of our Opiate Replacement Medication Therapy. So we certainly attend to all the latest research and try to be aware of different things that may be occurring, because there are a lot of things going on over the next few years that may be quite a bit different than what we've seen in the past.

**LEG. ANKER:**

Exactly. And as far as, you know, what you just said, are there conferences that you attend, you know, every three, four, five months that, you know, you can go to, or do you have a group that you work with outside of the County to gain more insight and information?

**MR. FLESCHER:**

Well, we certainly get a great deal of information from the New York State Office of Alcohol and Substance Abuse Services who fund the majority of our programs, so they're in regular contact with them. They have information they send out as well as other information that we subscribe to newsletters and a variety of things.

**COMMISSIONER TOMARKEN:**

The National Institute of Drug Abuse, which is part of NIH, is shifting its emphasis to prescription drugs because heroin is not the biggest issue, although it's still obviously a big issue. But their biggest concern now is all these legal drugs that are -- people are getting their hands on inappropriately. And so they're trying a multi-faceted approach of drugs that are safer, replacement drugs for the old style narcotics that we're all familiar with. So It's already at the Federal level and the director at NIDA is trying to get them to shift their emphasis and come up with different solutions, because the nature of the addiction world has changed over time.

**LEG. ANKER:**

And I don't want to get into the whole issue as far as who is responsible, but is there some type of funding available from the pharmaceutical companies that seem to have created issues with some of these drugs, OxyContin and Vicodin and drugs like that?

**COMMISSIONER TOMARKEN:**

Well, I think -- I'm not sure, you have to run your question by me again. But I think one of the things to keep in mind is in the medical community in the last 10 to 15 years the treatment of pain has become a major issue. And, in fact, in some states you can -- doctors can be fined if the patients complain that they haven't been treated appropriately for pain. So, as usual, we overreact and we tend to give too much narcotic medication for -- analgesic medication. And now part of that is we're suffering the consequences of medicine cabinets being full of extra drugs and people not thinking about throwing it out, etcetera.

So we've -- the medical community, in order to avoid prosecution and legal issues, is overly prescribing. And so that's becomes a major input into the increase in the number of people getting into substance abuse. I can't speak about the pharmaceutical companies, if they're involved in --

**LEG. ANKER:**

They have some type of responsibility and helping us deal with this issue, that's, you know --

**COMMISSIONER TOMARKEN:**

They actually are -- some are actually changing the format of their medication so that it can't be ground up and can't be injected, that sort of thing, and that's a very big help. But still, there's enough out there that they're just beginning to approach that.

**CHAIRPERSON BROWNING:**

I'd like to let, Mr. Marks, I think you were going to respond -- were you going to respond to the cost difference?

**MR. MARKS:**

Cost issue, yeah, and I just want to get back to Legislator Anker. When, you know, we look at the cost, we tend to want to look at the total cost of treatment as opposed to medication to medication.

Now just to back up, now Suboxone has been off patent since October of 2009 actually. It's rare when, you know, a drug like this, you know, doesn't have a competitor for a year-and-a-half and it's a whole, you know, host of reasons why that's the case. So it is off patent but there is no competitor on the market yet.

Methadone's been on the market for years. There are generics, you know, on the market. It costs pennies; I mean, you're talking about 25 cents, 30 cents a dose. Our medication runs about \$10 a day, roughly. However, when you add in the whole totality of treatment, one of the issues that I think, you know, like Representative Kennedy brought up, for instance, was the issue like around travel. Well, if the County and State aren't paying for the travel every day, lots of savings are found there. So when you do the in total totality of what all the services cost together, actually, you know, it turns out that Buprenorphine tends to be, in fact, less than treatment, you know, for methadone. And when we come in to see you, I'll share some of those studies with you that actually take you through that. Thank you.

**LEG. ANKER:**

Thank you.

**CHAIRPERSON BROWNING:**

Okay.

**LEG. KENNEDY:**

Just two quick questions. Can we get the list of the agencies, Art, the names of the agencies that have signed on or are participatory at this point?

And then the other thing is is if we hopefully get, you know, a robust engagement, and let's take the example of the agency in Southampton; is it conceivable that we could have the induction process go on out in our clinic in Riverhead, the Riverhead Clinic? I mean, I know you've got the expertise and all the muscle up here in Hauppauge, but again trying to get somebody 40 or 45 miles here, geez, even if they have wheels and a license, just the gas alone, you know, is busting budget sometimes.

**MR. FLESCHER:**

There's certainly nothing to preclude that. I mean, again, the good news is that this is a very short tenure.

**LEG. KENNEDY:**

Right.

**MR. FLESCHER:**

But certainly it's not something that we would rule out.

**LEG. KENNEDY:**

Okay. So that possibility is open. Good, okay.

**MR. FLESCHER:**

Would you like me to e-mail you the agencies --

**LEG. KENNEDY:**

Sure.

**MR. FLESCHER:**

-- or would you like me to tell you now?

**LEG. KENNEDY:**

No, whatever, you can get give them to me by e-mail on a list, that's fine. Okay, thank you.

**CHAIRPERSON BROWNING:**

Okay. So I think that's it. The other thing I'll talk to you at another time about, I did just get an e-mail from Ken Crannell. The EMR Bond has been filed and it will be on the agenda on Tuesday. So that's a good thing.

Anyway, I guess -- anybody else have any questions about anything? No? Okay. So we thank you for everything, and I'll make a motion to adjourn.

**LEG. KENNEDY:**

Second.

**CHAIRPERSON BROWNING:**

Thank you.

*(The meeting was adjourned at 3:39 P.M.)*

*{ } - Denotes Being Spelled Phonetically*