

**HEALTH COMMITTEE**  
**OF THE**  
**SUFFOLK COUNTY LEGISLATURE**

A regular meeting of the Health 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 12, 2014 at 2:00 p.m.

**MEMBERS PRESENT:**

Legislator William Spencer - Chairman  
Legislator Kate Browning - Vice-Chair  
Legislator Robert Calarco  
Legislator Monica Martinez  
Legislator Rob Trotta  
Presiding Officer DuWayne Gregory

**ALSO IN ATTENDANCE:**

George Nolan - Counsel to the Legislature  
Sarah Simpson - Assistant Counsel to the Legislature  
Lora Gellerstein - Chief Deputy Clerk  
Craig Freas - Budget Review Office  
Elizabeth Alexander - Aide to Chairman Spencer  
Bill Shilling - Aide to Legislator Calarco  
Debbie Harris - Aide to Legislator Stern  
Greg Moran - Aide to Legislator Trotta  
Lisa Pinkard - Aide to Legislator Martinez  
Josh Slaughter - Aide to Legislator Browning  
Tom Vaughn - County Executive's Office  
Amy Keyes - County Executive's Office  
Lisa Santeramo - County Executive's Office  
Connie Corso - County Executive's Office  
Dr. James Tomarken - Commissioner/Suffolk County Department of Health  
Jen Culp - Suffolk County Department of Health  
William Moore - M.D., Stony Brook University Hospital  
April Plank - Stony Brook University Hospital  
Anne Nolon - Hudson River Healthcare  
James Sinkoff - Hudson River Healthcare  
Jeanette Phillips - Hudson River Healthcare  
Wilfredo Morel - Hudson River Healthcare  
Joseph Loiacono - Good Samaritan Hospital  
Mark Bohrer - Good Samaritan Hospital  
All Other Interested Parties

**MINUTES TAKEN BY:**

Lucia Braaten - Court Stenographer

*(\*The meeting was called to order at 2:00 p.m. \*)*

**CHAIRMAN SPENCER:**

We have a quorum, so we're going to stand for our salute to the flag, led by Legislator Trotta.

*(\*Salutation\*)*

Thank you. In our tradition, please remain standing out of respect for all those that are serving and fighting for this country and abroad.

*(\*Moment of Silence\*)*

Good afternoon. Welcome to the June 12th Health Committee. And we have a scheduled presentation and we also have another presentation by Hudson River that was -- that they're going to be presenting to us with regards to the merger. But, first, I have no correspondence besides one of the Legislators, Legislator Browning, had posed a question for Dr. Tomarken regarding County employees of the Maxine Postal Health Center. And we're going to -- Dr. Tomarken has been asked to give us a response.

Are there any speakers in the audience that wish to be heard? For the public comment, I have no speakers. Going once. Fine, the -- oh.

**MR. VAUGHN:**

Actually, there's two members of Hudson River that wish to make some public comments and I think they're walking in in a moment right now.

**CHAIRMAN SPENCER:**

Okay. Well, they're going to be part of the formal presentation, so I'm going to go ahead and start, and that way we can vote to -- if that's fine with you, Tom.

I'm going to ask if Dr. William Moore and April Plank from Stony Brook will come up to the podium, please, or come sit at the table. Thank you for joining us. And they are going to give us a presentation on lung cancer screening. Thank you.

**DR. MOORE:**

Thank you for having us. Is this on? Can you hear me okay?

**CHAIRMAN SPENCER:**

There's one you can push and it stays on, and then the other one you have to hold it.

**DR. MOORE:**

So, yeah, this one's on. All right. Thank you very much for having us. The Stony Brook University over the last about a year-and-a-half, two years, has been working on implementing a lung cancer screening program, and that's actually where we started, and April and I are the Co-Directors of that program. And the name of the center is The Center for Lung Cancer Screening and Prevention.

The reason that we wanted to come here is a couple of reasons. First, Suffolk County has been at the forefront of really making sure that lung cancer and smoking cessation is part of the general public knowledge. One of the things that's happened in the last few years is the increase in the age of smoking, people who are allowed to purchase cigarettes from 18 to 21. Suffolk County was a leader in that. And, also, stopping cigarette smoking inside of public restaurants and in bars, which

has been a major improvement in the overall County, and those things have both led to more wide regions, including Nassau County and New York City, and then, of course, national level implementation of those programs.

So we are, at the end, going to suggest yet another thing that Suffolk County can be a leader in, and I think we do need to give you an idea of where the current state of lung cancer is right now. So I have a few objectives. We're going to talk a little bit about lung cancer epidemiology. I'll keep it brief, I promise.

A little bit of history of lung cancer screening. It didn't just start two years ago, this is a long saga. I'll really briefly touch on this alphabet soup of acronyms, but focusing really on that first part of it here, the National Lung Cancer Screening Trial, and then some objective things that can help us take care of our patients.

My training is a radiologist. I'm a chest radiologist; there are about 300 in the country. I do intervention also, so I do everything from diagnosis all the way through treatment, and there are only a handful of us in the world who do that, so it's a unique position to be in. And I'm very excited about what we're going to be doing.

In terms of the burden of the disease, lung cancer is extremely common. There are 200,000 -- 226,000 new cases of lung cancer in the United States every single year. It's the number two cause of cancer-related -- of cancers in the U.S., in New York State, about 13,000 of those. The mortality rate, this is the number one killer of people from cancer in the United States; 160,000 people die every year, and in New York State, about 8,700 patients die. A lifetime risk of developing lung cancer is 7%. So, in this room, you probably have a few people who will have a chance of having lung cancer. And then, of course, the death rate, the probability of lifetime risk from dying from lung cancer is about 5.8%. This is not exclusively a smoking-related disease, but it is heavily smoking related. The equivalent of this, if you think about the number of patients who are dying, it's the equivalent of two jet planes crashing to the ground every single day. That should --

**CHAIRMAN SPENCER:**

Wow.

**DR. MOORE:**

-- push -- yeah, it's a shocking number, because there would be such an uprise from the public if that were to happen every single day, but this is what's happening on a regular basis every single day.

Eighty-five percent of patients who have lung cancer are actually smokers, but that means 15% are not. Twenty percent of the people in the United States right now are either current smokers or former smokers. And if we could institute that nationwide lung cancer screening, we have the potential of saving one jet full of people every couple of days. So that's another ridiculously high statistic.

I'd like to show these two graphs. The first one is -- this is the death rate for males from lung cancer, and you can see that lung cancer is far and away the most common cause of cancer-related death. It's actually more common to die from lung cancer than it is to die from prostate, colorectal and pancreas combined. That's -- okay. We wonder why this sudden increase. Anybody have any ideas? I always like to do this as an audience response thing, but I won't torture you all. But 1945, 1940 to 1945 something important happened in this country. World War II, and everybody got a gun, a pack of smokes, and sent on their way. There was a massive increase in the number of people who smoked. Shortly after that, you had Korea and Vietnam, and you continue to see this

massive increase in smoking-related deaths. There is about a 20-year lag time, so you actually can see this rate of death dramatically increasing.

In about 1963, 1964, the Surgeon General said, "You know what, smoking is probably bad for you." And then in 1980, C. Everett Koop really went to the next level and put warning labels on these things, on the cigarettes, and every single cigarette pack that's sold nowadays has a warning on it, and now look at what happened, this dramatic decrease. So, if you guys don't think, and I know you believe wholeheartedly, that a policy could actually affect patients' lives, there it is right here, right on your screen, an absolute decrease in the number of patients dying from lung cancer based on, in my opinion and others, on a warning label.

This is women, so this is the death rate among all women. And if you look at this, more women die from breast cancer -- I'm sorry. More women die from lung cancer than breast cancer, colorectal cancer and pancreas combined. We have breast cancer walks, as we should. We have pancreatic societies; we should. But more women are dying from lung cancer than all of those diseases combined.

Now there's a precipitous increase right around 1960, 1965, right around the same time as the cigarette companies started specifically marketing to women. Virginia Slims, which continues to sponsor the Women's Professional Tennis Tour, had this massive increase in marketing, and, therefore, and increased population. The current population that the cigarette companies are targeting? Young teenage females, and they do that because the young teenage females will convince the young teenage boys to start smoking also.

So all of this stuff is things that have been worked on. The legislation has stopped cigarette advertising on television, has decreased the number of ads that they could actually put out, all of which has been very, very effective, but there's still more we can do.

Okay. I assume that we'll just continue on. The history of lung cancer screening, I'm not going to go through the entire story of lung cancer screening. But suffice it to say, it started 40 years ago. The first studies were done out of Mayo, Hopkins, Sloan. They were done in the 1970s, and there were follow-up studies done 20-plus years later, and they all focused on using chest X-ray, because that was the state-of-the-art technology at that time, and they all were bloody disasters, none of them actually worked. The PLCO study is the largest study that used chest X-ray, and then had 150,000 patients, again, not showing any real benefit.

Fast forward to CT screening, which started in the late '90s or mid '90s, to become really an important modality. And you could see that there are multiple studies. All of these were cohort studies, not really well designed, but some of them quite large. Thirty-one thousand patients in the I-ELCAP study, which was started out of New York City by Dr. Henschke. And what they showed in some of these studies is that the death rate from lung cancer was pretty well controlled if you found it early. That then engendered the single most expensive NIH NCI study ever performed. It was the National Lung Cancer Screening Trial: 53,000 patients were randomized to either chest X-ray, essentially no screening, or a screening with low dose CT. And what they found was that we found more lung cancers in the low dose CT, but, most importantly, we saw a dramatic difference, a 20% difference in the mortality for people who had a low dose CT versus just a chest X-ray screening.

This study continued on for six years, and the most expensive trial ever run by the NIH and the NCI was stopped. They said it is unethical for us to continue this study, so they stopped it, and all the people in the chest X-ray arm got moved over to the CT arm. Amazingly important piece of information. But the NIH had stopped this study. They spent millions of dollars on it. For them to stop it, it's a dramatic -- a dramatic event. It sent shock waves through the entire medical world. This hit every newspaper in the country.

So the effect of finding an early stage lung cancer, to put it into numbers, if we were to look at an early stage lung cancer, a person with Stage 1 lung cancer, worst case scenario, they have a five-year survival of about 73% if we do nothing. If we take out the lung cancer, that's the worst case scenario. Most studies show 90%, 85%. The best case scenario for a Stage 4 lung cancer is a 13% five-year survival. It's dramatically different, a 60% difference in survival here. The problem is we only find a small percentage, about 15 to 20%, maybe 30% of the patients at early stage. Most patients are found at more advanced stage. That's why lung cancer screening is so important. We can affect the overall survival of these patients. And there are not a few of them, there are literally thousands of patients locally who could benefit from lung cancer screening.

I put this in against other -- everybody's suggestion, but I do want to talk a little bit about radiation. Another thing that's hit every single newspaper in the country in the last year or two, radiation dose given carefully is very, very low in a low dose CT, between .6 and 1.5 millisieverts. And, in general, the radiation dose that we give from our CT scanners are probably even lower than that, but that's with a low-dose screening protocol.

If you look at the background radiation you get in the U.S., it's about four times higher than your average low dose CT. If you were to look at mammography, it's a very similar number. And nobody's really arguing that the radiation dose for mammography is really dangerous. So, if done correctly -- and this is how I look at my low dose CT: When I first started doing radiology, which is about 10, 11 years ago, we were doing CT scans for about 7 to 10 millisieverts without even worrying about it. If I can do a person's lifelong CT screening for the same radiation dose as I used to do a CT scan, I've done a good job, and that's kind of what we're looking at. At 15 years worth of screening, I can probably get 10, 15 CT scans in for the same radiation dose, what we used to do back a few years ago.

The last thing that we should ask about, and I want to talk about it before I turn it over to April and talk about specific examples, is the cost. It is not all worked out by any means, but there are many very well done studies, and this is probably the best study that's out there, about how much this costs. So, if we were to take every single person in the United States right now who should be screened and we screen them, it would cost the U.S. about 27.8 billion dollars over 15 years. That would yield nearly a million Quality Adjusted Life Years, so a million additional healthy years for these patients, and then an overall cost of about \$28,000 per Quality Adjusted Life Year. If we add smoking cessation into that process, which is an absolute 100% part of our program, and every program of excellence in the country, we pull that cost down to \$16,000 per Quality Adjusted Life Year. Compare that with breast cancer screening, it's about 34 to \$50,000 per Quality Adjusted Life Year. So giving an idea that it's very similar in cost to breast cancer screening, and, in fact, might be cheaper.

