

**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, December 10, 2015 at 2 p.m.

***Members Present:***

***Legislator William Spencer - Chair***

*Legislator Kate Browning - Vice-Chair*

Legislator Rob Calarco

Legislator Monica Martinez

Legislator Leslie Kennedy

Legislator Robert Trotta

***Also In Attendance:***

Presiding Officer DuWayne Gregory

George Nolan - Counsel to the Legislature

Jason Richberg - Chief Deputy Clerk/Suffolk County Legislature

Elizabeth Alexander - Aide to Legislator Spencer

Bill Shilling - Aide to Legislator Calarco

Ali Nazir - Aide to Legislator Kennedy

Craig Freas - Budget Analyst/Legislative Budget Review Office

Katie Horst - Director/Intergovernmental Relations/CE's Office

Kerri Suoto - County Executive Assistant/CE's Office

Beth Reynolds - Principal Executive Analyst/County Executive's Office

Phyllis Seidman - Bureau Chief/County Attorney's Office

James Tomarken - Commissioner of Health Services

Jennifer Culp - Assistant to the Commissioner of Health Services

Dr. Carolyn Milana - Medical Director of Stony Brook Hospital Nursery

Dr. Jeffrey Reynolds - CEO of Family and Children's Association

Steve Chassman - Executive Director of LICADD

Lisa Clark - Pediatric Nurse Practitioner at Stony Brook Children's Hospital

Tom Schmidt - Methadone Maintenance Treatment Program/Dept. of Health

Dennis Nowak - Suffolk County Child Protective Services

Judy Richter - Chair of Huntington Hospital Drug Task Force

All Other Interested Parties

***Minutes Taken By:***

Lucia Braaten - Court Stenographer

*(\*The meeting was called to order at 2:32 p.m. \*)*

**CHAIRMAN SPENCER:**

Okay. Good afternoon, and I apologize for the delay, but welcome to the last Health Committee meeting of the year. We've had a great year so far, and we've covered a variety of different topics. But I think today we have a very important issue that impacts a lot of people, not only in Suffolk County, but throughout Long Island. So to get started, can we please stand and have the a salute to the flag, to be led by Legislator Trotta.

*(\*Salutation\*)*

Please remain standing for a moment of silence for all the families that were impacted by the heinous acts of terrorism in California, especially during this important season, that there's a lot of broken hearts that are out there. And also for those men and women who are serving this country, both at home and abroad, who will be away from their families during this holiday season.

*(\*Moment of Silence\*)*

So today we're going to have a bit of a different committee meeting. We are convening a panel. So I'm sure many of you saw the recent article in Newsday that addressed the issue of heroin-addicted babies, which, you know, technically is known as Drug Withdrawal Syndrome in newborns, which is called Neonatal Abstinence Syndrome. And we know that opioid addiction is a vexing pervasive problem, and we know that it affects people of all socioeconomic status. It's a problem that's been growing, especially the heroin epidemic. We continue to look for solutions. We know that solutions -- we're thinking out of the box, but including more treatment program, more access to Narcan. Legislator Calarco has said that we should even look at the manufacturers that may have kind of contributed to this issue initially.

I also wanted to mention our Presiding Officer, DuWayne Gregory, who had a press conference recently with Legislator Hahn on this particular issue of the Neonatal Abstinence Syndrome. But we know that it's an ugly truth, that opioid addiction is ravaging the lives of both the young and old, and we are losing our family members, and it continues to grow in record numbers. Use of opioids such as heroin, Oxycodone methadone during pregnancy, though, does extend beyond the individual. It can affect the most innocent in our society, our newborns, who have had no decision to be born addicted by any means of themselves. And this is something that I think where we as a society and we as Government have the biggest issue to protect.

So just a couple of brief facts before we get started. In 2012, there were 23 million Americans over age 12 that needed treatment for some form of substance abuse. In 2012, there were 2.1 million people in the U.S. who were addicted to prescription opioids, and half a million addicted to heroin; numbers continue to rise. But bringing these numbers closer to home in Suffolk, the heroin overdoses have tripled since 2010. There were 38 death then. There were more than 100 deaths last year, and thousands more who are addicted.

In the Town of Huntington, which I represent, we saw that there were 27 overdose deaths alone just in a 16-month period. And that seems like a huge number, but that was actually the second lowest numbers of the western towns.

Nationally, there's been a five fold increase in the number of babies born with Neonatal Abstinence Syndrome. And in 2009, the birth rate for babies born addicted to opioids has more than doubled in Suffolk County. In 2014, there were 171 infants, compared to 93 infants in 2009.

So with us today, let's begin with our panel, and I'm going to ask if you would come forward.

There's name tags at the table in front. But I'm very pleased to have Steven Chassman with us from LICADD, and he will give kind of a global view of the issue from an agency perspective. We have Dr. Jeffrey Reynolds to discuss prevention and continuance of care for moms from an agency perspective. Dr. Carolyn Milana from Stony Brook University Hospital Nursery to discuss the long and short-term medical impacts on infants. Lisa Clark, Nurse Practitioner at Stony Brook Children's Hospital to discuss care for moms, and access to care and gaps in services. Judy Richter, who's a Licensed Master of Social Worker -- Social Work at Huntington Hospital and Chairperson of the Hospitals's Drug Task Force. Dennis Nowak from Child Protective Services, and he can give his thoughts on the effects it's had in the County from a day-to-day perspective. So thank you very much. I appreciate each of you for being here.

And I think that what I'll do is I'll start with Steven. So, Steven, particularly for you, and I've seen you, we know each other very well, I think you're very well-known throughout the County, but if you could maybe just give us a global view of the issue of heroin-addicted babies from an agency perspective.

And I'm going to ask, since we have such a large number of distinguished panelists, if you could each give us about two minutes to tell us your thoughts. So, Steven, thank you.

**MR. CHASSMAN:**

Thank you, Legislator Spencer, and to all the Legislators. Just know, for an agency that's been around for 60 years, we're seeing over 1,000 people a month. Disproportionately, there's young people, and, of course, there are young women coming through.

For those Legislators that don't know, when you talk about opiate dependence or substance use disorders, this is a psychiatric illness that impacts one's physical, psychological and social wellness. So not to foster empathy for young mothers, but just know, even though the behavior may appear as irresponsible, these are young women, well, primarily young women, who are in the throes of an obsession and compulsion, that, regrettably, because of a heightened state of denial, okay, are not aware or are fearful to seek prenatal care. So we try to engage young women.

There are gender-specific issues that agencies like mine need to ask specific questions. Are you pregnant? Are you aware that maybe you've had unsafe sexual practices? I think this has highlighted yet another facet of the opiate crisis where our health care systems do have flaws, and we need to do better as a community. We saw this with the 911 Good Samaritan Law. It seemed like a no-brainer to have people, young people call for help, but we needed legislation around that. It seemed like a no-brainer with I-STOP. But I think we need to on an individual agency level ask the right questions of women who are clearly fearful and in the throes of an obsession and compulsion, obsession to recycled thoughts, and they lead to compulsions, which are repeated behaviors. And, unfortunately, because of social and legal fears, they are not accessing health care. So we have to ask the right questions.

And, from a Legislative standpoint, if a social worker can make recommendations, we need to do a host of community education. And, much like we did in the '80s and '90s around another epidemic, we need to talk to young people about safe practices, whatever that is. That may be the unspoken problem here, that unplanned pregnancies. As long as men and women has pressed grape, drugs have served as a sexual aphrodisiac, and I think we've missed that conversation about safety measures. LICADD certainly knows that as we talk about injection drug practices, but, certainly, with young men and women, and older men and women, not engaging in safe practices that are inadvertently leading to a heightened state of denial, and, of course, putting unborn children at risk here.

So, with that, I thank you for the opportunity.

**CHAIRMAN SPENCER:**

Thank you, Steven. As usual, very well said, and I think you really framed it quite nicely. I, you know, know that there's only a few people in this room, but this is being broadcast live, and there will be a transcript. We also have News 12 and Newsday who was here, and NPR Germany who's also just covering this issue. So it's -- I think it's great to be able to kind of get the issue out there, especially the more people who are aware, the better off we are.

Our next panelist, Dr. Jeffrey Reynolds, who has definitely been distinguished in addressing these issues throughout Suffolk County. I'm going to ask if he could discuss prevention and continuance of care for moms, and from an agency's perspective. Thank you.

**DR. REYNOLDS:**

Thank you. And thanks for convening this discussion. I think it's a really important discussion.

By way of background, at Family and Children's Association, we serve more than 20,000 Long Islanders each and every year. A disproportionate number of those 20,000 Long Islanders are young women, and so we run several programs that cater to this population, not the least of which are two New York State OASAS licensed chemical dependency treatment centers. One of those centers, for example, we recently began offering child care on site, not because it was a brilliant idea, but because we had to in order to get young women through the door.

You know, one of the best opportunities we have to approach and intervene with substance using women is the time when she's pregnant. For many folks, that's a very significant milestone in their lives, and in a lot of cases, that is an event that can precipitate some really incredible changes. As we have this discussion here today, the advent of a growing number of pregnant women who are struggling with addiction should be an opportunity for us to revisit some of the historic wrongs that have kept women out of the addiction treatment system.

We make mistakes in a couple of areas when it comes to treating and intervening with this population. The first place that we have a boatload of missed opportunities is when it comes to screening. Very often we are seeing women who go through entire courses of prenatal care with very scant conversations about their substance use. We're missing an opportunity. So when we talk about prevention, it doesn't have to be complicated, it simply needs to be an ongoing conversation about drug and alcohol use during pregnancy, not only your own drug and alcohol use, but your partner's drug and alcohol use and your family history as well.