The single best modality out there right now for screening is screening with optical colonoscopy, and that costs about nine to \$10,000 per Quality Adjusted Life Year, just to give you an idea of what that is.

So the one other thing that I wanted to talk about was smoking cessation. When a patient comes in to have smoking -- have a lung cancer screening study, it's a teachable moment. One of the most important things in a physician's life is when you see a patient, you have to tell them what you -- well, first, you have to teach them. You have to teach them what they need to know about their own lives. You have to teach them what they need to know about their own disease process, but you have these teachable moments. So, when a person comes in for a lung cancer screening, they're concerned that they have lung cancer. If you tell them at that sitting, "You should stop smoking," and give them the resources they need like getting involved in a smoking cessation program, perhaps medication, if you do that at the time of screening, there are studies that have

shown you have a -- 23% of active smokers will actually quit, versus if you don't have that teachable moment and that whole process, it's about 4%. So you are actually increasing the number of patients who are stopping smoking by actually giving them a lung cancer screening study, so that's a pretty impressive number.

The selection criteria for lung cancer screening, they're pretty strict, and we do stick to them very, very tightly. They're between the ages of 55 and 80, and having smoked 30 pack years or more, which is one pack per day for 30 years, or two packs a day for 15 years. Current smokers are, of course, some of the people we want to get a hold of, because we want to encourage them to stop smoking. Or if they have quit -- have not quit within the last 15 years. If they quit more than 15 years ago, they should not be screened. The other population, because, again, all studies have to have exceptions to them, is between the age of 50 and 80 with 20 pack years of smoking, and an additional risk factor like radon exposure, asbestos exposure from occupational diseases, other underlying lung disease or a family history of lung cancer, radon being the second most common environmental cause of lung cancer, not such a huge problem in Long Island as it is in New York and in New Jersey and more Upstate New York.

I put this in here just to show you that the process of reading these studies is extremely structured. You can't read it, nor should you be able to, nor do I want you to, but it is extremely structured down to the millimeter size of these nodules. We have very, very strict guidelines that all the Centers of Excellence in Suffolk County are currently following. Just to give you an idea, there are two Centers of Excellence in Suffolk County, one is Stony Brook University, the other one is J.T. Mather Hospital, and I have the privilege of running both of those centers, so they are very similarly run.

So I want to give you a case presentation, and I'm going to turn it over to April.

**MS. PLANK:**

Just in the last few minutes of summarizing, we thought it would be interesting for you to see a case, a real case. So this is a woman. I'm going to call her Lilly, she's 56 years old, healthy, works full-time, and had no symptoms. Heard about lung cancer screening, came in for a low-dose CAT scan and this was her finding. I know we're not radiologists in the room, but if you look on your right side, you see that white area where Dr. Moore is circling, that's not normal. She was worked up and this was a lung cancer. She underwent surgery, she did the gold standard for lung cancer treatment. If the patient is early enough, is to have a lobectomy. We're all given five lobes when we're born. One of them was removed, and now we're six months out. She has quit smoking and she has an 85% chance of being alive and well for many years to come. So it's a very satisfying thing for us in the career.

We've seen people with lung cancer over the years, we see about 1100 people a year at Stony Brook that are being worked up. Of the 400 that are diagnosed, only about 50 of them historically at Stony Brook get to have surgery, because the rest are late stage. So that's why we're real excited about lung cancer screening, because we're hoping to capture people at early curable stages.

So what are we asking from you? We're asking if you will consider partnering us -- with us on some of our action plan items. It's our job in the field to educate health care practitioners, which is what we do at various hospitals, with Grand Rounds, and going to primary care physicians, and running community forums in libraries. Again, this is our responsibility. What we're asking of you is if you would consider partnering with us on some policy changes. We thought that if somebody who's licensed to sell tobacco would also have a mandate to have some sort of poster or an awareness for lung cancer screening, that would be a good start, and this is a sample. It could look any way you guys -- the committee would like, but this was just a sample of just the key points that perhaps we could have in places where tobacco is sold. "If you're a smoker or a former smoker 50 or older, you

may qualify for lung cancer screening. Contact your health care provider." We could have participating programs on there or not. Right now in Suffolk County, there are two, like Dr. Moore said, and as other institutions join us, their names could be added as well.

The Lung Cancer Screening Program at Stony Brook, we started September 30th. So in the last seven months, we've screened 165 patients. Only 10 of those 165 required a more aggressive workup than a one-year follow-up. Eighty percent did have pulmonary findings, so only, you know, 20% were we able to say, "You're CAT scan's completely normal. Eighty percent of them had some findings, but the majority of those were not concerning findings. Forty percent that we have seen were smokers, and all the patients that were smokers, except for two of them, were interested in a smoking cessation program. So we are mostly excited about how we're going to impact health cost and their health morbidity and mortality down the road.

And we're also looking at distress, because we recognize that any screening program does elicit some anxiety and distress, and so we're looking at that and addressing it. And about 40% of our patients remain distressed even after we give them negative findings, and that's something that we're addressing.

And we thank you for your time. In conclusion, lung cancer screening has been shown to increase survival. When we add smoking cessation to a screening program, the program becomes cost effective. And, as Dr. Moore said, there's a four-fold increase in smoking cessation in patients who are screened for lung cancer, and there are many reputable societies that are giving us new objective criteria, so that the abnormal findings can be clearly categorized. We'll take questions or comments at this point.

**CHAIRMAN SPENCER:**

Thanks very much for your presentation, and I do have a few questions. And I appreciate you presenting before this committee. And I'm sure you're aware that I'm an Otolaryngologist, so I've done the operations where I've removed the voice boxes of those because of smoking. And I agree with the science, the science is very clear. I did want to ask a couple of questions with regards to when we look at just overall yield, when you -- you know, you have said you've screened, since you started the program 165 patients, and, right now, you had three that came up positive out of that. So you're looking at like about a 2% yield, would you say, in terms of following the criteria there? So -- yes.

**DR. MOORE:**

Yes. So there's a couple of components to that. So inside of a screening protocol, there's going to be your initial -- if you were to screen everyone in the entire United States right this second that had the appropriate history and enough smoking history, etcetera, you would find a large number of lung cancers, probably, I'll make up a number, let's say 400,000, far, far more than exists right now. So that's your incidents, so your prevalence scan. So you're going to see how many people actually have this disease. Then, as you follow them up over time, the number of lung cancers should start to go down dramatically. So that's then the follow-up period. So we're now in that first initial screen phase. So three out of 100 is -- 160 is higher than we'd expect if we were continually screening the population. We expect to see about three to four lung cancers per 1,000 patients screened, which is almost identical to breast cancer screening right now. But that's going to take years to develop that number. So our number is higher than it will be in the future, but the number of patients who we see who have positive results are higher. So we are seeing a large number of patients with small little pulmonary nodules that are two to three millimeters, and we just -- we see them, we follow them up in a year and do nothing much else. So the prevalence of the disease is probably close to one, a little less than 1%.

**CHAIRMAN SPENCER:**

So my question relates to when you look at breast cancer, where you have such a huge genetic component, when you talk about smoking, you have a large behavioral component. So, on the one hand, there seems to be an opportunity for more prevention. But on the other hand, too, when you look at smoking, we know that lung cancer is just a very small part of just the mortality that's associated with it. You know, you've got COPD and just a lot of -- myriad of other symptoms that are associated with it.

So when we talk about saves in this particular population, what about other comorbidities? And does that decrease your yield? You're taking it like everyone that you save from lung cancer, you're just going to save them in general. So at what point -- you know, does that skew the numbers a little bit? If you're looking at three in 1,000, how many of those patients are likely to have other comorbidities that are going to be life-threatening, and should that be included in part of your analysis in terms of the numbers?

**DR. MOORE:**

I'm so glad you asked that, because I forgot to mention it earlier. One of the most common things I will find besides lung nodules is cardiovascular calcification. So I see tons of aortic calcifications, and almost -- not every patient, but a large number of these patients have coronary artery calcifications. So one of the things that we're going to roll into this program is coronary artery calcium scoring. And so what you can then do is additionally risk-stratify these patients with cardiovascular disease.

Although we're saying lung cancer is the number one cancer killer in the United States, it's absolutely true, the number one killer, however, is cardiovascular disease. And a comorbid or cofactor in cardiovascular disease, yes, genetics, but if you smoke, it's a much higher risk. So absolutely correct, and we are hyper acutely aware of that, and we find tons of patients who have cardiovascular disease in addition. So absolutely correct, and thank you for bringing it up. And it does affect the overall survival. And the studies that actually have looked at that, the NLST looked at the number of patients who died from lung cancer and from all cause mortality, and it improved both of those.

**CHAIRMAN SPENCER:**

Okay. So you're going to be able to help save people from other comorbid factors.

**DR. MOORE:**

Absolutely.

**CHAIRMAN SPENCER:**

I think that as far as looking at what you're presenting from a physician's point of view, I would love to partner with you. I'm the President-elect of the Suffolk County Medical Society, which we interface with the Medical Society of the State of New York and the AMA. I definitely think that there's a great role for what you're doing, obviously, among -- you know, just within the health community.

So to get back to your -- what you're asking specifically of us, and, again, I look forward -- and I'm being considerate of the committee, because I could talk to you for an hour on this particular topic, but specifically for us, and this is where it's difficult for me as a Legislator and as a physician. You know, we recently raised the smoking age, and when we talk about your requests and looking at the first four, it's very easily done. I would question or have concerns where you're talking about every place that tobacco is sold, there should be signs.

And I'm very much a believer that where there's potential benefit to save lives, that, you know, if we need to move past bureaucracy and convenience for the opportunity to save lives, but I want to

make the connection between -- I'm sold on the importance of screening, you've got me, you've made a great case. What you haven't made a case for at this point is when I -- from my point of view, if I put legislation on the table saying every place tobacco is sold that you need to have a sign, those gasoline retailers who are competing against national chains are going to come to me and say -- you know, any time you hear the word "mandate," then it's going to clash with business. So, if you say a life saved versus business, then I'll argue for the life saved, but the question is the efficacy. And when you talk about someone going into a place to buy a pack of cigarettes, a lot of times, you know, especially in this day and age, everyone from the point, you know from birth knows that cigarette smoking is bad for you. So if you're going into 7-Eleven and -- or you're going to buy a pack of cigarettes, that message of cessation or screening, I would need some proof that that's going -- that they're going to be receptive to that, because I think that that sign -- I'm going to tell these retailers you now have to deal with another government mandate, you've got to go out, you're going to have to put another sign in a place filled with crowded signs.

So that's a bit of lift for me, and I'm curious to hear your arguments there. But I think a better place may be, and where you may have a lot more cooperation, and where the message may be more receptive, is in physicians' offices. I would gladly put a sign in my office, and I would gladly bring that before the Medical Society that -- to recommend that, and distribute the signs, and to do whatever, to download and print. You know, I think doctors would be receptive. But I think business owners are going to make the argument, another mandate, it's not going to work. Where people are looking to buy cigarettes, they're not looking at your screening signs.

So do you have any sense of studies, or yields, or effectiveness in putting it in retail locations? And what about the idea -- because I could tell you right now, just the whispering to my colleagues, that they're like, "Another mandate, we don't want that."

*(\*Laughter\*)*

You know, so just could you talk to that?

**MS. PLANK:**

That's very fair. I don't think we have the information that we need yet to make a strong case. But I can tell you that in the 165 patients that we've screened, we do ask them how did they hear about screening, and we do -- we do see the majority of them, and I can give you exact numbers, I'm not prepared to give you now, but probably three-quarters of them will say, "I saw a commercial," or, "I saw a sign."

So at Stony Brook, for example, I can only speak to what we do, we've gone out into the community. We do have signs in some of the physicians', the primary offices that partner with us. But in addition to that, we have some signs in local supermarkets and we run an occasional television ad, and we run an occasional radio ad, and we run an occasional newspaper ad. And so many people will say, "I went to my doctor and said, 'Hey, I heard about lung cancer screening,'" and then the Doctor, will say, "Oh, okay." So, you know, it's our job, like I said, to educate the physicians, but many of our patients are coming to us based on some announcement that we put out there.

**CHAIRMAN SPENCER:**

I understand. And I think that maybe, definitely, where you've mentioned the public service announcements, the supermarkets, and I would partner with you, the Medical Societies, and maybe doing it from a voluntary basis with regards to the point of sale, I think a lot of the people would say, "Yeah, sure, here's a sign, I'll put it up." I think that the mandate may create resistance. I think if it's voluntary, I think we actually may get more compliance. It's just a thought.