When it comes to treatment, there's a whole bunch of gaps in the system when we look at how treatment is handled. Those gaps exist for men and women alike, but they're much more significant when it comes to pregnant and parenting women. What we need, really, is a seamless integrated continuum of care that includes substance abuse treatment on demand, that includes psychiatric evaluation and ongoing care, that includes OBGYN ongoing care, and that includes pediatric health care for that child who should be having regular and ongoing evaluations every three months. Typically, the way folks access those services, if they do at all, is in a pretty fragmented kind of way, where there's no handoff, there's no connections between some of those providers, particularly as we talk about low income women, the barriers to care, particularly in less urbanized areas like our own become very, very clear.

The last thing I'll mention, and it's important that we factor stigma into this, and, certainly, Steve mentioned that, one of the things that we see time and time again, and New York is not one of the states that's taken aggressive action around women who use during pregnancy, is the fear of being identified, the fear of having your children taken away, the fear of criminal prosecution. There have been some criminal cases that have made the national headlines that strike fear in the hearts of

people who might otherwise come for help. But as we talk about all of the high level medical care, and I know my friend Tom Schmidt is going to talk about medication-assisted treatment, which is really important, we also have to talk about all the ancillary services that get women into care. And so transportation, child care, baby-sitting services, counseling services, vocational and GED services, that unless we're meeting some of those basic needs at the same time we're meeting the OBGYN and medical needs, we're not going to get that woman on the pathway to a healthy life.

So I very much look forward to a robust discussion, and thank you again for putting this discussion together.

**CHAIRMAN SPENCER:**

Thank you, Dr. Reynolds, very well said. Thank you. Our third speaker, Dr. Carolyn Milana of Stony Brook Nursery. And I'm hoping she could make a couple of remarks regarding the long and short-term medical impact on infants.

**DR. MILANA:**

Thank you very much for letting me come and talk today. I'm a pediatrician, and in addition to being the Medical Director for the Newborn Nursery at Stony Brook, sadly, drug abuse and withdrawal is an issue that I have come to face every single day in my practice, which is not something I really expected as a pediatrician. Drug use by pregnant women is a troublesome issue and it has twofold problems, one is for the mother and the second is for the baby. The same opiates that cause addiction in the mother are going to cause addiction in the baby. As soon as babies are born, the first thing that happens is they're cut off from their drug supply and they withdraw.

Babies born to addicted moms will require longer hospital stays than normal-term newborn babies. And babies who are exposed to opiates can experience withdrawal within six hours of birth, and it can last for up to two to four weeks following delivery. No two babies will go through withdrawal symptoms the same, they're all a little bit different. But the typical symptoms that these babies will experience are they tend to be small, so they're born smaller than other babies. We have babies in our nursery who are four-and-a-half to five pounds sometimes when they're born. They're irritable, they require round-the-clock care to support them, things like keeping them in a quiet space, keeping them swaddled. They love to be rocked and held to kind of help their withdrawal symptoms a little bit. They do experience tremors, and the tremors are usually so bad that they get skin breakdown just from sheer rubbing on their blankets and clothing. They have difficulty feeding due to their inability to suck and swallow and coordinate those activities. They have diarrhea. They experience weight loss due to the high metabolic demands that are placed on them because of the withdrawal symptoms. And in many cases, their symptoms are so severe, they require a short stay in our Neonatal Intensive Care Unit, and they'll require drugs to help them get through the pain of the withdrawal.

The cost of these babies are -- is tremendously high, and it soared to an average of \$53,000 nationally. And frequently these babies will end up removed from the care of their mothers, which places an additional burden on our foster care system.

In the hospital, there's a limit to how much we can provide for care. We do try to support these babies and their families. All of our babies are seen by social workers. We frequently report to Child Protective Services, and we do send out public health nursing when they go home. But, unfortunately, this is where our support ends. There's only so much we can do in the hospital. Most babies will stay a week to two weeks, usually, and then that's it. We send them out into the community with very little support for their moms.

You know, I agree with you, that this is actually a tremendous opportunity to get moms who are

addicted and not in a treatment program into programs that help. I also know that if any of you have ever taken a newborn home, you realize that although it's exciting, it's also tremendously exhausting, and it's stressful, and that this is a time where moms who don't typically have strong support systems are going to return to their drugs of abuse, even if they are in programs. So they need to be reevaluated. We need to really look at the treatment programs that they're in. For those who aren't, we need services out there that we can offer to them, places that we can send them to get into rehab. And, you know, all these moms love their babies, even the ones who lose their babies to foster care, and I think this is an opportunity to really intervene and get people into drug programs.

**CHAIRMAN SPENCER:**

Wonderful. Just a quick follow-up. As far as long-term benefits, once these babies go through withdrawal, is there any information as far as how they do, as far as intelligence, their risk of addiction when they become, I guess, teenagers? Is there any increase that we're seeing there? Do you have any information on that?

**DR. MILANA:**

I'm not sure there's any real long-term studies, because the problem is more acute now. You know, any baby who's born to a parent who is an addict is certainly at an increased risk of using drugs when they get older. It sort of depends on the drug of use that, you know, will depend on their long-term outcomes. You know, moms who are addicted to heroin do tend to have babies who develop developmental delays. You know, the opposite to that is moms who are on methadone or Suboxone, their babies will withdraw. They're certainly at increased risk for going on to use drugs when they're older, but their moms are in programs and they are functional members of society, which adds a lot to their care.

**CHAIRMAN SPENCER:**

I would imagine with a developing brain, as far as when we look at levels of dopamine and nucleus accumbens, as far as development of higher critical thinking, there must be some long-term impact. And I'll ask that of the panel. Maybe if -- you know, if -- I'm sure that as far as just the social circumstances, that you'll see that a lot of these babies will probably have a higher percentage that find themselves battling addiction themselves. But I'm wondering if there's any biochemical impact to that neonatal brain, but thank you. Thanks for -- and we'll weigh in on that.

Lisa Clark and Judy Richter are the next two speakers. Lisa is a Nurse Practitioner, and Judy has a Master's in Social Work. And the issue I'd like you both to discuss would relate to care for mom, accessing care and gaps in services, and I think that fits both of kind of your areas of expertise. So, Lisa, Nurse Practitioner at Stony Brook first, please.

**MS. CLARK:**

Thank you for having me today. I am a Pediatric Nurse Practitioner, and people will say why am I talking about moms. For the past 20 years, I've been working in addiction in newborn nursery with moms and babies, and had to learn all of the problems of how the mother's health and drug abuse affect the infant. So while it's easy to have sympathy for our children that are born addicted, we must remember that the wellbeing of the mother and baby are interconnected. And since delivery is stressful for any mom, it's even more stressful for these women.

Women who suffer addiction are often guarded about their disease and history, and they may be experiencing a negative stigma, not only from their family, they're afraid from their doctors, and they're afraid when they come into the hospital.

At Stony Brook, we have been working together to make a coordinated effort. We started our own Task Force about three years ago in trying to coordinate services and doing the ask, as we talk

about. You have to ask about drug history, you have to ask about what drug use, you have to ask about mental health. The concern always is, is when you ask, what do you do, because when they're -- when they tell you the problem or they test problem, what are our solutions?

The increase in availability of the prescription drugs that what I-STOP had done, when I-STOP turned off the ability to get those drugs, many young women moved on to heroin, and when they moved on to heroin, the number of treatment abilities did not happen. And so it became more and more of a problem as to you can't get your pills, so now it's easier to move on to heroin because of the low cost of heroin itself, so many have transitioned to heroin addiction.

A recent study just out this month in the Journal of Drug and Alcohol reports that they have been looking at the demographics of heroin use, and this is what they said: It has now totally shifted to women who are white and are of higher income, and that is what we are beginning to see. Not to denigrate any socioeconomic group, but we are seeing a change in the use of drugs, and not to stereotype anyone.

The illness of addiction, as we've talked about, prepares, particularly for the inability to control its use, and continues despite the negative consequences. So even if you're going to lose your child, you're still using. Even though you know you might lose your child, they just can't stop. It's even more complex with women in pregnancy. Drug use in pregnancy is very hard to quantify. This is a sensitive issue that is associated with the illegal activity connected with drug use. Furthermore, it's often hidden populations, people living in the margins.

So the question today I was asked is how big is the problem? Some have estimated the problem in the literature, doing blind studies when people just walk in to deliver, anywhere between 10 and 30% of your population. I can tell you from our screening, just basically lack of adequate care. Or a woman who finally says, "I have a problem," when they walk in the doors is somewhere between 5 and 600 women have been screened yearly at Stony Brook. It doesn't mean that they're positive, but they are screened for the potential at-risk of having a drug problem. So if you look at those numbers and how many women who might have it, a third of them, you're looking for a lot of beds in the future and presently for that kind of care.

We've been trying to create a trust between the patients and the community so we can get early recognition in pregnancy and to assist in the identification of substance abuse. For the pregnant women, people are always concerned about what drugs, and Buprenorphine, which is Suboxone, which is out there now. So you don't really have a sense of how many people are being treated.

We know from the methadone services that we provide here, you have a sense in the County who's receiving methadone, but I will tell you that the shift has happened. We are seeing many more women come in on Buprenorphine, Subutex, Suboxone, which does not require any kind of additional counseling, but, yet, they're being serviced through private providers.

Some of the problems that we've been able to see is that the in-patient beds are limited. So if a pregnant woman comes and admits to abuse and goes to our anti-part, and we may be able stabilize her with some medication, but then her discharge becomes extremely complicated for the reason of who will take care of a pregnant woman with addiction. We don't seem to have a good handle on who will do that.

Insurance is requiring outpatient failures. I have been told on phone calls that have to fail three times. The pregnancy, it -- you have nine months, so, you know, you're not going to make those failures. And the opiate replacement or addiction services, some of the insurances do not have any local connections, and so the patient may have to travel over 15 to 30 minutes or longer to find

where they're into another county or into the city based on their insurances.