**DR. MOORE:**

Yeah. I was just going to add in that Mather they screened about 120, 130 patients, and a good 75 to 80% of them were also the exact same thing. They saw an ad, they saw some literature that we left at a physician's office, or, more likely, the Newsday or Three Village Herald, where we put out ads, and that's where they're coming from. They're not coming from necessarily the physicians. We've already talked to you. They are actually patients of those physicians who we've already talked to, but the patients are often the ones who start this, so -- and, again, I understand your mandate comment, and I think it is -- I understand.

**CHAIRMAN SPENCER:**

Thank you. Legislator Browning has a question.

**LEG. BROWNING:**

Good afternoon. You know, I know that we probably have an increase here, right here in New York, because of 911, of lung cancer. You know, I see my husband's breathing, he's a 911 responder, and, definitely, it's affected him.

But going back to my former employment, school bus industry, take a ride out to a school bus yard in the winter, when the buses are all starting at the same time. I mean, have you looked at anything like that as far as the diesel exhaust? I mean, I did a study for a college paper on the affects of diesel exhaust on asthmatics, and, granted, some of them are smokers, but there was -- many of them were not. And, you know, taking the different days, the temperature, and what the air quality was like. And, definitely, you know, I'd like to know what -- you know, what you know about the diesel exhaust and lung cancer with diesel exhaust, because I think that's a place where science could be put.

**DR. MOORE:**

So, in terms of the auto mechanic industries, the single biggest cofactor for that particular cohort of people is break pads. Break pads back in the '60s, '70s had a huge amount of asbestos, yeah. So there's actually a high risk of mesothelioma. There's about a 30-fold increase in lung cancers.

Diesel fuel absolutely is a cofactor. In fact, one of the things we ask in our screening forms, and I'll go back a little bit, we talk about here occupational exposures, and diesel is one of the things that I will look for, and it is something that we do consider a cofactor as an occupational exposure. But the biggest thing I would expect in a bus yard would be asbestos. And then also you have your military, who especially in the Navy, were exposed to huge amounts of asbestos. And if they were on a ship, even worse; if they were in a shipyard, just as bad.

**LEG. BROWNING:**

So, and again, I would recommend, you know, there's, you know, a lot of people who drive trucks, school buses, that don't smoke, yet they notice a difference in their breathing. I mean, I could tell the difference, you know. And when I stopped driving, I noticed that I didn't have that problem anymore that I used to have in my chest. But also -- so, again, making sure that you're not just targeting the smokers.

The other thing is insurance. Okay? You have some people that have health insurance, some people who don't. So what types of insurance do you accept, and what if I don't have insurance?

**DR. MOORE:**

So one of the big benefits of working at the University is I don't care what insurance you have as a physician. That's one of the reasons I've continued to stay there forever. I have taken care of literally in the same day a multi-billionaire, and a guy who was from Turkey who had absolutely nothing, which is kind of one of the great benefits of being there. And it's why I continue to stay at

the University for -- it's been 10 years as an attending, and 14 years I did my residency at Stony Brook also.

So I'm kind of sidestepping your question, so I'll actually answer your question. Insurance is one of the reasons why we are also here. We are in the middle of a bit of a battle with Medicare regarding payment for lung cancer screening. And as of right now, there is the U.S. Preventive Task Force that suggested that it should be paid for. One of the groups that advised, as Medicare has suggested, that it should not be paid for. And Congress put out a statement recently, I think it was a week or two ago, that they are behind lung cancer screening and it should be paid for.

We're going to be meeting with the Congressman from my district in a few weeks, and what we're going to be asking them is to again support this concept. And we would ask you guys also to support, whenever you talk to any of the other Legislators, and whoever else you can, that the science is there, and that should be paying for it.

Right now, many insurance companies will pay for it, and if they -- if the patient does not have insurance and can't pay for it, the University always has had the ability to absorb those costs as much as humanly possible. And then also the program at Mather right now is free, so there is no cost for it right now, and that's one of the reasons that program has been so robust.

**LEG. BROWNING:**

And as far as advertising, you know, we see these commercials on TV with people who are smokers and some of them are really frightening.

**DR. MOORE:**

Right.

**LEG. BROWNING:**

And I think the one where he's sitting in the doctor's office and looking at his children and having to tell them, I mean, I think we need pretty graphic and scary commercials. And if that doesn't scare you out of smoking cigarettes, I don't know what would.

**DR. MOORE:**

Those commercials are perhaps a bit too grotesque.

**LEG. BROWNING:**

I think they're -- I think they work.

**DR. MOORE:**

They are pretty accurate. So my background and one of the reasons that I do have a personal vendetta against lung cancer is when I was a teenager, my father died from lung cancer, a Navy guy, heavy, heavy smoker. So I actually have a personal vendetta against the disease, in addition to a scientific vendetta against the disease. So I absolutely agree with you, there does have to be something that happens to absolutely convince these kids that you're not going to be 15 forever and you need to avoid this if you can. And there's no reason to start it, and it is a very addictive drug. It is what it is, it's a very addictive drug, and we need to do our best to help prevent that, if we can.

**LEG. BROWNING:**

Thank you.

**CHAIRMAN SPENCER:**

Thank you very much. That was really a very informative presentation, Doctor. I really appreciate your time. April, thank you for coming out. I look forward to working with you.

My -- I know that there was a preliminary meeting, and I am definitely passionate about this issue. I just went through the battle on the whole smoking age issue, and I do think that we can improve quality of many lives and save a lot of lives. So we'll continue to work together.

**MS. PLANK:**

Thank you.

**DR. MOORE:**

Thank you so much.

**CHAIRMAN SPENCER:**

Thanks. So our next presentation, we have again with us, welcome back, Hudson River. We appreciate you being here, and I know that you can continue to work with us as we move forward in our transition, and I know that we're moving on to the next phase.

So I'm going to ask Dr. Tomarken if he would come forward, and with Jim Sinkoff, Anne Nolon. And I know that you've brought back our friends from Hudson River again. I consider you friends at this point, you're no longer guests.

**DR. TOMARKEN:**

Almost family.

**CHAIRMAN SPENCER:**

You're family. That's right, you're family. So, Dr. Tomarken, if you would introduce them, or I'm sure that there's a presentation. And I appreciate your patience. I had Dr. Moore, who I had committed to him for two o'clock. But I know this is going to be an in-depth discussion, so thank you very much, appreciate it.

So we are considering the -- again, Hudson River adopting -- Dr. Tomarken, I had a couple of cards, and you can -- I don't know if we'll have the formal presentation. The cards are relating to this issue. We have Ms. Phillips and Wilfredo Morel. Do you want them to speak separately with their public comment, or do you want to proceed with the formal presentation?

**DR. TOMARKEN:**

Let them go first.

**CHAIRMAN SPENCER:**

Let them go first, very good. All right. Ms. Phillips, welcome. It's always good to see you. You're very recognized, both a distinct person and because of your reputation, and thank you for being with us again. I always feel so bad when I look in terms of the last time you were with us. I feel very badly because of -- you stayed there all day long, and I know that you came from Westchester, and I think we had a really long meeting that day. And part of that was -- I think part of it was because of my smoking testimony, but you were very patient. And I know that was very grueling, and you still always conduct yourself with the utmost class, and I appreciate your consideration of this Legislature. Thanks for being with us. And anything you'd like to say, go right ahead.

**MS. PHILLIPS:**

Well, thank you very much. And I am pleased to before you -- to be here before you again today, and, as you said, as family. So when family has to sit through a long time or dinner, or whatnot, you do that and you do that graciously.

**CHAIRMAN SPENCER:**

That was a long dinner.

*(\*Laughter\*)*

But good to have you. Just speak into the mic so we can get it on the record there.

**MS. PHILLIPS:**

Okay. As one of the founding members of Hudson River Healthcare, much like Suffolk County Health Centers, we were founded in 1975, which was in response to the unmet need in our community for our families. We, too, at Hudson River Health Care shared in the Dr. Martin Luther King, Jr. dream, and that legacy is woven into our community, much like that of the MLK Center. Part of our history does share in the March on Washington, and many of the things that Dr. King, as a great American icon, stood for, here we are celebrating the 50 year celebration, if you will, on the war on poverty. So we're much within the ranks today.

Our health center, in and of itself is a nonprofit Federally Qualified Community Health Center that is committed to providing comprehensive services to all members of our community. And as a Federally Qualified Health Center, the majority of our Board is governed with our patients. Fifty-one percent of our Board represents the patients. In addition, the Federal Seal means that we must provide comprehensive care in areas that are in most need, and to all who seek it and offer those services on a sliding fee scale.

Hudson River Healthcare currently has two Suffolk County residents on our Board of Directors. Sister Margaret Smyth from Cutchogue, and Angela Earl from Medford. We've been so impressed by the local Community Advisory Board process, that the County has established and maintained for many -- for many years. That advisory structure, much like our own and from our own beginning, has remained an important source at Elsie Owens Health Center, and also regarding the delivery of health care services. We are committed to presenting regularly to these Advisory Board Members, giving them updates, and so that we, too, all become a -- one family, if you will. We're pleased to work hand in hand with you as we provide care to those most in need, and we're looking forward to expanding this exciting partnership in Wyandanch at the Martin Luther King Health Center.

Those are my comments for this evening -- this afternoon, rather. The evening is still coming, in my mind. For this afternoon, and I thank you very much for allowing me the opportunity to present to you.

**CHAIRMAN SPENCER:**

Ms. Phillips, as always, it's a pleasure to have you. When you're speaking, I don't even turn on the clock. You know, you've earned that consideration from us. But thank you again for what you do, and I'm very honored that you are here, I'm very honored that you're in Suffolk County. And I do feel that our residents can only benefit from your presence and your organization. Thank you.

**MS. PHILLIPS:**

Thank you.

**CHAIRMAN SPENCER:**

Thank you very much. Wilfredo Morel also with us, also a very familiar face. And, Wilfredo, please come up to the podium and share with us any remarks that you have.

**MR. MOREL:**

Good afternoon, everyone. As he said, my name is Wilfredo Morel and I'm a member and part of the family at Hudson River Healthcare. My responsibility there is Director of Hispanic Health.

One thing that the Reverend, Vice President and wonderful woman, founder, Jeanette Phillips failed to say is that this morning, me and her came from a funeral, in which I'm sure some of you have heard, but our Health Center is in mourning, our community is in mourning as a result of this individual. And at first it may not make sense, at first, but it will as I tell the story in reference as to why HRHCare just go beyond than just providing health care.

This morning, we were basically paying respect to Jimmy Mack, Jimmy Mack known in our community, also by the newspaper known as James McNair. He was basically the person who perished driving with Tracy Morgan, who's no one that we -- someone that we all know. James McNair was one of our most amazing, amazing community members, and volunteer and employees of our organization. The reason why I share that is you go online, what we were talking about, community, community building, it is not so much about serving the person of -- giving them the way to live longer, but it is about basically integrating that person into our service, integrating that person into the doing of the work. Jimmy Mack was that. He was a driver, he was a street outreach worker, he was a comedian, he was an artist. I mean, the guy had it all.

My presentation was about how do we reach out to the community. He was a perfect example. We used the art. I'm an artist personally. I'm an educator in health care. I'm a public health -- in the fight, but also I'm an artist who tried to use the art as a way to reach community, especially when it comes to our HIV service category. It is true that we have services for them, but it is also true that we have to have the representation around our Board of Directors or by the community, Community Advisory Group that definitely teach us and give us the key and the information that we need to know to better serve our community. Jimmy Mack was that. He was in our community. He was all that, but he was an advocate, and he also was community representation.

I -- you know, I'm here just -- just to say, you know, it is true, that we had to go through the legal -- the legal area, you know, to basically make sure that whatever we do, we do it right for the people that we represent. But it is also true that in serving our community, it goes beyond, beyond the medicine. At Hudson River, we truly believe, we truly believe in basically the whole person. We do that with our African-American community in which we definitely believe in what, you know, MLK did, what he stands for, in terms of reaching out to that and making sure that the services go there. When it comes to our Latino population, when it come to our Haitian population, it goes beyond just the language. It goes beyond just basically the -- you know, the clinical part, but it is also the celebration of the culture, celebration of those traditions that then bring them to care and educate them along those lines.

So, in supporting and doing that, please understand that and let's render respect to Jimmy, and thank you very much. Thank you.

**CHAIRMAN SPENCER:**

Thank you. Thank you very much. I really appreciate, again, your comments, and we do pay respect to the late Jimmy Mack and just what he represented in the community. And, you know, we thank you for bringing attention to that.

And to our table, the Commissioner, I always appreciate, again, your professionalism and presence. And I'm going to ask just the presenters. We're fortunate to have had, I guess, at this particular point gone through the Elsie Owens, the Kraus Center in the Hamptons, and the Maxine Postal, where, as far as the FOHC model of care and the benefits of FOHCs, and, you know, we appreciate it. We've been there, and just -- you know, just in the consideration of all of us and my colleagues, we want to give you our undivided attention. So, if you could -- and I'm trying to phrase this in a delicate way, you know, as far as if you could cut to the chase, so to speak, the Legislators on the committee would be very, very appreciative. We would love to hear about any particular highlights

and just this specific proposal. But we -- so part of the benefits of what we're saying, that you're no longer a guest, you're family, well, that's part of it, we know who you are. Okay? So, with that, please go ahead and present.

**DR. TOMARKEN:**

I'd like to note that the Senior Vice President of Operations from Good Sam Hospital is here today, Joe Loiacano. And I just want to acknowledge his presence and thank him for coming. And I'll let everybody else introduce themselves and then we'll edit our proposal.

**CHAIRMAN SPENCER:**

Thank you very much.

**MS. CULP:**

Jen Culp, Department of Health.

**CHAIRMAN SPENCER:**

Hi, Jen.

**MS. NOLON:**

Anne Nolon, Hudson River Healthcare. Is that on?

**CHAIRMAN SPENCER:**

I think that you have to hold it.

**MR. SINKOFF:**

Jim Sinkoff, Hudson River Healthcare.

**CHAIRMAN SPENCER:**

Nice to see you both again.

**MS. SANTERAMO:**

Lisa Santeramo, County Exec's Office.

**CHAIRMAN SPENCER:**

Hi, Lisa.

**DR. TOMARKEN:**

This will be a little ad-libbed as we -- but first, in the beginning, it's I.R. 1581-2014, which is requesting the Legislative approval of a contract with HRHCare for the operation of the Martin Luther King, Jr. Community Health Center.

The proposal shows that the transition of the Martin Luther King, Jr. Community Health Center to Hudson River Healthcare, utilizing the FOHC model of care to provide essential health services to the medically underserved and uninsured. This would maintain continuity of care to patients and expand services in compliance with FOHC requirements.

Go to slide five, the key benefits of this particular proposal is preserve and expand access to care, preserve the teaching program through the Good Samaritan Hospital, increase Federal resources to the health center through the FOHC benefits, and have a net savings to Suffolk County of 8.6 million through the five-year CBG agreement.

We'll give a quick update on the Kraus Family Health Center.

**MS. NOLON:**

I'm really taking it seriously. I jumped to Page 15, to do -- make two points, if I could, about the Kraus Family Health Center.

We opened our doors on the 17th, and many of you were with us on the 15th to celebrate the completion of the Phase II. And, actually, it wasn't the 15th. What date was it?

**MR. SINKOFF:**

The 21st.

**MS. NOLON:**

Twenty-first, our celebration and opening, and we were just so thrilled to be able to open the doors completely with the brand new facility, and it's just a lovely, beautiful, beautiful location, and a clinic setup. So I think any of you would be pleased. Certainly, Jay Schneiderman was very happy.

From March through May at the Health Center, we saw 1,000 patients, a little over 1,000 patients in 1800 visits. Fifty-five percent of those patients are uninsured and on a sliding fee scale, 39% had Medicaid. And the Residency Program with Stony Brook and with Southampton Hospitals begins on July 31st.

**MR. SINKOFF:**

First.

**MS. NOLON:**

It's July 1st. So I think we'll jump to page -- quite a few pages back to talk about our relationship with Martin Luther King and with -- and with Good Samaritan Hospital. Would that be okay with you, Jim?

**MR. SINKOFF:**

The question is do you want to go through the --

**DR. TOMARKEN:**

Yeah, let's go to 19. We'll skip to Number 19, Page 19, the Agreements and Contracts Related to the Proposal. The contract between the County and HRHCare is for a five-year period for administrative management and primary health care. There's a sublease agreement for the current site between HRHCare and the County. And there'll be additional contracts between the County and HRHCare for provision of public health services and the custody of medical records.

How is the proposal funded? The project consists of operating costs. The County's payments to HRHCare will total 14.6 million over five years. After State Aid, the net cost is 13.3 million. With the continued County operations, the net cost would be 21.9 million. Compared to the HRHCare net cost of 13.3 million, the savings to the County over five years is 8.6 million.

HRHCare's FOHC status will enhance the project by applying its all-inclusive rate structure and the Federal Tort Claims Act protections. The County is not liable for medical malpractice/professional liability of the HRHCare staff.

The FOHC sliding fee schedule for office visits and laboratory services will be applied to patient visits. And the public health services of TB and STD will continue to be provided at no cost to the patient, as required by Public Health Law. And if you focus on this chart, on the far right, total one to five years, the numbers that I just read are there, the 13.3 million dollars of net County expenditures for services through this proposal. And if you continue on down in that column to where it shows you 21.9 million dollars, that's the net County expenditures for services through the County, and the

difference between those two numbers is the net savings to the County at the bottom of 8.6 million dollars.

**MR. SINKOFF:**

So, continuing on, Slide 22, as with the other health centers, we will expand access to dental and behavioral health services, we will expand evening and weekend hours, and we will begin to go through the transformation process of bringing the health center to PCMH, Level 3 certification. This is particularly innovative here because we're looking forward to working with the clinical leadership and the academic leadership at Good Samaritan Hospital to bring a new model of teaching into the health centers facilitated by the Electronic Health Records. As you know, we are Joint Commission accredited, and we will bring this site into that accreditation.

Then, turning to 23, and I might ask my colleague, Joe, at some point to come to the podium just to speak on this, but this really goes, I think, to our partnership with Good Sam. And I would say very heartily, this has been a very terrific partnership. The hospital leadership, Joe, and his team and the entire team there, has really worked very, very hard to be very considerate of all the transition issues at the health center. Given that Good Sam has, you know, staffed the center for a long period of time, we have certainly been very cognizant and aware of transition issues there, and they have worked with us to support the successful transition through continuity of staff and the hiring of staff that will come on to HRH's payroll.

Last, but not least, there's a long-term commitment to maintain a clinical and academic relationship with Good Sam, what we hope will be long into the future.

And I'm going to just pause for a moment and turn the podium over to Joe Loiacono.

**MR. LOIACONO:**

Good afternoon.

**CHAIRMAN SPENCER:**

Good afternoon.

**MR. LOIACONO:**

Well, thank you for the introduction to Jim and HRH. And it's a pleasure to stand here and tell you a little bit about Good Sam's relationship with Hudson River Healthcare. I can pretty much just echo what Jim just said. Good Sam has enjoyed a 40-year-plus relationship with the County operating the Martin Luther King Health Center. We take that relationship very seriously. And after working with Jim and the folks at HRH, I can say that we are very confident in transfer of stewardship of that -- those very important community programs to Hudson River, the relationship and the opportunity to maintain a relationship with the Hudson River Healthcare group going forward. So even though Good Samaritan will not have a direct operating relationship with the community center, we are developing, Jim and the HRH folks and I are developing basically an academic and a clinical relationship with them, and in order to continue our teaching program and in order to continue to deliver babies and care for the patients at HRH that need hospitalization. Thank you.

**CHAIRMAN SPENCER:**

Thank you very much. I do appreciate the presentation, and you did cut to the chase, and I know you put a lot of work into that, but --

**DR. TOMARKEN:**

Yeah. Just a couple of quick points --

**CHAIRMAN SPENCER:**

Sure.

**DR. TOMARKEN:**

The proposed transition is mid-September of this year. There'll be no disruption in health care services. And we will collaborate with the MLK Community Advisory Board to respond to any of their community concerns. Thank you.

**CHAIRMAN SPENCER:**

So I know that we've kind of gone through this process before, and I have some specific questions and then -- with regards to this agreement. And I'll start with, I guess, the last one we did, the TB and STD, I guess, mandated functions. That was going to be by a separate contract. Is that included in this particular agreement and that's different from the previous agreement that we did, where it was going to be a separate --

**MS. CULP:**

Right. So, moving forward, we have a separate agreement for TB services and STD services. As each health center transitions, we will be adding that health center to the existing contract. So within the contract already is Elsie Owens at Coram, Southampton. Next week Tri will transition, Tri-Community in Amityville, that will be brought on, and then MLK.

**CHAIRMAN SPENCER:**

And what is the cost of that contract? Because that, obviously, if there's a contract that we're paying for, if that's going to take away from that bottom line of savings. Can you give me the numbers of what that contract is at this point, how much we're paying for those services?

**MS. CULP:**

We don't have the exact number. The way we've set up the contracts is that the -- if a patient has insurance, then that insurance would be billed. For the uninsured patients that are seen, there's a -- we would reimburse at the Medicaid rate. And then if a medication had to be given, it would be reimbursed at the 340B rate, which both the County and HRH have as a benefit.

You know, we have looked at kind of trying to pull the numbers out. We really kind of look at it as a wash. We are responsible under New York State Public Health Law to provide these services, so we need to be providing them either through us or through partners in the community.

**CHAIRMAN SPENCER:**

No, that's fine. I understand it's a wash, but if -- one of the things that this Legislature is hearing is that we're getting very specific numbers as to -- I'm hearing that the net cost would be 21.9 million with continued County operations, and compared to the HRHCare, the net cost of 13.3 million, with a savings of 8.6 million, so -- but we're getting those services already and that's included in the 21.9 million dollars. So if that's any significant money, we have to provide those services, then that's going to deduct from that bottom line savings. So I guess that's my point. If it's 300,000, or whatever, then it's not 8.6, it's 8.3, you know, so that's -- so I really think that that's important for us to have those numbers a little more specific than it's going to be a separate contract, because you're right, we do have to do it. But we're currently doing it, so that should be part of the analysis. So is there any sense that --

**MS. CORSO:**

The only reason that I'm here is because with Margaret Bermel's retirement --

**CHAIRMAN SPENCER:**

Yes.

**MS. CORSO:**

I've been kind of trying to fill in the finance side for them. And I just wanted to just make a little distinction, if I can.

**CHAIRMAN SPENCER:**

Sure.

**MS. CORSO:**

So part of the reason that we're not as efficient, or we won't be able to provide the service, is because they get enhanced rates. So on the services that are part of this 21 million dollars, they are going -- they are able to get -- you know, leverage Federal dollars that the County is not entitled to, whereas when you carve out the -- it's the Family Planning, it's a different funding stream. So that is like a sum-certain fixed cost. So whether HRH provides it or the County provides it, it's the same number, so that's why we don't include it. So what's happening is we're actually -- if you did a cost analysis on just that, it costs 300,000 for the County, it's going to cost 300,000 for HRH, so there's no savings. The reason that we do it this way is to actually show you where we're going to save money. So we could -- we could include the line, but it's just going to be like a plus and a minus.

**CHAIRMAN SPENCER:**

Okay. All right.

**DR. TOMARKEN:**

Connie, does that affect the 8.6 net?

**MS. CORSO:**

No, because you're going -- you're going to add 300,000 cost and 300 revenue, so it's a wash. That's what's going to happen.

**CHAIRMAN SPENCER:**

But when you're looking at that operations cost at 21.9 million dollars, that already includes that, or it doesn't?

**MS. CORSO:**

No, we pull it out.

**CHAIRMAN SPENCER:**

Oh.

**MR. FREAS:**

Dr. Spencer.

**CHAIRMAN SPENCER:**

Yes, okay.

**MR. FREAS:**

WIC and Family Planning aren't included in the -- contracts, in anybody's contract savings analysis, because they're -- as Connie said, they're separate programs, separate funding streams.

**CHAIRMAN SPENCER:**

Okay.

**MR. FREAS:**

STD and TB are a little bit different. I will say, however, that if you look at prevalence for STD and TB in any of these -- in any of the health centers, the amount of visits that we treat, it's -- when we've tried to calculate it for the health centers that require A9-6, it's not a significant amount of funding. It's not going to change the -- it's not going to get -- you're not going to have \$700,000 of STD and TB that's going to be required, and, therefore, it's not going to change the savings, again, for the ones that we do A9-6. And it's not going to change it so significantly that it's going to change the calculation in savings.

**CHAIRMAN SPENCER:**

Okay.