Access to substance abuse treatment programs for pregnant women can be affected by a couple of factors. The out-of-pocket costs, so even if they take your insurance, if this is for outpatient, they may not take it for Subutex treatment. So you can be listed as a person who is taking, say, an insurance plan, or even a Medicaid -- one of the Medicaid plans, but -- and you are treating people with Subutex or Buprenorphine, and you will not see that patient for that disease process and charge additional out-of-pocket costs.

**CHAIRMAN SPENCER:**

Lisa, let me -- definitely, I see you have a beautiful statement and I want to get into it.

**MS. CLARK:**

I'm sorry.

**CHAIRMAN SPENCER:**

No, no, I really appreciate it, and I want to come back to it, because I want you to get all that information out. Let me get the rest of the panelists introduced and then -- so we can get into that a little bit more. But I think you really very eloquently laid out what the problems are and started to get in depth into some of the issues, and I think you did a wonderful job.

**MS. CLARK:**

Thank you.

**CHAIRMAN SPENCER:**

Thank you. And I do want you to finish that information. But let me move on to Judy. And, Judy, from a social work perspective, when, you know, all right, that baby is there, they go through the withdrawal program, and now they're on their way home, and they're going into a whole world that will just reinforce this behavior, what do you give them? What do you say? What do you do? What are you missing? So go ahead.

**MS. RICHTER:**

Thank you, Dr. Spencer, for letting me be here today to speak, and I'm going to touch on that. But I've been a Social Worker at Huntington Hospital for the past 16 years. I currently work in the emergency room. So, unfortunately, I have been witness firsthand to see the tragic loss of life from opiate addiction. When you see a gurney coming in and a 20-something-year-old laying on that gurney lifeless, and an EMT on top of that person trying to perform CPR, and that's a loss of life, it affects you. Also, when you work with countless families and patients that are suffering through addiction and you feel their anguish and suffering and pain, that affects you.

So what we did at Huntington Hospital is we formed a Drug Task Force, and the Task Force is made up of doctors, nurses, social workers, ancillary staff, and we strive to promote education, awareness, and help families and patients that are suffering through addiction.

I note today we're here to talk about the newborn babies being born addicted, and how the -- statistically it's higher in Suffolk County. I can't really tell you why that is, but just have some thoughts on some ideas. One is that I think that for the pregnant addicted woman, she is living in the shadows. She's afraid to come out, maybe not being honest with her doctor. There's a lot of stigma, shame, guilt, and she's probably not getting the proper prenatal care that she needs. As we know, we heard there's a lot of effects on these babies, low birth weight and a lot of other medical conditions that -- when they're born.

I think we really need to do a lot of education and awareness around this issue, because there are

places where these young women can go. Morning Star, Nassau University Medical Center, North Shore LIJ at Zucker Hospital has a perinatal psychiatric unit. They can all help the woman who is addicted and pregnant, but I don't think that people know about these services, and I think we need to provide more education and awareness around this. And we need to let the moms know that if they go there, they're not going to be stigmatized. That's really important.

One of the things we do for all of our patients that are coming into the hospital is we created an addiction service packet, so when they leave, they're leaving with something and some resources and referrals they can later look at.

I think another thing that needs to happen is maybe some of the clinics like the Dolan Family Health Center and -- which I think they are doing this, and some of the doctors need to start using SBIRT as a tool, as a screening tool, so that they can see who is at risk of substance abuse, start the conversation, and so that we can have better outcomes.

**CHAIRMAN SPENCER:**

Judy, please, with SBIRT, just --

**MS. RICHTER:**

Oh, sure.

**CHAIRMAN SPENCER:**

-- ten seconds, so that we can put this on record.

**MS. RICHTER:**

SBIRT is Short Brief Intervention and Referral to Treatment. Most of -- I believe most of the hospitals are going to start having to use this by 2016, and it's a series of questions, five short questions that you'd ask a patient to see if they triggered, and then make a referral and intervention for treatment.

I think one of the other things we can do is also look at how other states and counties are handling this issue. In Alabama and Tennessee, a woman can be prosecuted for using drugs that are not prescribed during her pregnancy unless she seeks treatment. I'm not saying this is a good thing or a bad thing. I know there's a lot of negative and positive ramifications from that, but I think it's something we should look at to see what's working and perhaps not working.

Yesterday, I knew I was coming here, so I went up and I spoke to some of the staff on the Labor and Deliver, Maternity and Nursery, and most of the nurses, they all agree that there's definitely an increase in women coming in that are addicted. But they're also seeing a repeat in the same women coming back and giving birth to a second child that is addicted, and that's pretty alarming.

I also think that we need to look at these babies that are being born, because they are at risk. You know, a mom, as I think it was said, that's going through addiction, you know, if she's going through treatment, that's great, but there's also a lot of stressors, and it doesn't -- we don't know. We can't prove when she's -- just because she's going through addiction, we don't know if she has a safe place to live, and everything she needs, and all the resources for that baby. And before we discharge them home from the hospital, we really want to try to make sure that they have everything in place. I think we have our Child Protective Services, they do a really good job at this, but we are having babies that are dying. I mean, we had this at Huntington Hospital where we had a young woman who was addicted, and her partner was also addicted. We did refer it to CPS, and I think about two weeks later, that baby died because those parent were high. They were -- the baby was in bed with them and the baby suffocated. And this is not an isolated incident, this is going on across the country. So these are just a few of the things I think we need to do. Thank you.

**CHAIRMAN SPENCER:**

Thank you. Thank you so much, Judy. You couldn't have mentioned CPS. We actually have Dennis Nowak, and it's a great segue. And, Dennis, thank you also for being here. And can you talk about the -- from what you've seen, the impact this issue has had in the County from a day-to-day perspective as someone in the CPS Department?

**MR. NOWAK:**

Yes. Thank you. Thank you very much for convening this panel. In preparing for the panel, I reviewed several dozen cases that we've seen over the past few months, and I'd like to give you some real case examples. And what I've done here is just summarize these cases on the allegations and the outcomes. I've removed all confidential and identifying information, but this will give you an idea of what we're seeing.

Case number one, Child Protective Services received a report from a hospital that a mother gave birth to a baby girl, and both tested positive for cocaine and opiates. The newborn experienced withdrawal symptoms, was suffering from tremors, sneezing, tense muscles, and producing loose stool. The mother, who denied drug use, left the hospital against medical advice, while the baby remained in the neonatal intensive care unit. CPS petitioned the case in court. The baby and the mother's other children were placed in the custody of the maternal grandfather. The mother's supervised visits with the children were suspended when she continued to test positive for heroin, despite participation in a drug treatment program. CPS indicated the case for inadequate guardianship and parental drug use against the mother, and the case continues with the Department's ongoing Child Preventive Services Bureau for ongoing case services and case monitoring.

Case two, mother gave birth to a --

**CHAIRMAN SPENCER:**

Before you do case two, just the question begs to be asked. Is it a crime for a mother to give birth to an addicted baby automatically, once that occurs and CPS -- or is it continuing negligent behavior? So if you get a report from a hospital, automatically, does that necessitate CPS taking custody? Can you -- you know, do you understand what I'm asking?

**MR. NOWAK:**

Yes, I do. First of all, CPS is not a criminal justice organization, but operates under civil and -- civil regulations and under the Family Court Act. If it is shown, whether it's heroin or any other drug, has a negative impact on the child, a report should be made to Child Protective Services. And hospitals are mandated reporters, so they're mandated by law to report a case to us. So, most often, we do receive reports from hospitals on newborns who are exposed to drugs, whether it's heroin or any other type of drug.

One of our first actions would be to petition to the court for custody of that child. We have to prove our case. So, most often, we do maintain custody. Our first responsibility is to find a relative caretaker. We try to avoid placement in foster care. We do that by placing with a relative. And many of these cases that I have with me today, that's the situation, we place with relatives. On the case that you're speaking about, it's quite possible that Child Protective Services petitioned the court for custody, but was overturned in court and was required to return the child home. So, without knowing the specifics, I couldn't speak to that, but that's what happens. And we most often will act immediately to remove a child.

And as we've heard already, these children are spending one to two weeks in the hospital. Oftentimes, the parent will be discharged home, or leave against medical advice on their own, leave

the hospital, and the child be left in the hospital. Many times we take custody then and, again, look for other resources.

One of the things we're finding is that with heroin abuse, oftentimes couples are involved. We're finding this more so than with other drugs, and that the other parent may not be a resource for the child. So we are going to other relatives, maternal and paternal grandparents, aunts and uncles, so that often happens, but the pattern is the same over and over here.

Case two, mother gave birth to a baby boy. Mother was in a methadone program, but she continued to use heroin while she was in the program. Child was born with signs of methadone, cocaine and heroin, and the baby did suffer withdrawal. The father had a long history of drug use and criminal activity and was incarcerated. The baby was placed in the direct custody of the maternal grandmother. CPS indicated the case both parents for inadequate guardianship and parental drug use. We continue to provide services to the family and monitor the case.

Another mother, baby born, a baby girl. Both mother and newborn tested positive for methadone upon delivery, and the baby was suffering from withdrawal. Mother had a history of using heroin and crack cocaine. Subsequent report came in from the hospital that while the mother was visiting, she was still using heroin, and dropping off during her visits with the baby, so the baby was at added risk. Again, that case was indicated. The mother admitted to abusing crack cocaine and heroin at least six months into her pregnancy. She also stated that she was in treatment, a methadone program, but admitted to struggling with sobriety from heroin and relapsed several times. CPS petitioned for removal of the baby in court and that child was placed with maternal grandmother.

I could go on and on, but to save time, the pattern is the same. What's alarming here is I reviewed cases from just a 6 to 8-week period. I came up with 30 cases where heroin was a factor, and many of them with newborns. We have court cases of older children in the care of parents, cases of parents drunk, driving under the influence of drugs, or dealing drugs where they've been stopped by the police. It's not unusual for the police to make an arrest and then to make a call to Child Protective Services to tell us to come get the children who are in the precinct.