**MR. FREAS:**

It's unlikely that it would, let me put it that way.

**CHAIRMAN SPENCER:**

Thank you. No. I think I have a better understanding, so I appreciate that.

My next question relates to -- I appreciate the Administrator from Good Sam being here. And so now we've got like an agreement currently with Good Sam that's in place, and we're bringing in this third party. Has this already gone through the Board approval process with Good Sam? Good Sam is on board? Does what we do here affect -- you know, it's a three-person relationship. So have you already gone through that process, or is this pending Board approval?

**MR. LOIACONO:**

This is a longstanding contractual relationship with the County. That contract is due to expire at the end of the summer, or thereabouts. And we're not entering into a new contract with the County, so it doesn't require it to terminate that or expire that contract, doesn't require a new Board approval. However, with a teaching and services agreement, which we would enter into with Hudson River, we would acquire -- require Board approval. And, no, we have not gone to our Board yet, but we fully expect full support from the Board. They're aware of our discussions with HRH at this time.

**CHAIRMAN SPENCER:**

And if there was an untoward decision, would that impact what we're doing here, if they -- I'm assuming that everything's going to move forward, but --

**MR. LOIACONO:**

We're very confident that everything is going to move forward. I can never speak for the Board, you know, in advance, but, you know, the Board is fully aware of what we're doing. Our senior management, our corporate management is in on all of the discussions that I've been having with HRH, and we're extremely confident that we won't have any disapproval or anything with our Board of Directors, no.

**CHAIRMAN SPENCER:**

Great. Thank you. Thank you very much. My biggest concern, and I did express this offline with the Executive's Office, and maybe you can shed some light on this, is when I look at Hudson River, and when I think of just a community health center, the history, the Board, the operations, the materials, everything that's involved, the employees, and so you come into -- I mean, you see hospital systems when they take over or merge with a hospital, for instance, that that hospital may maintain their own board and operations, and over time you'll see kind of a merger of really the operations and the administration. So what I'm having a difficult time understanding when I look at Hudson River, and I see -- you know, you say, well, we've -- you know, we did Elsie Owens, we did the Hamptons, we -- you know, I don't -- I understand you as an entity, but how are you able to

come to a municipality and negotiate something as large as taking over the operations? And to me, it seems that even after you -- you know, you said, "Well, we're doing this one on a particular date, July 1st, and then we're going to go into this next phase of operation." So how many people are there? How are you able to oversee the transition? You must have an infinitely large staff or funding.

I need to understand better how you're able to do this, because it would seem to me that when I see the same people who come here to this Legislature, it looks like the four of you guys, and I can just see the four of you guys out in the Hamptons. And I know there are other people that are involved, but I need -- if someone could just walk me logistically through the process. And if you're going to be doing and instituting your -- as I see the Hudson River model, how are you able to fulfill that model and do all of the things that are associated, and then take this on when we just finished the other thing? I thought that -- you know, it seems like that would take you a year or two to do the transition. So give me size, scope, and logistically how this works, or someone's not watching the shop. So I'm going to be really tough on you guys right know, because that's my biggest concern.

**MS. NOLON:**

Should we leave now?

*(\*Laughter\*)*

No. I just -- I remember having this conversation with John Kennedy when he said after our very first presentation, "Can you move on to the next one right away?" Or, "How quickly can you move all these health centers in?" And I said, "We really don't want to do that. We want to take our time and do it right."

And I think that this year, when we were asked to take on rolling in, lifting the whole network, the rest of the network of health centers into -- in bringing them onto Hudson River Health Care's organization, we thought a lot about that before we said yes. And I think with our organization, it starts with our Board of Directors and their vision and commitment to community. And so the first place we turn to do any of these projects before we go ahead is to get the support and the go-ahead from the Board. Now that doesn't come easily, as approvals don't come from you easily. An approval from our Board is very important, that we put forward a plan of action.

So we have used our Executive Council, which is not large, and you have met everyone on that Executive Council: Jim and I; and Allison Dubois is our Chief Operating Officer; Kathy Brieger, who presented to you on the Planetree Training Center and the training programs that we have, formerly our Chief Operating Officer; and Dan Miller, our Chief of Clinical Quality; and Carmen Chinaea, our Chief Medical Officer. Am I missing anyone?

**MR. SINKOFF:**

Allison McGuire.

**MS. NOLON:**

And Allison McGuire, who is our Chief of Community Initiatives and Strategic Initiatives. You have not met her because she's working with all of the other partners and community partners position us in those strategic opportunities for the future. And Mrs. Phillips as our guiding founding Board Chair, and forever as our Executive Vice President in community relations. It is that team that plans the roll-out, it has planned the roll-out for this. And we have brought together, in a very organized planning fashion, a number of consultants who have helped us in various areas, including Labor, including our health care, a Federally -- Federal entity, and the State regulations. And the people who we need in the communications effort, to be sure that we have --

**MR. SINKOFF:**  
Facilities.

**MS. NOLON:**  
Pardon me?

**MR. SINKOFF:**  
Facilities.

**MS. NOLON:**  
And in the facilities, overview of the facility planning for the future, as we look at each one of the facilities. And we have groups and Task Forces working with those people who are our consultants to help us with the overall lift.

Our Board approved nearly a million dollars in working capital, and that comes from our savings, and that comes from running the organization. I've been there 37 years, and this -- this was the first time that we asked to use savings, that kind of savings, to be able to lift a process, and we're trying to fundraise more to help support that. And as a not-for-profit, we have turned to the New York State Health Foundation and others that continue to help to give us the dollars to be able to continue that. We have that money in the bank to be able to use, but any money that we use we'd like to replace with another grant.

So we are supporting ourselves in doing this. It hasn't been easy. A very quick answer could be we're working all the time. And with that, I'm going to turn over the mic to Jim Sinkoff who does work on all the time on this in his focus as Chief Financial Officer for the organization. He's very aware of not only organizationally system-wide how this impacts on the organization, but also how his work is 100% occupied, and that's given that he's working 200%, so we still have some time for back home.

**MR. SINKOFF:**  
So I could quip and say that I'm very familiar with the HOV lane at this point.

*(\*Laughter\*)*

**MS. NOLON:**  
As long as I'm in the car.

**MR. SINKOFF:**  
But there are a series of things. I think when we started this process, one of the biggest challenges was we're not able to as clearly fix timelines, which in any good plan, the clearer you can fix a timeline, the clearer you can sort of build the resources that are necessary to do the kind of transitions. The way we have approached this, and I think this is going to Anne's point, but a little bit more in the kind of project management scope of this, is we have a fairly robust centralized system for infrastructure. So the deployment of infrastructure is in many ways replicable without a lot of incrementalism in the process. We clearly have had to hire additional staff and we're hiring what we would call centralized staff here in Suffolk County on the I.T. side, on the H.R. side. So we're actually bringing on new employees in Suffolk County to reside in Suffolk County.

Part of what you probably know is many of us, you know, have -- our locus of operation is up in Peekskill, and so on and so forth. We're now decentralizing some of that into Suffolk County, so that our ability to respond and to react to all sorts of needs is not dependent upon, you know, a geography that we're under.

So we also have tremendously strong vendor relationships on the infrastructure side, and we've been in touch with all of the clinical vendors through the process, basically engaging them as partners through all of these processes. So they are married to our timeline, so that they can go through the transition as they need to go through the transition. The timelines for recruitment of individuals is either accelerated or decelerated, depending on what we're doing. So at MLK, for instance, you know, we are employing the individuals at MLK, we're employing the providers at MLK. So the -- in the parlance of business, if you will, the barrier to entry is the classic kind of MBA lingo, is much reduced, because the overarching goal is to maintain continuity and to do everything that's as least disruptive as possible. So that, you know -- you know, that allows us to accelerate timelines.

I can tell you that we're also really aware of all the effort that our staff are putting in. So we have 18 individuals that will be out in Amityville starting today, they'll be there today, Friday, Saturday and Sunday, to make sure that all systems are operational and a go.

I would also say that our colleagues at the County on the operational side and the department side are working hand in hand. We have weekly meetings on kind of operational things to tick off, you know, in all of these pieces. So we are working on all fronts.

What I would -- you know, as a last piece of this, and this goes to Anne's point, when we started our 2014 budget process, we were very aware of the scale and scope of what needed to be undertaken if we were going to meet the Legislature's expectations and the community's expectations. And we did set aside significant resources, understanding that we were going to have to hire individuals, we were going to have to raise our profile, and we were going to have a number of bills that were going to come, you know, kind of in a little bit of a domino series of effects.

Last, but not least, I would say that the residency programs have been probably the longer piece of our work, and really understanding to make sure that the residency programs are intact, the residents are continuing their continuity with the patients, and so on and so forth. And that's where our partnership with Southampton, and Stony Brook, and Good Sam, and eventually North Shore and Southside will come to bear and make sure that there's continuity on that level.

**CHAIRMAN SPENCER:**

How many health centers now are Hudson River controlled, of the entire organization?

**MS. NOLON:**

We have 22 health centers, and subrecipient health centers, five in Nassau County, so it would be a total of 27. We do not directly operate those five health centers, but we work with them as the -- they're our subrecipients under the Federal 330 Act.

**CHAIRMAN SPENCER:**

Is there a vision that the Central Board has in terms of how -- do you -- you know, do you have an infinite expansion capacity that you would continue to just bring on, or is there kind of an overall vision that you want to have 30? What's your overall -- I understand your mission, but as far as just with regards to, you know, if anyone calls up and says, "We want to be an FQHC," "Call Hudson River, these guys, they'll" -- you know, "they'll take on anything."

**MS. NOLON:**

We just don't take on anything, that's for sure. Yeah. In our geography, what -- we felt the responsibility in Suffolk County, as the only FQHC, to be the solution and to work through the solution with our partners. And in our -- the Hudson Valley service area, we have -- we're located where we want to be in the communities that are in need. And I've made a commitment to the staff that in this next year, we are working on maintaining the quality that we've achieved, because

we've achieved the highest level of quality in terms of our Joint Commission, and NCOA Level 3 patients in our medical home. And in order to do that, there is a stopping point, at which time you have to be more introspective, and make sure that we don't lose a part of the system, and that quality, those quality indicators don't go away, that we just can't meet them.

So I believe that this year, with this tremendous lift, with our commitment, we are not going to shy away from the commitment that we've made, we will do it well. We will finish it, we hope, with the last health center near the end of the year, or, at the very latest, the beginning of the following year. And we will maintain the quality. We will get these health centers up to the standard that we expect and will accept, and then we will work to staying put for quite some time.

**CHAIRMAN SPENCER:**

Well, I commend you on what you have been able to do, and I think that you know probably better than I do that you can have a process of being able to come into the door and kind of -- you know, I guess, Hudson River is here, and change the signs and change the operations and everything. But I think that the overall quality of care, because as you get bigger and bigger, and if you look at the day-to-day operations from one particular manager and how they may treat a particular family member, or whatever, that you can maybe infiltrate and -- not infiltrate, it's not a good word. You can come in and set up operations, but maintaining quality does require definitely a lot of eyes and ears. And as you expand more and more and get a lot of outside people into the process, that becomes very difficult to do. And I can tell you that from sitting on a board, a hospital board at times, and watching a system get bigger and bigger.

So I hope that it doesn't -- I hope, and I will support you, but I am very much concerned, and I'll continue to express my concern by asking for updates, because there is at some point the day-to-day operation that comes down to a provider and a patient, and how they are -- they are treated. And so if, you know, you're too big and not able to watch the quality, then I think that that's where things may start to fall apart. And I'm not saying that will happen, but I'm sure you're aware of that, so.

**MR. SINKOFF:**

If I could just comment very quickly on that. So I think we're pretty sensitive to that exact same issue. And there -- a couple of things that are going on is we expect Suffolk County to be its own kind of regional hub, if you will. So individuals like Carlos Ortiz, who you've met, Dr. Napolitano is taking on some additional roles. And there will be more control of what happens in the clinical operation in Suffolk County with connections to, you know, the Chief Operating Officer, the Chief Fiscal Officer, and so on and so forth, but with a lot of local control over how care is rendered, to make sure that it is comparable and standardized across the system. In order to sort of measure that, we do produce reports at the physician level with an eye towards now what is in the public health sphere, meeting the mandates of healthy people 20/20.

So we're in 2014, we've got about six years ago. Let's call it 2015, we've got five years to go, and we've started to now already measure our system as it compares to meeting the targets of healthy people 20/20. That is delivered in terms of the results at the provider and site level with site Medical Directors that oversee each one of our sites.