Every year we investigate approximately 9,000 cases of child abuse and neglect, and that's all types of allegations. Approximately 26% of all reports involve allegations of parents' drug abuse. We indicate on average of the 9,000 cases that we investigate, approximately 27 to 30% we find some credible evidence of child abuse and neglect. The rate is higher for drug abuse allegations. Typically, we indicate 36 to 40%. What's alarming is in this past year, I've done this chart, the rate of indication for drug abuse has jumped to 54%. So we are seeing more serious cases and we're able to substantiate those allegations in those cases.

This year alone, we will investigate 2,400 reports of drug and alcohol abuse. And, again, those cases will be indicated a higher rate, return to the courts at a higher rate for those. It is putting more strain on the system. As we have to petition more cases to court, it does take more time and effort on our workers' part.

Now we talked about the lack of treatment and services. We are required by Federal Law on the Adoption and Safe Families Act to arrive at permanency for a child within 15 months. That means to find -- foster care is just a temporary placement, even if it's with a relative. We have to return a child home, facilitate or finalize an adoption, or place the child with a willing and fit relative who's willing to provide ongoing care. We have 15 months to do that. If a parent cannot receive treatment within 15 months and be sober during that time, the likelihood of a child returning home is less likely.

**CHAIRMAN SPENCER:**

Wow.

**MR. NOWAK:**

So it's presenting more and more challenges to the Department in finding services, connecting families with services, and supporting the families and the relatives that are now taking care of children in the County.

**CHAIRMAN SPENCER:**

Wow, truly, truly shocking.

**MR. NOWAK:**

Our service delivery for cases that are passed on to ongoing service delivery, our average length of service was about 16 months. In the past year, that's jumped up to 18.5 months. That doesn't sound like a lot, but when you are serving 1400 cases ongoing, that's a big difference.

**CHAIRMAN SPENCER:**

Thank you. Really an interesting perspective for what you go through. And that's just in Suffolk County, I'm assuming, that you're giving -- you're quoting those statistics?

**MR. NOWAK:**

Yes, that's correct.

**CHAIRMAN SPENCER:**

Do you have any information as far as Nassau? Do you work with CPS? Is there any cross-county coordination?

**MR. NOWAK:**

There are times when we will have a secondary role on a Nassau County case, or a Nassau County case -- Nassau County workers may have a secondary role on Suffolk County cases. It all depends where the parent is living at the time and where the child is. So there is some crossover, but not a lot. It really is pretty much separate.

**CHAIRMAN SPENCER:**

Thank you. Thank you very much. Our last member, certainly not least, Tom Schmidt is Suffolk County Methadone Maintenance Treatment Administrator. And if you could maybe give a couple of remarks regarding long-term treatment, and numbers, and how successful it is.

**MR. SCHMIDT:**

Sure. All right. Actually, that's a great place to start. A couple of comments I want to make.

Steve pointed out earlier that people who are addicted are suffering from obsessions and compulsions. And I guess the academic in me wants to point out that because this is about behavior and how people operate, babies are not addicts. They may be drug-exposed, they may be physiologically dependent at birth as a consequence of that exposure. But since addiction is continued use of a drug despite significant adverse consequences, and obsession and compulsion, babies are not addicts. They may suffer the consequences of their mother's addiction, but they in and of themselves are not addicts.

The other thing that concerns me in a general way about these conversations, and I'm glad you mentioned long-term care, is our expectations with regard to chronic illness. There are a few chronic illnesses where we expect a short term of treatment to affect it. By definition, it doesn't effect a cure. It may manage the illness. And we also expect with chronic illnesses there'll be

periods of time where people do well and people don't do as well, and we seldom condemn the form of treatment they're in or the patient when they fail to maintain stability as a result of treatment. And we need to keep that consideration in mind when we're talking about opiate-dependent individuals or people with opiate use disorders, because some of those people may do very well. They maybe achieve abstinence, maintain abstinence for the rest of their lives. Other people will have intermittent problems throughout their life even with treatment.

And then, finally, I work in methadone treatment, which is one of the three medications that is currently approved for the treatment of opioid dependence. Only two of those can be used with pregnant women. We mentioned Buprenorphine is the other. Suboxone is generally not appropriate because it's a combination medication of Buprenorphine and Naloxone. And because the consequences of Naloxone used during pregnancy are unclear, generally, if a woman is going to be maintained on Buprenorphine, they switch to a Buprenorphine-only formulation like Subutex.

Women who are maintained on partial agonists like Buprenorphine or methadone, which is a full agonist, may have children who are born physiologically dependent and need to go through withdrawal when they are born. Not every woman maintained on those drugs will give birth to a child who's physiologically dependent; some do, some don't. It's not correlated with -- I can speak to methadone. I don't know enough about Buprenorphine, but the mother's dosage is not connected to the likelihood or severity of withdrawal in the infant when they're born.

So, all that said, what we do know after roughly 65 years of work with methadone is methadone treatment can be a very effective form of remediation of opioid-use disorders. And I emphasize treatment. We don't just hand out methadone, we do treatment. We have counseling services, we have vocational services, we have psychiatric services.

The other thing I want to mention is while there's an enormous demand for methadone treatment services, and we have an extensive callback list right now, women go to -- pregnant women go to the front of the line, they always have. A woman contacts us for help and they're pregnant, they get admitted within a couple of days. They will be maintained throughout the pregnancy, even if they don't otherwise meet criteria for admission to methadone maintenance treatment, which typically requires at least a year's opioid dependence and being able to prove that, which for us typically means you've been in treatment somewhere before these days typically using medications like Suboxone. So people don't call us at random, they call us because they're looking for methadone treatment.

So, certainly -- but it's important, because I didn't hear that from the audience. People don't realize that methadone -- being pregnant and using opiates is a door into methadone treatment. There is not restrictions with regard to duration or even current physiological dependence the way there would be for other groups of people, and it is still the gold standard of treatment for women who are opioid users during pregnancy.

**CHAIRMAN SPENCER:**

So thank you, panel, for addressing each of those particular issues. I have two questions. And what I'd like you to do, in no particular order, is to just kind of weigh in. And the first question relates to the information that came out in the article in Newsday relating to the discrepancy in terms of two counties, one with a population of 1.5, the other with a population of 1.35 million, but, yet, Suffolk has triple the number of heroin-addicted babies. And there could be some discrepancies in reporting, but we -- it seems that the reporting is pretty straightforward. A baby comes into a hospital that is showing Neonatal Abstinence Syndrome, it has to be reported.

So I don't necessarily buy that, explaining the discrepancy. We understand that -- I heard in testimony that it is -- heroin use sometimes can be -- seemed to be more prevalent among higher

socioeconomic status individuals in the suburbs, and I heard white women. But I know that also in Nassau County, there is on the North Shore, the Gold Coast, there is a particular high concentration of wealth. I see there perhaps, maybe at least for me just thinking about this, just at a glance, logically, that, you know, maybe we would see maybe 20%, 30%, but 50%. But to have triple the number, you know -- and that leads me to my second question, and we'll answer each of the questions separately, would be what can we do here in Suffolk County today? Give us policy, give us information as Legislators. Give us information for our health centers that we can put into effect to address this problem.

So my first question is why do you think there is the discrepancy? And, Lisa, since you were speaking so eloquently and I had to do the Chairman's prerogative and interrupt you, I'll let you answer that question first. What do you think we could do? I mean, why do you think there's a discrepancy?

**MS. CLARK:**

I do think some of the discrepancy has a little bit in recording, you know, in the sense how the State collects the data on the diagnosis you're discharged with may possibly have a little discrepancy. But I agree with you, that there is a bigger -- seems to be a bigger number of population having withdrawal. In our nursery, we have lots of babies every month that are experiencing withdrawal.

The population, I don't know the population data. Could it be that we have more adolescents, young women, you know, 20 -- you know, 15 to age 30 in our population, as opposed to Nassau County, because we're looking at population data? I don't know. We'd have to look at that to see if there's more population.

And what we can do is really an emergent need for now. We have very limited resources that we know about. I think that Suffolk County could probably create some kind of guide in pregnancy use for treatment, not just the methadone, but all the treatment services, outpatient clinics, outpatient services for drug and withdrawal, because we really don't see -- every day we try to call and look around, and, you know, what providers are treating this, what providers will take this. And the social work really has a very large amount of services to provide, trying to figure out where we can send these women. But the data really says that you're looking at high school and young adult populations, so maybe that could be where the discrepancy lies, not just access.

**CHAIRMAN SPENCER:**

Thank you. Thank you. Before I ask the second person, we have -- we're privileged to have our Suffolk County Commissioner of Health, Dr. James Tomarken, who's also here. And any time he wants to weigh in, he gets to weigh in, so he's asked. So thanks, Dr. Tomarken.

**DR. TOMARKEN:**

Thanks. I want to advise you of some recent activity that the Department has taken. And I have had open discussions just the other day with the DSRIP people at Stony Brook and their OB and Pediatric people, because what we want to do is we want to integrate the need that we've all, all the professionals here have discussed into mainstream health care. We wanted to get it -- we want to get it into primary care and behavioral care, and we don't want it out as a separate entity carved out of medical care.

What we want to do eventually, hopefully, is to have a central referral source. So whether you're a doctor in your office, you're at the methadone clinic, or a mental health clinic, or a hospital, you pick up the phone, there's one number to call, and you get a variety of services, you get assessment, you get into methadone within a day or two. That's what we're trying to establish. Now this is -- this is going to take some time, needless to say. But part of what DSRIP is about is integrating behavioral health and substance abuse problems into primary care. So they've been -- they're excited, they're

interested. We have a meeting scheduled early in January. There'll be more updates and more development. But that's the course I think that this should take.