So the scale is an issue and we are continuing to scale it, but we're also giving over important control over what happens between the patient-physician relationship at the site and not from, in this case, Peekskill, if you will.

**CHAIRMAN SPENCER:**

Well, good luck to you.

**MR. SINKOFF:**

Thank you.

**CHAIRMAN SPENCER:**

I appreciate that. And I asked you to cut to the chase, so I've had about a 20-minute back and forth. My colleagues are about to -- about to -- they're dying to get in and ask you questions, but -- and so, you know, the last thing I'll leave you with is you're right, you know, a reputation takes a lifetime to build and a minute to lose, and, you know, all you need is one scandal and 22 health centers, and then it's Hudson River, whether or not -- you know, so I hope, and I'm sure you're looking out carefully for that.

**MR. SINKOFF:**

Sure.

**CHAIRMAN SPENCER:**

Our Presiding Officer would like to ask some questions.

**P.O. GREGORY:**

Thank you, Mr. Chair, and thank you all for coming out again. I just have several questions, one of which there was a mention in your presentation, but is in the actual presentation, but just the staffing level. We've spoken offline. I just want to -- if you could reiterate that to me what the plan is for the staffing, how you're going to address it, I guess, yeah.

**MR. SINKOFF:**

So I think this is a bit of a joint conversation with us and with Good Sam. We're, obviously, both very concerned about making sure that we retain employment first and foremost.

In level -- in terms of detail, we did meet with the MLK staff directly, both representatives of Good Sam and Hudson River Healthcare. We fielded a myriad of questions from the staff. I certainly will let the Good Sam folks speak to the impressions that they got post that meeting. What we got was that nerves were calmed, greatly calmed, the anxiety and the nervousness of the transition. We will not harm anyone on their base compensation, and we expect to not harm anyone on their fringe benefit costs. So our expectation is that an employee who is earning "X" and fringe benefits of "Y" today, post transition, "X" and "Y" and there won't be any change in that. There may be particulars around what the Good Sam program looks like versus the Hudson River Healthcare program, and we're going to have to work out those differences, because, structurally, our benefit programs don't mirror one to the other. But economically, our intent is to keep -- to hold people harmless, number one.

Number two is we will be offering employment to every Good Sam employee at the site. We will be hiring the physicians, so the Federal Torts Claims Act protections can bring to bear. And we've gone through a crosswalk, because some roles are a little bit different, but not so different, so we'll do some retraining and people will be coming on board.

The biggest impact in the transition, bar none, is the use of an electronic health records system. So today people are using people, tomorrow they're going to be using electronics. There has to be a retraining, and a retooling, and a re-education to go from paper to electronics and what that means.

The other, you know, system of care difference is, is we register patients at our health centers. So many employees will be able to now take on more direct patient contact in direct contact with the patients of the health center through registration and other processes. So we expect the lion's share of the employees to be retained in the transition from MLK to HRHCare, and we've worked pretty hard to make that happen.

**P.O. GREGORY:**

Okay. I'm a little confused.

**MR. SINKOFF:**

Sure.

**P.O. GREGORY:**

I thought I heard you say you are going to take all the employees, and then you said the lion's share.

**MR. SINKOFF:**

I said we're going to offer employment to employees.

**P.O. GREGORY:**

Oh, okay.

**MR. SINKOFF:**

Sorry if that was unclear.

**P.O. GREGORY:**

So --

**MR. SINKOFF:**

We're going to -- I'm sorry. We're going to offer an opportunity for everyone to apply. That's -- I'm sorry.

**P.O. GREGORY:**

Okay.

**MR. SINKOFF:**

I'm misspeaking. We're going to allow everyone to apply for a job in the new model.

**P.O. GREGORY:**

Okay. And how many employees are there?

**MR. SINKOFF:**

There will be a total of 33 offered opportunities to apply.

**P.O. GREGORY:**

How many employees are there now?

**MR. SINKOFF:**

I'm sorry?

**P.O. GREGORY:**

How many employees are there now?

**MR. SINKOFF:**

There are currently -- I think there are -- hold on, let me just do my math.

**P.O. GREGORY:**

Like 39 or something.

**MR. SINKOFF:**

Forty-four.

**P.O. GREGORY:**

So there are 11 that won't be offered employment. And I realize at least one or two are County employees.

**MR. SINKOFF:**

Putting aside the County employees, this does not pertain to the County employees, these are only the MLK employees. Doesn't relate to the County employees.

**P.O. GREGORY:**

The 33 number?

**MR. SINKOFF:**

This is only current MLK employees.

**P.O. GREGORY:**

Oh, gotcha, gotcha.

**MR. SINKOFF:**

Not the County.

**P.O. GREGORY:**

You mean Good Sam.

**MR. SINKOFF:**

Good Sam, yes.

**P.O. GREGORY:**

Gotcha, okay.

**MR. SINKOFF:**

Sorry. We use it all interchangeable. Sorry.

**P.O. GREGORY:**

Right. So is Good Sam, are they, to your knowledge offering employment to, you know, some of the other employees?

**MR. LOIACONO:**

Okay. I'm sorry. I'd like to introduce Mark Boehrer, who is our Vice President for Human Resources at Good Samaritan. Mark and I have been working closely with HRH in an employee-by-employee crosswalk in order to make sort of a preliminary determination of what types of employees might be able to transition into the roles identified by HRH. At the same time, and I'll let Mark talk to that process, Catholic Health Services and Good Samaritan are working -- will work, and have already begun to work, with employees at the Martin Luther King Center to transition folks into other positions that are open and that are qualified, obviously, within Catholic Health Services or Good Samaritan.

So we have a plan to try to transition as many people as possible, and I can't say specifically, because we've only just begun that process. It's our hope to transfer everybody, but, you know, we're working through on a case-by-case basis to transition folks into positions at Catholic Health

Services or Good Samaritan. And I'll let Mark just talk briefly about how that process works.

**P.O. GREGORY:**

Thank you.

**MR. SINKOFF:**

Thanks, Mark.

**MR. BOEHRER:**

Good afternoon. So as you can imagine with a hospital the size of Good Samaritan, with nearly 3,500 employees, and there being normal turnover of staff, at any time there are many vacant positions that need to be filled, and are filled just through internal transfers from one department to the other. So the difference in the need that HRH has to staff the MLK Health Center and the existing employees that work there now has already shrunk because of two staff members that have applied and accepted for positions elsewhere within the hospital. Should there be any other staff that need to be -- to look for other positions, we not only have the opportunity for positions within Good Samaritan Hospital, but since Good Samaritan Hospital is part of a health system, Catholic Health Services of Long Island, that employees, over 17,000 employees, we will certainly look to our sister organizations across Long Island for other opportunities for those individuals.

**P.O. GREGORY:**

Okay, yeah. That was pretty much my understanding. I just wanted to have it on the record. And I believe there is someone that's potentially or probably will retire as well, so that will shrink the number down by one as well.

**MR. BOEHRER:**

Sure.

**P.O. GREGORY:**

Yeah. I just wanted it on the record for the benefit of my colleagues, so thank you. Thank you.

**MR. BOEHRER:**

You're welcome.

**P.O. GREGORY:**

And I appreciate the level of effort that HRH has put forward, because I know initially the salary structure was of concern, and you guys certainly have addressed that, so I'm very grateful for that.

One thing I would like to ask also, another thing I would like to ask, is the new location, I know the County Executive, when he was Supervisor, I don't know if you guys had discussions about this yet, but when he was Supervisor, he had proposed moving the location to Andrews Avenue, or in that vicinity as a part of the whole Wyandanch Rising project, and I haven't heard much about it. I'm not sure. I know there's a lease, I think. Is it 2016 or 2017? I forget. Or maybe something like that. I know it's coming up very shortly.

**MS. SEIDMAN:**

Good afternoon. Phyllis Seidman from the County Attorney's Office. Actually, what we're doing currently is entering into a short-term sublease with HRH pending further discussions about where the Health Center will eventually land.

**P.O. GREGORY:**

Okay. All right. And just, I guess, the last question would be, as I asked with Tri-Community, to set up a meeting, a community meeting, an evening meeting, I would ask, to make it more

convenient for the constituents in the area to be able to, you know -- to, you know, get information about the transition. I think that's very important. And this health center is important to me. Personally, as I kid, I used to go there, so I used to get my shots and stuff, so --

**MR. SINKOFF:**

Looking forward to having you back.

**P.O. GREGORY:**

Yeah. So, you know, and it's our first health center. I went there as -- my brother, my twin brother and I went there for our shots, and, you know, it's special. My mother kind of got a little choked up, "What are you doing to my health center?" But she's grateful. She's an RN, so she understands it, and she -- you know, she knew there were changes, and once I explained it to her, she was very grateful, but -- so thank you. Thank you. Thank you for all that you're doing. You guys are doing a great job, and you're showing a willingness to, you know, meet the questions that are brought to you, and they're very much appreciated.

**MS. NOLON:**

Thank you.

**CHAIRMAN SPENCER:**

Thank you, Mr. Presiding Officer. Legislator Calarco.

**LEG. CALARCO:**

I just have one quick question for you. It's something that's come up since the last -- since we dealt with the Tri-Community Health Center, and it was -- I thought there was some discussion at that time about the diabetes programs. And as you probably know, we have diabetes classes that we do in partnership with Cornell Cooperative. Is there an intention to continue to do those classes, to authorize, you know, Cornell to come into the health centers to run those types of programs?

**MR. SINKOFF:**

Yeah. So we've already completed a discussion for Elsie Owens, and I know that Kathy Brieger is in active discussions with them about the remainder of the health centers, you know, through the transition. So it is our expectation that that service will be ongoing and a joint effort between HRHCare and Cornell Cooperative Extension.

**LEG. CALARCO:**

Fantastic. Thank you.

**CHAIRMAN SPENCER:**

That's very comforting, it really is. We fully support that. And you can see that just diabetes and obesity is such a national hot topic issue that it's pervasive in our communities. And I know that you do a great job to be able to utilize a great program that Cornell has in place.

**MR. SINKOFF:**

Sure.

**P.O. GREGORY:**

I can't tell you how important that is to this committee and to me as a Chair that they are involved, and I appreciate that. Legislator Browning.

**LEG. BROWNING:**

Okay. I guess Good Samaritan seems to be pretty happy with the transition. A question for Good Samaritan as far as your employees. Are they union members?

**MR. LOIACONO:**

No.

**LEG. BROWNING:**

They're not. And, you know, I know that at the last General Meeting, with the other health center, with the County-owned health center, there was some discussion and recommendation to discuss card check recognition, and I would like to know if you've had that conversation.

**MR. LOIACONO:**

Card check?

**LEG. BROWNING:**

Oh, no, sorry. That's not for you, this is a County question.

**MR. LOIACONO:**

Oh, okay, sorry.

**LEG. BROWNING:**

No, but I appreciate it. I got your answer, I appreciate it. Thank you.

**MR. LOIACONO:**

Okay. Thank you.

**LEG. BROWNING:**

So at least they're moving forward, and I guess the County Attorney's Office, the issue did come up at a previous meeting about card check recognition. And I would like to know if you guys have discussed that, and is there any agreements on that?

**MS. SEIDMAN:**

Yeah. Well, the language that you were concerned about last time is in all County contracts, it's standard language. So if you are operating in a County-owned or leased facility, then it's a requirement, the card check, and the lobbying language is in the contract already. It's standard, it's boiler plate in the exhibit. This Legislature --

**LEG. BROWNING:**

As far as organizing a union, as far as union organization?

**MS. SEIDMAN:**

Yes. You can't deter and you can't encourage, you know, it's neutral.

**LEG. BROWNING:**

No.

**MS. SEIDMAN:**

I can point out the language for you afterward, if you'd like.

**LEG. BROWNING:**

Yeah. I don't think she's answering the question that I'm asking. You do know what card check recognition is, right?

**MS. SANTERAMO:**

Yes.

**MS. SEIDMAN:**

Yes, I'm fairly certain that I do.

**LEG. BROWNING:**

Okay. That is if employees choose to join a union, that 50% plus one signs a card, they don't have to go through the National Labor Relations Board for an election.

**MS. SEIDMAN:**

That's correct.

**LEG. BROWNING:**

That the card check is recognized.

**MS. SEIDMAN:**

Yes, that's correct.

**LEG. BROWNING:**

And that's in County language? Okay. If you can send me a copy of that, I'd appreciate it.