This has been -- and I've done this, been involved in this work back in the '80s where we had methadone programs for pregnant patients, completely separate from medical care. OBs weren't involved except at the end, etcetera, etcetera. That's not the way it should go. It should be an integrated health care approach, and that's what we want to do. And because DSRIP is involved with all of the health care system, and then SHIP will come along after that for the other population, that's where it belongs. And they're embracing it and then we're going to work forward on it starting on the first of the year.

**CHAIRMAN SPENCER:**

And just for the record, the DSRIP, the Delivery System -- what's the R? Incentive Program, but --

**DR. TOMARKEN:**

Reform.

**CHAIRMAN SPENCER:**

Reform. Delivery System Reform Incentive Program. And, really, what we're seeing is that the Federal Government CMS is spending a lot of resources into figuring out how we can practice and deliver health care.

**DR. TOMARKEN:**

And the important -- other important point to make is that we want to see -- we want to identify and get people into treatment before they give birth, and we want to support them after they give birth, because these mothers are very vulnerable, the children are very vulnerable, and we need ongoing involvement and support after they give birth.

**CHAIRMAN SPENCER:**

Thank you, Commissioner, really appreciate that. Steve, what do you think? How come Suffolk is an outlier? How come we're doing three times as -- you know, I guess worse than Nassau? What are your thoughts?

**MR. CHASSMAN:**

Very concerning statistic, 105% increase in five years. And if this opiate epidemic or crisis has done anything, it's highlighted some of our flaws in our health care system. I can only speculate why Suffolk County -- you and I are in and around Huntington. Depending on where you are, Huntington or Huntington Station, it can mirror suburban life, even urban life, and as you head out east, you have rural life. So you have a whole bunch of different demographics kind of coming together and socioeconomic backgrounds. Access to care is always the question, but I'll speak to you as a health care professional how you stop epidemics.

We always think in terms of micro, mezzo and macro. Micro: When we do screening, brief intervention, referral to treatment, we need to ask the right questions of young women. Are you pregnant? If the answer is yes, can we help you get to prenatal care? Can we help you do, you know, options planning for getting medical assistance and opiate treatment, or treatment for opiate dependence? So on the micro level, putting a whole host of support around young women.

As was said up and down the line here, you're dealing with people who are sick with a psychiatric condition called Substance Use Disorders that do not have highly evolved coping skills for fear, for pain, for -- and keep in mind, they are addicted to the most powerful anesthetic on the face of the planet. So, in a lot of ways, like all people with psychiatric conditions, void of logic and reason.

So micro, we need to ask the right questions. An agency like ours, LICADD, we're A and B on the road to C to Z, so we make 500 referrals a month.

Second to that is Mezzo, community education and prevention. We need to go out, and LICADD speaks to over 30,000 students a year from Montauk to Huntington, letting young people know, not just young women, but young men and women, that there is help out there, that there is treatment available, working, as Dr. Reynolds said, to stamp out the stigma of addiction, that this is a disease, and there is treatment. And if you find yourself pregnant and alone, or pregnant and addicted, that there are a host of services in Suffolk County and the greater Long Island that can help you. So community education and prevention is key on the mezzo.

Macro: We need to red-carpet, for lack of a better term, make some policies, or maybe carve out some holes in policies so that we can red-carpet young women, despite legal and social fears and consequences potentially, because the health of their unborn child is at stake. Allow them through policy, through public service announcements, let them know that they will be welcome in hospitals and prenatal care, and a whole team of doctors and health care professionals will support them and their unborn child, so that health and wellness is really the end goal here.

**CHAIRMAN SPENCER:**

Wonderful, very well said. I'm going to go to the opposite end. Tom, you were the last to give your introduction. Why is there a discrepancy in Suffolk County, from your perspective, from what you see in the treatment situation, and what else can we do to maybe prevent drug-addicted babies in Suffolk? What could we do now?

**MR. SCHMIDT:**

It's a little beyond the scope of my expertise, but I would suggest --

**CHAIRMAN SPENCER:**

Your opinion is very important.

**MR. SCHMIDT:**

As suggested already, there may be some demographic issues here where we have a younger population. We do have -- we may have a younger population here. I'm going to speculate that the folks at Stony Brook are seeing people who predominantly live in Brookhaven Township.

**MS. CLARK:**

No, we can get them from all over Suffolk.

**MR. SCHMIDT:**

Okay. All right. The reason I say that is when we look at our population in terms of where people live, it's shifted from up here in western Suffolk. I grew up in Brentwood and the Town of Islip used to be the epicenter of heroin use and opiate use in Suffolk County; it's now shifted to Brookhaven Township. So I think --

**CHAIRMAN SPENCER:**

Brookhaven, yeah.

**MR. SCHMIDT:**

And growing up, Brookhaven was the woods. So that's a big difference between now and then, and it may partly explain what's going on here.

I also -- as much as underreporting might not be a problem, I'm troubled by the fact that, you know, there are New York City counties, and certainly they're part of this epidemic as well, that have

lower rates than Suffolk County does. And that surprises me, even just in terms of the absolute numbers, given their higher populations. There may be some reporting issues here as well. I'm more a treatment person than a prevention person, actually.

**CHAIRMAN SPENCER:**

Thank you. Thank you. Dr. Reynolds, what are we doing wrong? What can we do better?

**DR. REYNOLDS:**

So, you know, at every step along the continuum, there's things that we can do differently. You know, you and I have talked extensively about provider education, and we did a round of that around I-STOP and overprescribing, yet, still, the CDC says that one-third of women between the ages of 15 and 44 have gotten an opioid prescription once a year. And so 30% of women out there are being prescribed opioids for probably chronic pain, rather than acute pain, so we know it's an issue.

When it comes to provider education, more and more you hear OBGYNs say, "Look, if you're struggling with a problem, that's specialized care." You need to go somewhere that can manage very, very high risk pregnancies. And so I think -- and it's not all that complicated, it's not all that specialized, particularly for a round of prenatal care. And so part of this is educating providers about how to have that conversation, and actually convincing them that they can manage these pregnancies in a way that makes sense.

The collocated services piece is really important. And, yes, there are resources here in Suffolk County that are available for women who are pregnant and parenting, but there aren't enough of them. And so if you call Morning Star, very often you're going to be told, "We don't have any beds available." If you call Phoenix House, you're going to be told, you know, "Can you call back tomorrow, we might have somebody who's leaving." That's not the way to put together a responsive system of care where you provide treatment on demand. We want to make sure that every service is collated, that child -- collocated, that child care is available, and that folks have -- don't have to go to five different organizations to get the help they need.

Finally, you know, the recovery support piece is really important, and while it's really important for young men, and we've talked a lot here about recovery homes, how many homes exist for women and their children when they leave the hospital that are safe and secure? And so all of the same problems that we've encountered and been talking about for the past decade when it comes to managing a crisis have now come home to roost and are twice as bad when we talk about women and their kids.

The last thing I'd say is the funding remains an issue. Treatment is less available today in Suffolk County than it was five years ago, and is even less available today than it was 60 days ago, because we're losing treatment slots. The fact that Tom mentioned that he has a call list where people are waiting for methadone treatment is craziness at the height of a crisis, right? We'd never allow that to happen for any other disease. And so, you know, for a decade we sat around scratching our heads, saying, "What could we do, what could we do, what could we do?" The answers are here. We know what works and what doesn't. We have to find the will to get it done.

**CHAIRMAN SPENCER:**

Thank you. Back to the other end. Dennis, Child Protective Services, is there anything we can do on that end for children, as far as what can we do, children having babies?

**MR. NOWAK:**

First of all, to start, we support preventive services and treatment, because by the time it gets to us and we are taking a child into protective care, it's too late. We want to prevent that up front from

happening, so that we receive fewer calls from hospitals of drug-addicted parents giving birth to children. So that's part of the solution.

Once it gets to our point, we definitely need more supportive services for families that are taking care of the children. Again, we are required to seek permanency for children. Whether it's with relatives who are adopting or return to family, they all need supports. So additional supports in the community are definitely needed for these families to wrap around them.

Could you imagine? It's difficult enough taking care of a newborn. Now you are a relative, let's say a grandparent or an aunt and an uncle taking on the responsibility of taking care of a newborn while you are concerned about your son or daughter who are addicted, so you're dealing with that issue as well. So it's a double-edge problem here, so the supports are needed.

**CHAIRMAN SPENCER:**

Thank you. Thank you. More support. Dr. Milana, what do you think from your perspective, running a nursery? What are we doing in Suffolk, maybe compared to at Stony Brook, versus what they're doing at Nassau University Medical Center? Does that have -- is there an impact on reporting there? What's your opinion about the discrepancy that would be so disproportionate?

**DR. MILANA:**

You know, I really don't know. I wish I had a good answer for you on that one. To be honest with you, I'm not sure why it's so much different here than it is in Nassau County. I grew up in Nassau County and I live in Suffolk County now, and I'm not sure what the difference is or why it would be so different out here. I can tell you, in addition to being a physician, I am also the mother of three children who are preteen and early teenagers who are growing up in this County and it scares me to death every day. So I wish I had a good answer for you, but I don't on that one.

I do have some thoughts about things that we could do to help, you know, these kids who are out here, because I'm not -- I don't just do babies, I do older kids, too. And I think we do really need other services out there. I think the idea of having some sort of centralized location that we can go to for people who are in the hospital is a fantastic idea. It's something similar to what New York State does now with it's quit line services for smoking. You call one number, you are sort of hooked up with the services you need, and these people will then follow you up.

So one of the problems I have now, when I send moms back out into the community, or even older teenagers back out into the community, is we can give them referrals. I can say, "Here, this is where you're going to go." We can hope that they will get you in, but I never really know for sure what happens to them after that. Sometimes they don't have a bed available. Sometimes it's days and days before they actually are able to get into the treatment plans that they need. And in that time, I think you're losing a lot of ground. You know, if you have to wait -- if you're motivated to quit and you have to, say, wait a week, maybe two weeks, odds are you're not going to quit, you're going to go back to doing what you're doing.

So I think just having the services more readily available, having more of them. And I think it goes beyond just drug replacement therapies. I think you also need the other services. I think you need counseling, I think you need support.

**CHAIRMAN SPENCER:**

Thank you. Last, but certainly not least, Judy is our Social Worker. What's your opinion?

**MS. RICHTER:**

Again, I agree with everything that was said, but I don't really have an answer as to why Suffolk County is higher than Nassau County. I do know, though, when people do come into the ER and

they are looking for addiction services, I, nine times out of ten, cannot find them a bed that day, and that's very discouraging, because if they're there, they're in a crisis, they want treatment. And when I have to send them away and say, "Well, maybe there'll be a bed in five days," that's not satisfactory, that person is really at risk.

And I think that what also goes underscored, is we don't really talk about the medical aspects of addiction, we never hear about that, but people that are addicted are suffering severe medical aspects. They are having heart attacks, they are having compartment syndrome, they are intubated. There is a whole host of serious medical conditions from the use of heroin that we are seeing at the hospital. And not only -- also, with the babies that are being born, you know. And it's costing hospitals a lot of money for the treatment in the County, and we really need to have access to services improved, and also be able to follow these moms and babies when they leave the hospital, and have a place for them to go that is safe.

I know, in doing some research, I don't know if it was Tennessee or Alabama, but two of the neonatal nurses actually started a residency for babies that were addicted and their moms, because they felt that it was kind of like a subacute type of facility. But they felt that they could be treated better in those types of facilities than they could be at the hospital, because they didn't have all the noisy machines from the hospital, and they just felt that they had better outcomes there.

**CHAIRMAN SPENCER:**

Well, I think that I -- this panel can be kind of a beginning of this conversation. And what I'd like to do, we have the technology to -- we reacted heavy to the panelists -- kind of be involved in a continuing online conversation that we'll have, and where, you know, my office will coordinate it, and where we'll have kind of an online blog as you have information that you find out, or things that you want to share. And it gives you a direct connection with your -- with the Legislature, too, but I think that if we have a blog where as we have suggestions that each of us will receive that information and we can weigh in.

This conversation has to continue, number one. I do think it always begins with shedding light on the issue as always the most important thing. And so I'm very appreciative to the members of the press for taking this up, to Newsday who brought the story to our attention. We're going to be continuing with Legislator Calarco's initiative as we look at the pharmaceutical companies that are making billions and billions of dollars, and, yet, you know, I think they have to be part of the solution, they have to provide resources to the solution. I know the Presiding Officer has made this a priority and he's very much interested.

So I do -- you know, there are some out-of-the-box ideas where we -- you know, do we have to get to a point where we're -- as part of the prenatal workup, are we doing some basic tox screening on everyone? You know, that way it's fair. Is there -- are the economics there to justify it in the medical community to where we could identify expecting mothers early, and will that have an impact on it? I do think that it's very widely known that you shouldn't drink when you're pregnant. It would seem to be common sense that you shouldn't use drugs, but there does seem to be a more common prevalent message about drinking and pregnancy. So there is a role for education, to make sure that -- you know, there's the sense that perhaps maybe because it's a pharmaceutical, if you're talking about opioids, that maybe the perception that it's not placing the baby at risk. So getting that education out into the community is also very important.

I think Nassau has a very beautiful program for mothers, that it's kind of a safe community to where they have centralized services, both with regards to social and health care, and they're protected by the police. And these are mothers that are involved in domestic incidents and who are drug-addicted, and things like that. And I had a chance to visit their program, and, you know, maybe we could look at something like that here in Suffolk County.

So I do think that we're not going to solve the issue today, but I do think that we've made a significant step in starting the conversation and heading in the right direction. And so for that, I'd like to thank our distinguished panel, really, for your time, for your expertise, and I look forward to working with you into the future. Thank you very much. Let's give them a big hand.

**(\*Applause\*)**

What I'd like -- and I do think for the panelists, if there are members of the press who would like to speak to them or have one-on-one interviews, if you would make yourself available. I know Newsday, News 12 is here, and, again, I think NPR Germany is here, too. So thank you. ADK? Okay. ADK, I apologize, not NPR.

**AUDIENCE MEMBER:**

Not me, I'm Newsday.

**CHAIRMAN SPENCER:**

Okay. You're Newsday, okay. So we have several members of the Administration that's here regarding a particular issue. I do want to be respectful of their time. I know they are here to talk about I.R. 1939. And I think there's a request that we cover the agenda, is that what it is? Out of order?

**MS. ALEXANDER:**

Yes.

**CHAIRMAN SPENCER:**

Okay. So thank you. I appreciate Commissioner Tomarken for being here. I saw, I know, several members of the Administration, Deputy Executives who are here. So they did request that they could come and join us today. Did I see Jon Schneider? Who is -- who's directing the team? Jennifer, are you directing the team, or is it Dr. Tomarken? I'm going to request that you come forward at this time, if you wouldn't mind. Hi. Dr. Tomarken, thank you again for being here. Jen, it's good to see you. You have -- you're here, I understand, to kind of discuss I.R. 1939 and give us some perspective on the issue; am I correct?

**DR. TOMARKEN:**

Yes. It's both 39 and -- what is it?

**CHAIRMAN SPENCER:**

And 93?

**DR. TOMARKEN:**

It's 1990 and 1993.

**CHAIRMAN SPENCER:**

Yes. Okay, yes.

**DR. TOMARKEN:**

I just want to give you some background. And these are two health centers that are in -- the leases have expired, and they need either to find a new site or to be renovated. We have the opportunity, again through DSRIP, to have a matching grant for a substantial amount of money to do this work. We submitted the grant early in the year, and we're told that it would -- we would hear some time in the spring. For several times the State has delayed and still to date has not yet awarded the grant, but it's our responsibility to -- in order to maintain our high rating with the grant, to have the funds

appropriated, and they were passed in the Capital Budget in the earlier part of the year. So we're just here to get them -- get the funds appropriated so that if we get the grant, that we have the matching funds available.

**CHAIRMAN SPENCER:**

So what's the deadline? So it's critical. I can see from your presence here that this is passed and that it's passed in the next General Meeting. So what's the consequence if it's not passed now? Well, I'm sure it puts the grant in jeopardy. What's the deadline that we're looking at?

**DR. TOMARKEN:**

Well, our understanding is the appropriation has to be done this year.

**CHAIRMAN SPENCER:**

Oh, I see.

**DR. TOMARKEN:**

By the end of this year and --

**CHAIRMAN SPENCER:**

It's in the Capital Budget.

**DR. TOMARKEN:**

Right.

**LEG. CALARCO:**

I think the issue, Dr. Spencer, with these two resolutions is that there are identified offsets to pay for the two projects out of this year's capital budget, and this was something the County Executive, I think, identified when he presented his budget to us in the spring, that he was going to be pursuing these two projects in this current year using offsets. And so if we don't appropriate the money in this current year, then he would have -- we would have to find offsets in next year's budget, because this project is not in the Capital Budget for next year.

**CHAIRMAN SPENCER:**

So these two resolutions, 1990 and 1993, one is, you know, Wyandanch, one is the new Patchogue Health Center. Is there any differences between the two as far as the program and the matching funds, as far as -- I know they're different geographic locations, but are these resolutions identical other than the amounts and the location? Is there any difference in terms of the --

**DR. TOMARKEN:**

No.

**CHAIRMAN SPENCER:**

No.

**DR. TOMARKEN:**

Just the differences you mentioned.

**CHAIRMAN SPENCER:**

Okay. All right. George, how much are the -- are we appropriating in these resolutions?

**MR. NOLAN:**

Well, Wyandanch is 6.8 million, and the -- Patchogue is 7.5 million.

**CHAIRMAN SPENCER:**

Is that the -- that's the amount that will be matched in each of those?

**MR. NOLAN:**

That's our amount.

**DR. TOMARKEN:**

Yeah, it could be up to that amount. We don't know what will be required. But whatever is granted to us, we have to meet that match, and that's what we asked for in the grant, or was asked for.

**CHAIRMAN SPENCER:**

What -- and when will we find definitively what we're going to receive? And so we want to -- we want to get as much money as possible, so we're trying to make the best of -- is that why Gil is here? Is he -- usually, if I see the Commissioner of Public Works -- are you involved in this particular --

**COMMISSIONER ANDERSON:**

No.

**CHAIRMAN SPENCER:**

No, okay. So what is the plan? How were those numbers arrived at?

**DR. TOMARKEN:**

It's a 50-50 match.

**CHAIRMAN SPENCER:**

I get that, as far as we're looking to -- what are we looking to do in those particular facilities?

**DR. TOMARKEN:**

In Patchogue, it would be a new location. And whether it would be a build or rent and renovate a different location, it still has yet to be determined. And in Wyandanch, it could be the same, it could be a new location or it could be a renovation of the existing location. And some of this is predicated on how much money becomes available as to what makes -- what's fiscally doable and how -- what different options are available, what properties are available or aren't, etcetera, etcetera.

**CHAIRMAN SPENCER:**

I guess what I'm trying to ask -- I understand what we're doing and I understand the benefit of it. How did -- you know, we're looking to build or renovate, but we've got a very specific hard number. How is that hard number derived. Because I have read the resolutions, but how do you -- you know, you're looking at Wyandanch, 6.3 million. Why not 10.5, why not 2 million? How did we come to this? Is this appraisals? Is this real estate in the area? What's the plan?