**MS. SEIDMAN:**

I certainly will.

**CHAIRMAN SPENCER:**

All right. Any other questions from my colleagues? No. Well, so, again, I appreciate you taking the time to give us the presentation, you know, thank you for responding to our questions. And I feel we have an obligation to, again, work with you to provide the highest level of services for our constituents, and I think that -- I think that your heart is in the right place.

I did, and I think that the answer to the question, I did see one concern. I heard that, you know, there are 44 position, there are 33 jobs, and you're like, "Oh, yeah, sure, everyone will have a job." Everyone will be allowed to apply for a job. And I know the devil's always in the details. So there's like 43 positions, but we're going to let all 43 of you apply for 33 jobs, which means that 10 of you are out. But it seems that with 3500 employees, it seems like the hospital is saying that just in that number of employees, that there's constant transition, and that the intention is that no one will be left out in the cold, as opposed to that, you know, "Yeah, we'll offer everyone a job. Not everyone's going to get a job, but we'll offer everyone, or we'll let you apply."

So I don't want -- you know, sometimes when you're talking to like a Legislative body, semantics and language count. And we've been in that position before, where we've had testimony that, you know, "Well, we didn't" -- you know, we want to know that your intention or our intention is, as much as we can, only to preserve County jobs, we realize that to run an organization, to get the savings to run it efficiently, and we respect your operations. But a big part of that for us, as Legislators, is to make sure that we protect constituents from unemployment, and so --

**MR. SINKOFF:**

Sure. So, you know, clearly, in the first comments, you know, misspoke to the accuracy. I think the important thing that we've done with Good Sam, and in all our conversations that we've had with the other hospitals, is we're doing our level best to try to not leave anybody out of this transition. And we are very much looking, you know, as I think Good Sam was able to provide some testimony to our hospital partners, to also work hard at the same effort. You know, there is a little bit of a different model of care, and we're trying very hard to make it all come together. So I

didn't mean to misspeak on the -- in my first instance and I hope I clarified that.

**CHAIRMAN SPENCER:**

I think that after going through three transitions, that you have definitely a little leeway, that we know your heart's in the right place and you guys are doing the right thing. So thank you, thank you for being here.

That's all I have. So we appreciate the committee's presentation. I do have a couple of other items that -- follow-up for the Commissioner and -- but what I think we'll do is one of them is related to a particular resolution. I see that Walter is with us, is in the back, and I think once we get to that resolution, we'll ask him for his input on that with the Methoprene -- I'm sorry, 1,4-Dioxin.

Commissioner, there was an inquiry from Legislator Browning, and she was -- with regards to just employees being utilized at the Jail Medical Center, and also utilizing these outside contract agencies. And she wanted some information as to, you know, where we at all -- as much as possible, utilizing existing County employees to fill those jobs, and she wanted specifics. But, Legislator Browning, I was just addressing you had made a specific inquiry, so I think you can articulate it better. That was as far as our correspondence. So I have the Commissioner here and Jen to, at your request, to respond to your inquiry.

**LEG. BROWNING:**

Okay. You know, we talked about with our other -- with our health center, the County-owned health center that was just transferred over to HRH, there was about 35 employees, and I don't have, unless -- I'm not sure if I got that list, I think I did, of the employees who work at that center. I'm assuming that by now we know where they're all being transitioned to. And on top of that, the Jail Medical Unit has a number of agency employees, and I'd like to know how many agency employees are working at the Jail Medical Unit, and what their job titles are, the LPNs, RNs, what are they?

**MS. CULP:**

In regards to the Jail Medical Unit, like any 24/7 medical operation, we do rely on agency staff to help fill in gaps that occur because of holidays, vacations and sick time. So we do in a variety of titles. So RNs, we some NPs, some Pharmacy Aides. So where we have gaps coming in, we do utilize agency staff.

I asked yesterday and we -- typical over the two facilities, the three shifts, the 24-hour shifts, five to six. We do anticipate with the new staff transitioning in from Tri-Community, it's about 16 individuals, that we will see agency hours decrease. But I'm sure that we will continue to use those contracts to fill in gaps when they do occur, which just naturally happens in hospitals and nursing facilities that operate 24 hours, seven days a week.

**LEG. BROWNING:**

Okay. Well, because my question is, is I believe we have -- we have 25 LPNs, I believe, that are currently on the preferred list.

**MS. CULP:**

Yes.

**LEG. BROWNING:**

And, you know, wondering why -- why wouldn't we take preferred list employees and put them into the Jail Medical, or at least offer it to them? I mean, granted, no guarantees they're going to say yes.

**MS. CULP:**

Right, so --

**LEG. BROWNING:**

And, you know, I believe there may be a few that are currently working as per diem employees in the Jail Medical who came off the preferred list. Why wouldn't we take those employees? Because I know, you know, this whole thing about, well, they're Jail Medical Unit and they're Jail Medical Attendants, but they're all LPNs. It's not -- it's not a tested list, you know, it's an open list, and I'm trying to find out why we would not take those per diem Jail Medical employees, who were former County workers, and now replace them with the -- take the agency people out and put the County worker back.

**MS. CULP:**

Well, agency staff is not always used on a regular schedule. So a lot of times we're looking each month where we have gaps and we'll be filling in with either overtime or agency staff. So they don't necessarily have a regular schedule where you would hire someone either full-time or part-time. But since -- I mean, even I'm looking going back past April, we did canvas all of the LPNs on the list and we did interview. We interviewed 14 for some open positions for JMA, and two were hired, four declined, and then there were about 11 that were not interested or didn't connect. So we certainly do, when we have County positions opening and they are JMA, we certainly are looking at that pool of individuals.

**LEG. BROWNING:**

Okay. The two that are hired are hired full-time or are they per diem?

**MS. CULP:**

They're County employees. I'm not sure if they're full-time or part-time, I'd have to find that out.

**LEG. BROWNING:**

Okay. I believe they're per diem.

**MS. CULP:**

They're County employees, so I think per diem --

**LEG. BROWNING:**

They're hired as per diems by the County.

**MS. CULP:**

Okay. They are County employees, they're not through an agency.

**LEG. BROWNING:**

Right. And I guess what I'd like to know is if we could -- how many -- -- you didn't say how many agency --

**MS. CULP:**

It really varies. When I asked yesterday, it was averaged about -- over the two facilities, Yaphank and Riverhead, for the three shifts, it was about five to six in various titles.

**LEG. BROWNING:**

Five to -- oh, five to six various titles?

**MS. CULP:**

Right.

**LEG. BROWNING:**

Okay. If you could give me a bit more specifics. I know it was short today. I'm not asking you to give it to me all today, because I know that you need time to go back and look at it. But of the five to six, how many of them are LPNs, you know, what those job titles are.

**MS. CULP:**

Sure.

**LEG. BROWNING:**

And, you know, if I could get a schedule of the hours and days that they're working. I mean, how many of them might actually be working on a full-time basis?

**DR. TOMARKEN:**

As you know, today, it could be five or six, with a certain variety of job descriptions, and next week it will be a different job description, because we use the agencies to fill gaps. So it might be an RN today, an LPN tomorrow, a Pharmacy Aide the next day, so it's not consistent.

**LEG. BROWNING:**

Your mic's not on.

**DR. TOMARKEN:**

I'm sorry. The job titles that we use for the agencies will change every day in terms of job titles. Whatever we need, we ask them. So it may be RN today, an LPN tomorrow, a Pharmacy Aide the next day, etcetera, etcetera. So whatever number we give you, or whatever titles we give you from the agencies, that changes, so it's not static.

**LEG. BROWNING:**

Right. And that's why I'm trying to ask for more specifics, because if there's one or two, you know, County workers who could be filling those agency positions on a full-time basis. You know, you're obviously hiring them because somebody's not at work that day and you have to fill that shift.

**DR. TOMARKEN:**

Right.

**LEG. BROWNING:**

So if you're hiring five people every day to cover, say, like an LPN, you're hiring a couple of agency people every single day to cover LPNs, why wouldn't we just have the County workers, just have them, one or two, on full-time?

**DR. TOMARKEN:**

Well, if we don't need a full-timer, then we can't necessarily hire a full-timer. I understand your point.

**LEG. BROWNING:**

Right.

**DR. TOMARKEN:**

We've canvassed that list, the LPN list twice.

**LEG. BROWNING:**

Okay.

**DR. TOMARKEN:**

And, you know, of the 20, 20 to 25, the interest is very low. But we will -- any time there's a vacancy, we always canvas that list to see if anybody's changed their mind, or whatever. And, again, just so everybody's clear, the LPN list is not a preferred list for a JMA position. JMA position is a specific job title for which there may or may not be a preferred list. We do this because we want to obviously offer positions to ex-County employees, but it's not the same as a preferred, a real preferred list, because it's a different job title.

**LEG. BROWNING:**

We have the preferred list of County employees who worked at the nursing home who are LPNs. The only difference between what they did at the nursing home versus the jail is the title. They are LPNs. The job description is exactly the same.

**DR. TOMARKEN:**

Civil Service rules --

**LEG. BROWNING:**

The Jail Medical Attendant is not a Civil Service test list, it's an open competitive position, I believe.

**DR. TOMARKEN:**

My understanding is that it's a Civil Service rule, that the preferred list has to apply to that particular job title. Functionally, I know exactly what you're saying and I agree, but I think we're hampered. But we got around it, in a sense, by just asking anybody on that list. But it doesn't function exactly as a preferred list would if it was for that --

**LEG. BROWNING:**

But how do you transfer 16 employees from the Health Center to the jail if some of them are going to be Jail Medical Assistants, how would you transfer them?

**MS. CULP:**

Everyone's who's been reassigned from Tri-Community is being reassigned within their title. So we have RNs going over, we have Medical Records Clerks, physicians.

**LEG. BROWNING:**

No Jail Medical Attendants?

**MS. CULP:**

We don't have any Jail Medical Attendants, right.

**LEG. BROWNING:**

There's no LPNs at the health centers?

**MS. CULP:**

Correct.

**LEG. BROWNING:**

Okay, I get that. Okay.

**COMMISSIONER TOMARKEN:**

You can only be a Jail Medical Attendant at the jail.

**LEG. BROWNING:**

You have to be an LPN to be a Jail Medical Attendant, right. So I guess I'm going to have to find out. So is there a list of people on the Jail Medical Attendant? Is there a Civil Service list of people waiting for a job as a Jail Medical Attendant?

**COMMISSIONER TOMARKEN:**

I don't believe so, because we would be required to canvas them first before we went to the LPN list.

**LEG. BROWNING:**

Okay. I see a member of AME. Do you have any information on this as far as the -- you would have to come to the mic. You would have to come to the mic, and if you can enlighten us on some of this or come back. Well, I'm not going to put you on the spot to answer the questions when you don't know I was going to hit you with it.

**MR. WILLIAMS:**

Kevin Williams, AME's Third Vice President. I'm actually the Health Services Liaison, so I'm very familiar with this issue.

**LEG. BROWNING:**

Okay.

**MR. WILLIAMS:**

I have had LPNs become JMAs. They just -- and I can state people. I wouldn't state them on the record here, but I know people who are LPNs who have become JMAs.

**LEG. BROWNING:**

Okay.

**MR. WILLIAMS:**

I know there are multiple people on the LPN preferred list because of the fact that with the Foley, closing the Foley, there were multiple LPNs. I don't know if they've been canvassing that list, I'm not sure about that, but what I was trying to do was to possibly grieve, because I wanted those LPNs to become JMAs. All right?

**LEG. BROWNING:**

Right.

**MR. WILLIAMS:**

I wanted those laid-off members to go to the jail. So I wanted to grieve the issue. It wasn't -- the issue is, like Dr. Tomarken said, is the fact that it's a different title. That's what jammed me, you know, I mean, like he said. And the fact that in the past, they had been hiring these agency JMAs in the past and it created an issue for us. Now, if you could help me with that issue to get those LPNs to become JMAs, they could be moved to that position, I would appreciate it.

**LEG. BROWNING:**

Right. And I know -- I know there are Foley workers who have been hired to work at the jail.

**MR. WILLIAMS:**

Yes.

**LEG. BROWNING:**

But they're per diem, they are not full-time. And that's what I'm trying to get to the bottom to. So if they're eligible to come work as per diems, why aren't they eligible to work as full-time JMAs?

**MR. WILLIAMS:**

They're capable of doing the job. There's no --

**LEG. BROWNING:**

Correct, LPNs.

**MR. WILLIAMS:**

I can give you examples of LPNs who are JMAs who are at the jail right now, I know who they are.