**MS. CULP:**

I believe it was based on, you know, estimates on a certain square footage of a medical facility, looking at the number of patients currently served, the goal of serving more patients. It's also expanded services. So you're looking at some dental, you're looking at maybe urgent care, behavioral and mental health care. The goal of DSRIP is to decrease, you know, unnecessary hospital admissions over five years. So with that goal, we're going to expect that folks will be seen more in the community than showing up in our ER, so it's about expanding those services, too.

**CHAIRMAN SPENCER:**

How competitive is the money that we're looking at? Because I'm sure that -- you know, are we -- you know, so if -- is it highly likely? I know you can't tell me we're going to get the money or not, but we got a particular number. Someone in the Federal Government would say, "Well, to build health centers in Suffolk is very expensive, you know, I can build four health centers for that money elsewhere, but I know there's a geographic need." So is this in line, these estimates in line with what they're looking for?

**MS. CULP:**

Yes. And we can -- and Stony Brook, as you know, is the lead for the DSRIP program here in Suffolk County. For the capital part of it, there were 34 submissions, and these applications ranked number two and three, and a lot of that is, you know, because of the match and the need in the community, that it really matches what DSRIP needs in terms of the community access to care.

**CHAIRMAN SPENCER:**

So out of 43, these were ranked --

**MS. CULP:**

Sorry, 34.

**CHAIRMAN SPENCER:**

Out of 34, these were ranked the second and third as far as --

**MS. CULP:**

For Suffolk County.

**CHAIRMAN SPENCER:**

Really? You should probably lead with that information.

*(\*Laughter\*)*

All right. Well, that's -- I think that's really important. Legislator Trotta.

**LEG. TROTТА:**

Correct me if I'm wrong. Didn't we get rid of our health centers?

**MS. CULP:**

We have transitioned out of the direct care of our health centers. But with the other health centers, the County remains committed to the facility, the sites. So this is in line with the other transitions. Yes, we don't provide a direct service, but we still are partnering with HRH in terms of sites, and facility, and space in the other health centers.

**LEG. TROTТА:**

Earlier this year they came before us and said it's going to save, whatever, a million dollars a year or \$5 million, and now we're here spending \$15 million. When that person, the HRH came here and said we're the only place, the only county that pays for the rent, or pays for the facilities, every place else they have them, they pay. So now they're coming to us and we're saying this? This is ridiculous, this is absurd. I would never vote for this in a million years, and the taxpayers should be outraged that this is happening. Done.

**CHAIRMAN SPENCER:**

He's done. Legislator Trotta is visibly upset. All right. Legislator Kennedy.

**LEG. KENNEDY:**

Hi, folks. I know we need our health centers, but I'm looking at 14-plus million in bonding that we will use if we get the match; am I correct?

**DR. TOMARKEN:**

(Nodded yes).

**LEG. KENNEDY:**

Okay. So that's over 28, close to 29 million for two buildings. I could probably go out and find it cheaper for you. This is a lot. We're past our credit card allotment in Suffolk County for bonding. We are in debt. To do both of them at the same time, to bond out for both of them, we have to be a bit more conservative. Pick one this year, and in two years or three years, we'll do the other. I can't do it at this time.

**CHAIRMAN SPENCER:**

Legislator Browning.

**LEG. BROWNING:**

No, no.

**CHAIRMAN SPENCER:**

Oh, you don't have anything?

**LEG. BROWNING:**

No.

**CHAIRMAN SPENCER:**

If -- Dr. Lipp, this is to you. If we get this funding, then we don't have to -- then it's covered in the budget for next year, right? It's part of -- is that what --

**MR. NOLAN:**

No, no. I think if -- if it was 50% funded, I don't think you would have to get -- need an offset, necessarily. You would have to -- you would still borrow the money, but you would not need an offset. These actually have offsets in this year's capital budget and program.

**CHAIRMAN SPENCER:**

So next year there would not need to be an offset?

**MR. NOLAN:**

Any project that is receiving 50% State or Federal Aid, you don't need an offset to fund it, that's all I'm saying. It's probably better to have offsets.

**CHAIRMAN SPENCER:**

Can you address for me, either Dr. Lipp or Jen, the offsets that are in the proposals? There's, I see, renovation to Surrogate Court. Are these -- rehabilitation of parking lots, sidewalks, new -- are these capital projects that are being closed out, or that are being delayed? The purchase of additional helicopters that, you know, we're not getting helicopters?

So I see in these the offsets that are being offered for this money, and I see some specific projects. Are these projects that are being deferred because we no longer need them? Are they projects that are -- that are no longer relevant at this particular point? What can you tell me about what we're offsetting.

MR. PAGLIA:  
Okay.

**CHAIRMAN SPENCER:**

And can you introduce yourself? I apologize. And tell us who you are and what you do. And I apologize that I don't recognize everyone that should. I've seen you before, but I just --

**MR. PAGLIA:**

I'm Nick Paglia from the County Exec's Budget Office. I work mainly on the Capital Program, all things Capital, I guess, Capital resolutions, purchase orders, contracts, and such, and put together the Capital Program also.

So the first offset, CP1133, renovation to Surrogates Court, that project has been put into the 2017 Capital year. So that 700,000 was moved out in the 2016 adopted Capital Budget. So that 700,000 is still in the program, it's just in 2017.

**CHAIRMAN SPENCER:**

Okay.

**MR. PAGLIA:**

1678, rehab of parking lots, a million dollars was appropriated this year. There is 500,000 still on the table. The new jail, of course, that project has been put off, I guess, for a few years, or indefinitely. The helicopter, Capital Project 3117, that's been paid for. That 1.3 million was put in the program as a -- I guess, as you could say, a placeholder in case there were cost overruns in the helicopter. They got the helicopter, and I believe they also got a very good trade-in on their existing helicopter that went out, so that 1.3 is available.

**CHAIRMAN SPENCER:**

How much does a used helicopter go for these days?

**MR. PAGLIA:**

I have no idea, as long as it flies.

*(\*Laughter\*)*

**CHAIRMAN SPENCER:**

All right. So this is -- so projects that are either being deferred or it's surplus money for projects that we didn't use. There's nothing that we're putting off that's a critical infrastructure issue that we should be addressing, and that's what you're representing to us from looking at this? We're not --

**MR. PAGLIA:**

Yes, absolutely.

**CHAIRMAN SPENCER:**

Okay. And so what happens if we don't do it, we lose the money, and we don't do these? Give us a sense of, you know -- say we don't have the money, we don't do it, we don't get the Federal money, what's the consequences of that, from just a -- you know, obviously, HRH, will they -- the centers not move forward? Will they stop? How critical is this repair or these renovations?

**DR. TOMARKEN:**

Well, I think it would be best if the contract people address that.

**MS. SEIDMAN:**

Hi. Good afternoon. Phyllis Seidman from the County Attorney's Office. So we do, if you remember, have a contractual obligation under our five-year community benefit grant contract to provide adequate space. And as probably you all remember also, the leases at the two health centers in question have expired. So with that, and with the opportunity that DSRIP presented, we thought it was probably incumbent upon us to move on that, because any move would not be, you know, into a place we could directly lease that's set up to house HRH's operation. So, you know, that's why we're at this point.

And I think it's important to remember also that over the five years of each HRH contract, we are saving under a care approximately \$77 million. Excuse me, I have something in my throat. So I think, really, that underlies this whole operation, that we are saving so much money. And we do have an opportunity to house them. And we did not go in this to get out of the health care business, per se. We got in it to get out of the direct care business.

**CHAIRMAN SPENCER:**

Phyllis, if we passed this and we're ranked one, and two and three for these projects, but let's just say we don't get the money, are we -- what do we do then? Do we have to come up with the rest of the money? The project, does it end? So, I mean, I have to think. I have to look at it as like, all right, it's a great opportunity for us to get a match from the -- from the government. We're in a favorable position. So if we don't get it, do we get our money back, and do we not -- is it the same consequences if we don't pass this resolution, or are we on the hook once we move forward with this, and then we have to find offsets for another \$13 million?

**MS. SEIDMAN:**

Well, I think, either way, we have to put some money --

**MR. NOLAN:**

Your mic's off.

**MS. SEIDMAN:**

Sorry. We have to put money into relocating the two health centers. As I said, it's either, you know, we pay a premium to a landlord for a build-out --

**CHAIRMAN SPENCER:**

No, I get that.

**MS. SEIDMAN:**

I'm sorry, did I misunderstand?

**CHAIRMAN SPENCER:**

But my question should have a very, very specific answer, and I -- Dr. Lipp, if we don't get the money, does this project -- do we have to then find offsets for the other half, because these are estimates for half? Or is there anyone from the Budget Office? I understand that we -- I understand your perspective from a social, administrative policy point of view, that this is something that we need to do, but I'm talking about from the practical. Tell me what happens. If we approve this and we do not get this money, what happens? Can anyone answer that question?

**MR. LIPP:**

Our understanding is they're not going to bond it if they don't get the grant. I'm not sure, though; is that correct?

**MS. CULP:**

That's correct.

**MR. LIPP:**

Okay.

**CHAIRMAN SPENCER:**

Okay. But if they do, I could explain what -- if they do bond it, I could explain what that means with or without the grant, if you'd like.

**CHAIRMAN SPENCER:**

Sure, that would be great. So I'm going to assume, which is probably a good assumption, that it would be a 15-year bond, okay? If we look at both items, both resolutions, the -- what was it, Patchogue and Wyandanch? Okay. And I believe the total is 14.3 million total price. If we assume that we're going to get the grant, that would be half the action, or 7.15 million would be the principal that we'd borrow. If we borrowed it all at once, it would be like nine-and-a-half million dollars total. About 600 and -- a little over 600,000, maybe 630,000 a year for 15 years would be what we're looking at. And, as they said over there, that would be -- basically, one way to look at it is it's a reduction from the overall savings that have been estimated going from our County staff providing the service to HRH providing the service.