**LEG. BROWNING:**

Okay.

**MR. WILLIAMS:**

I contacted them. So thank you.

**LEG. BROWNING:**

Right. And, I guess, maybe if you could reach out to -- I don't know if you have access to those members who were still on the preferred list, and maybe the union should reach out --

**MR. WILLIAMS:**

I have the preferred list at my office. I can give it to you, if you'd like.

**LEG. BROWNING:**

You should reach out to every one of them and ask them if they have been canvassed.

**MR. WILLIAMS:**

Okay.

**LEG. BROWNING:**

I would like to hear directly from them.

**MR. WILLIAMS:**

Okay.

**LEG. BROWNING:**

Thank you. So, I guess, if you can give me more specifics on the agencies, employees, and how many of them are working every day, and what the titles are that they work every day, say, for the past six months. Okay? Thanks.

**CHAIRMAN SPENCER:**

Thank you, Commissioner, for responding to the committee's inquiry, we appreciate it.

**TABLED RESOLUTIONS**

With that, we're going to move on to our agenda, starting with Tabled Resolutions. Clerk, Madam Clerk, are you ready? All right.

***(I.R. 1042) Establishing guidelines for the use of Methoprene in Suffolk County (Sponsor: Schneiderman).***

**LEG. CALARCO:**

Motion to table.

**CHAIRMAN SPENCER:**

I'm going to second the motion. Motion by Legislator Calarco, seconded by Spencer. All those in favor? Opposed? Abstentions? The motion is tabled. **(Vote: Tabled 6-0-0-0)**

***I.R. 1236 - A Local Law to require the use of biodegradable products by chain restaurants (Sponsor: Hahn).***

**LEG. CALARCO:**

Motion to table.

**CHAIRMAN SPENCER:**

Motion to table, Legislator Calarco, seconded by Legislator Trotta. All those in favor? Opposed? Abstentions? Motion is tabled. **(Vote: Tabled 6-0-0-0).**

***I.R. 1334 - Directing the Department of Health Services to test groundwater for 1,4-Dioxane (Sponsor: Hahn).***

**LEG. CALARCO:**

Motion to table.

**CHAIRMAN SPENCER:**

Motion to table; second that motion. On the motion, I'll second the motion. On the motion, Walter, thanks for waiting, and we appreciate you being here.

Last meeting I saw you briefly in the back, and I got -- I was very excited that you were here, and then I guess -- so I appreciate you coming back. Thank you.

**MR. DAWYDIAK:**

My pleasure, Dr. Spencer. I'm glad to answer any questions on this resolution.

**CHAIRMAN SPENCER:**

Certainly. Walter, Legislator Hahn's very much concerned with this particular chemical, 1,4-Dioxane. And the issues that we're confronted with is that we understand that the Department of Health tests groundwater. We also understand the Water Authority tests groundwater also. And we understand that there may be some differences in terms of what is tested. We're trying to figure out as a Legislature what is important for us to test, where we know that testing can be extremely expensive. We understand that, also, that there are sometimes a battery of things that could be tested for, just like if you take water and you dip a dipstick and you can see five or six different things that you can test for in a battery. So when we look at this specific issue, we had some concerns from the Administration that said, you know, what we want to do is to have a comprehensive list or a better way of being able to do it, as opposed to maybe having individual resolutions for all the potentially bad stuff that's out there. That was one of the concerns, and that this might be included.

So I don't know if you could speak to this particular chemical, and just what your position is. Is it expensive to test for? Is it part of a battery of things that we could test for? Is it wise to approve this, or would it -- you know, would it hurt because we're already going to test for it, or is it better for us not to approve it because it's starting to list individual chemicals?

So those are our questions. And I apologize for hitting you with so many, but I just wanted to kind of frame the issue for you. So if you could address that, I would appreciate it.

**MR. DAWYDIAK:**

Yeah. Thank you, Dr. Spencer. Those are all good questions, so I'm happy to try as best I can to briefly summarize where we are with this contaminant and all contaminants in general.

Dioxane is being tested for currently by large community water suppliers serving 10,000 or over. So the Water Authority and some other large public water suppliers began testing for it. Back 2013 the requirement came in. So, right now, the Federal and State Governments are in kind of an exploratory period. This chemical has been identified as one which is a concern with respect to groundwater and drinking water. They're collecting data. They're going to look at contaminant prevalence and risk to public health, and then determine whether or not it will become a requirement, and if it will become a requirement, at what level they should be testing this for.

Dioxane, in summary, was primarily used as an industrial solvent stabilizer for Trichloroethane, which was banned over a decade ago. The overall loading of Dioxane to groundwater and drinking water is minimal compared to what it historically was, but there's a lot of legacy Dioxane in our aquifer, apparently. There's also some possible incidental contamination from Dioxane as a personal care product from soaps, shampoos, detergents and cosmetics. The degree to which those are contributing is yet to be determined.

The drinking water limit right now is the unspecified organic contaminant limit, which is 50 parts per billion. That's a generic number for any contaminant without a specific limit. This chemical has been picked up in 40% of the Water Authority's wells, about 250 wells. The average concentration has been 0.5 parts per billion, so it's at roughly one one-hundredth of the drinking water standard as it currently stands. It's listed as a probable carcinogen, definitely a chemical of concern. It's something we would like to begin monitoring for in some way, shape or form as soon as we can, and we're undergoing that exercise right now.

So drinking water monitoring for parameters is exceptionally complex here on Long Island. There's probably no place with this difficult a drinking water system to monitor or manage, and no place where we look at so many contaminants so frequently. State Sanitary Code requires us to look at about 140 contaminants. We look routinely at upwards of 350 parameters, so we look at regularly more than double the number of parameters, which is the State minimum, and that list continues to grow on an annual basis. So there's a number of agencies that have picked and chose some of these additional parameters. Our list of about 330 to 350, it varies depending on method and year. It's close to the Water Authority's, but the number of parameters are not identical. And this is something which is a surprise to many folks, and it's part of the Comprehensive Water Resources Management Plan.

Those 200 or so discretionary parameters, the ones that we have chosen above and beyond, we're trying to develop a series of criteria and rationale as to why we look at these. Are there any that we've looked at long enough that are not a threat they we can drop it? Are there any that are missing that we need to add into this? We're trying to do this in a systematic way based on the usage patterns of the chemical, the solubility, the persistence, the mobility, the number of detections, and the environmental health concerns with these chemicals.

So we've set up a working session with the Water Authority, the U.S. Geological Survey, the State Department of Environmental Conservation, State Department of Health, and U.S. EPA. We're in the process of setting it up. We've reached out to them to schedule dates. We expect this to happen within the next month.

Our Water Resources Group has come up with a table of all of these 300-plus parameters, and who is looking at what on the Water Authority end and the Health Department end. We're looking to identify, again, gaps and unnecessary chemicals, so that we can allocate resources to look at the chemicals of environmental health concerns.

So, again, we're concerned about Dioxane. We hope to add it to our list of parameters. It may wind up being something that we look at in every sample. It may wind up that we follow the UCMR model and do one round of samples at the smaller community and non-community wells, and vulnerable private wells. From time to time, on an exploratory screening basis, we've contracted with Stony Brook University or the USGS to do the first round of samples. This test is actually fairly labor intensive. We have the equipment for it, but it requires a dedicated analyst, so it's an expensive test to run. Not that that's the only determinate, but it's a consideration. If it was something we could easily just push a button and add to our list of parameters, we'd certainly do it, but, again, as a resource allocation and prioritization issue that we're in the process of taking on.

So within the next month, we're going to have a draft analysis of our parameters with recommendations. We're going to go through with these agencies as to what we should look at, short and long-term. And then we'll be in a better position to determine what level of effort we'll be looking at with respect to Dioxane, and how we're going to get the monitoring done.

So, again, we commend Legislator Hahn on the spirit and intent of this resolution. It's definitely a problem we're coming to terms with. It's just that we would ask for another month or two for the outcome of this evaluation, so you have better information to make your decision.

**CHAIRMAN SPENCER:**

Wow, you're good. You really, seriously, addressed in great detail precisely every question that I had. And that makes a lot of sense, what you said, when you look at the cost and having kind of a comprehensive plan.

I think the sponsor's concern was that, you know, this didn't go into effect until next year, and why shouldn't we move forward with it. But I think that when you're looking and evaluating of what we should be testing and what we shouldn't be based on risk, and there is a cost that's associated with it.

Could you -- I'm going to ask, because I do -- I think that the sponsor is very much respected, has great intent to pass this great legislation. Could I ask you to please work with the sponsor on this particular item and address, you know, her concerns? Are you guys working together on this?

**MR. DAWYDIAK:**

Yes, absolutely. Legislator Hahn is on the Steering Committee for our Comprehensive Water Resources Management Plan. We're working with Legislator Hahn on this issue, as well as an overall plan for pharmaceuticals and personal care products in terms of drinking water, wastewater monitoring and improved management generally, so, yes, absolutely.

**CHAIRMAN SPENCER:**

And we have the LICAP, which I guess is working with Nassau, Suffolk and on the Water Authority end of things. But I hope that there can be some sort of coordination of effort there also, because I think this goes to the overall health of our aquifer. That would be great if there's some cooperation.

**MR. DAWYDIAK:**

Absolutely. I know the Comprehensive Water Resources Management Plan is on the agenda for the meeting that they're going to be having in late June, and I'll be sure to make sure that this issue also gets discussed.

**CHAIRMAN SPENCER:**

Thank you. Thank you very much. It was -- I was disappointed that you weren't here last meeting, but you were worth the wait. Thank you.

**MR. DAWYDIAK:**

Thank you, Dr. Spencer. I appreciate it.

**CHAIRMAN SPENCER:**

All right. So, with that explanation, we have a motion to table by Legislator Calarco, and a second by myself. We're going to call the vote. All those in favor? Opposed? Abstentions? It's tabled. *(Vote: Tabled 6-0-0-0).*

***I.R. 1394 - A Local Law to warn consumers of the dangers of liquid nicotine (Sponsor: Anker).***

**LEG. CALARCO:**

Motion to table.

**CHAIRMAN SPENCER:**

A motion to table by Legislator Calarco.

**LEG. BROWNING:**

Second.

**CHAIRMAN SPENCER:**

Second by Legislator Browning. All those in favor? Opposed? Abstentions? The motion is tabled. *(Vote: Tabled 6-0-0-0).*

**INTRODUCTORY RESOLUTIONS**

***Introductory Resolutions: I.R. 1512 - Amending the 2014 Adopted Operating Budget to reassign funding from the New York State Office of Mental Health to Federation of Organizations, Inc. for the Non-Client Service Dollar Program (Sponsor: County Executive).***

Motion by --

**LEG. CALARCO:**

Motion.

**CHAIRMAN SPENCER:**

Legislator Calarco, second by Legislator Trotta. All those in favor? Opposed? Abstentions? Motion is carried. *(Vote: Approved 6-0-0-0).*

***(1538) Establishing a County webpage dedicated to the promotion of Narcan Training Programs in Suffolk County (Sponsor: Anker).***

Motion by Legislator Trotta, second by Legislator Calarco. On the motion, the County Executive?

**MS. SANTERAMO:**

We support this resolution. We actually are almost completed with doing this. This is part of the County Executive's substance abuse initiative. We've been working with the treatment providers to create this website. The website is launched. We're working on gathering the information to actually input into the calendar, our information, the trainings we're responsible for are in the calendar already, but we're working on getting from the treatment providers, so --

**CHAIRMAN SPENCER:**

Exciting.

**MS. SANTERAMO:**

Yeah.

**CHAIRMAN SPENCER:**

Okay. Thank you. Thank you very much, we appreciate that. So we -- with that, we have a motion by, again, Legislator Trotta, second by Legislator Calarco. All those in favor? Opposed? Abstentions? The motion is carried. **(Vote: Approved 6-0-0-0)**

***I.R. 1581 - Requesting Legislative approval for a contract with Hudson River Healthcare, Inc. (HRHCare) for the operation of the Martin Luther King Jr. Community Health Center at Wyandanch (Sponsor: County Executive).*** I would like to make a motion to approve. Well, I'm sorry, this is in our Presiding Officer's District. He's going to make the motion to approve, I'm going to second the motion. All those in favor? Opposed? Abstentions? **(Vote: Approved 6-0-0-0).**

I have no other business before this committee. With that, we are adjourned. Thank you.

***(\*The meeting was adjourned at 4:16 p.m. \*)***