**CHAIRMAN SPENCER:**

And I just wanted to make sure. So I understand what you're saying there, but what I'm hearing, and correct me if I'm wrong, is that if we don't approve this, we don't get the grant, we lose a big opportunity to bring in money, and we have major infrastructure in these two communities that's not being met, and that's the consequence. If we do get it and we don't get the DSRIP grants, then we put the money back, we don't bond it, is that -- or is the money lost, once we start? That's what I'm still -- you know, are you saying to me that if we don't get this, we don't get the money, that we can --

**LEG. CALARCO:**

My understanding, Dr. Spencer, of what they're looking to do here is to have these appropriations made so that the funding line is preserved, but they're not actually going to be bringing us the bonding resolution on Tuesday, and the bonding resolution would only be coming over to us at such time that the DSRIP grant is awarded. So I would say that if for some reason the State grant does not become awarded, then we're going to have to evaluate our priorities and our ability, you know, what we're going to do and where we're going to go with these two projects. I know that both are, you know, vital to get done to be able to continue to provide services in the communities that they -- that the services are being provided, and both are in what are basically substandard and dilapidated buildings now in locations that are not so conducive to the economic development that both communities are looking for.

**CHAIRMAN SPENCER:**

Thank you. Legislator Kennedy.

**LEG. KENNEDY:**

Just a couple of questions. Refresh my memory. How long was the contract with HRH that we would keep the -- that we would maintain the buildings, how many years?

**MS. SEIDMAN:**

Well, all of the subsidy contracts are for five years.

**LEG. KENNEDY:**

Okay.

**MS. SEIDMAN:**

So, You know, some started in 2012 --

**LEG. KENNEDY:**

Okay.

**MS. SEIDMAN:**

-- through this year.

**LEG. KENNEDY:**

Okay. Each of these projects, should we get the money -- and I don't even know who I'm asking this to. Should we get the match, each of these projects we would own the property and the building?

**MS. SEIDMAN:**

I think that's yet undecided. Those are the decisions we're making now. You know, we are looking at different possibilities. We're looking at different parcels.

**MS. CULP:**

Right.

**LEG. KENNEDY:**

To be perfectly honest with you --

**MS. CULP:**

At this point, we're looking to appropriate these funds so that we keep our momentum going in order to stay in a good place to get these capital funds from the State. When that decision is made, we'll be able to come back for the bond, and we will then have the proposal as to what it's going to look like in both Wyandanch and Patchogue, and where these locations would be. Would there be renovations? Are they leasing, buying? All those decisions will be made once we really see the awards come down.

**MS. SEIDMAN:**

And all of those transactions require further Legislative approval, as you know.

**LEG. KENNEDY:**

I am aware. We will have no problem spending as a County the 14 million, I am sure, should we not get the grant. Is there any way we could choose one this year, and in a year, or two, or three apply for the other?

**MS. CULP:**

No. I mean, the capital projects are -- the applications are in now, so decisions will be made, you know, across the state at the same time, is my understanding, so --

**LEG. KENNEDY:**

The State offers all these grants periodically, two years, three years.

**MS. CULP:**

No. I mean, this is specifically under DSRIP. This is capital funds available under the DSRIP program with goals of reducing unnecessary hospital admissions, you know, by 25% over five years.

**LEG. KENNEDY:**

That's been going on for a long time. And I have great faith that the same grant will be offered in two to three years where we can change our Capital Program, maybe do one in here. We can't keep spending like drunken sailors, we really can't.

**CHAIRMAN SPENCER:**

With our contract currently, so if we do this, we have the -- I thought at some point with -- once we stopped kind of our subsidy to Hudson River, what happens to the real estate, does it turn into a rental agreement? So the people are purchasing, we're going to get the grants, we're going to do the renovations. Does it revert over to Hudson River after a period of time, or we -- we maintain the property? Will they turn -- will they start paying us rent to be in our brand new, sparkling, DSRIP-funded, taxpayer-funded facility?

**MS. SEIDMAN:**

Well, I guess it depends on what the transaction actually turns out to be, but I don't think the intention was to charge them rent, it was to provide them with a facility. And since the lease is on the two facilities in which they're currently occupying are up, the idea would be to put them in another facility and continue the same obligation to them.

**CHAIRMAN SPENCER:**

So once our period of kind of providing support ends after several years, aren't they going to be responsible in the future for -- because, you know, they get the federally qualified funds for these centers. Would it be their responsibility in the future to geographically find the location, and maintain it, and own it?

**MS. SEIDMAN:**

For these two centers, are you saying?

**CHAIRMAN SPENCER:**

Yes.

**MS. SEIDMAN:**

In general, we have either leases, or long-term leases or subleases on our other facility, which we are providing to HRH in exchange for them providing health care to the communities. Going forward, we would like to mirror the same deal with them to provide them with a facility. Otherwise, we could not guarantee that we could provide health care --

**CHAIRMAN SPENCER:**

Oh.

**MS. SEIDMAN:**

-- to the community. So, you know, one way or another, the lease with them to provide health care would probably mirror or exceed, depending on what this Legislature decides, the terms of the DSRIP grant. Other grants, HEAL grants, for example, require us to provide healthcare at the facility to which the grant money was applied for 12 years. So any lease with anyone to provide health care at that facility would need to be for 12 years. So I would imagine that the DSRIP grant will contain the same requirements or similar requirements.

**CHAIRMAN SPENCER:**

Okay. Legislator Trotta, then Legislator Kennedy. I'd like to try to wrap it up so we can call a --

**LEG. TROTTA:**

I just want to know, who thought it was a good idea that we're done paying these rents in five years to borrow money for 15 or 30 years? Whose idea? Where did that enter the mind of anybody where that's a good idea? I mean, this County is sinking in debt, and you want to build or borrow money to put someone in for five more years and then pay it off for the next ten? I mean, it's just not logical.

**MS. CULP:**

The CBG is what is five years for each health center, and each proposal varies in terms of the commitment the County has made to the facility spaces. So I believe Tri-Community may have been 12 years, Coram --

**LEG. TROTTA:**

We were told we had to carry their rent for five years.

**MS. CULP:**

No.

**MS. SEIDMAN:**

That's not correct.

**MS. CULP:**

No, no. It's always been the CBGs are five years. The support --

**MR. NOLAN:**

What's a CBG? What does this mean?

**MS. CULP:**

The Community Benefit Grant, which supports the direct operation of those health centers.

**LEG. TROTTA:**

We sat here and I was told that for five years they have to pay for it. They have -- we're paying their rent for five years, and that after five years, they would start taking over, they'd be on their own. I can pull it, because I could remember him saying, "No, it's only five years," and me saying, "Never mind."

**MS. SEIDMAN:**

Well, I don't know who on this panel would have told you that, because that's not the case. We are paying them a subsidy for five years for each health center, and then we have an underlying lease or sublease for each facility, which varies in terms, and which was approved. Each lease or sublease was approved by this Legislature individually.

**LEG. TROTTA:**

The leases we're responsible for is forever?

**MS. SEIDMAN:**

Not forever, they have variable terms.

**LEG. TROTTA:**

What are the variable terms?

**MS. SEIDMAN:**

I couldn't tell you off hand, I don't have them in front of me, but I think they range anywhere from

12 to 20 years.

**LEG. TROTTA:**

That's insanity.

**CHAIRMAN SPENCER:**

Legislator Kennedy.

**LEG. KENNEDY:**

Robert and Craig and -- the are you -- do you know what the traditional duration of a bond on land or bond on a building, how many years are involved?

**MR. FREAS:**

Well, Robert just did a 15-year calculation for this one and --

**MR. LIPP:**

So, if you look at just land, you could purchase land with a period of probable usefulness of 40 years, I believe. We've never issued bonds in my memory for 40 years. What we're talking about with 15 years is regardless of whatever the period of probable usefulness is, we package -- we'll package the bond, when we're ready to go out to bond, along with perhaps 120 other different projects. And what we do is we look at the average of all the periods of probable usefulness, weighted by the principal, and it comes out with the number of years. We're using, for illustrative purposes, approximately 15 years. We were doing -- we were averaging about 18 years, but the last two years less, because there are less land acquisitions and less sewer construction projects, which increased the period of probable usefulness. So 15 is probably like a rule of thumb, but it's not like we're paying just for this beyond the lease where it's a big package of other things that are in there. It could be a lesser amount of years, or it could be a greater amount, but 15 is probably good for discussion purposes.

**LEG. KENNEDY:**

I'm asking this question because I want to know how long the people will be paying for this. So 15, 18 years is your guesstimate?

**MR. LIPP:**

We're using 15 right now, but we need to have some in-house conversations amongst ourselves, and we're also trying to talk to the Comptroller's Office and the Budget Office --

**LEG. KENNEDY:**

Do that.

**MR. LIPP:**

-- about coming to an agreement as to what we should assume.

**CHAIRMAN SPENCER:**

Okay. Thank you very much. I really appreciate you taking our questions. Oh, we're going to recognize the Presiding Officer.

**P.O. GREGORY:**

Thank you, Mr. Chair. And this particular bill, 1990, is -- you know, obviously, it's in my district, and it's of particular concern to me. I used to attend this health center as a child, I used to get my shots there. It is the oldest health center in the system. So I'll be 47 in February, so it's 47 years old or older. It used to be an old supermarket. It was retrofitted, and it's really outgrown its needs. And I happened to be in the north Amityville Senior Center today, talking and meeting with

some seniors. They had a holiday party and I always go by to see them. And a woman from Wyandanch happened to be there, and she asked me, she said, "Well, what's going on with our health center?" And I said, "Well, you're in North Amityville." She said, "No, Wyandanch." I was like "Oh, okay. Well, you know, we're voting on something, we're looking."

So the community is engaged, they're excited about it. It's a real opportunity for them to get a building that suits their needs, and it happens to coincide with and be -- will fit into the overall plan of the Wyandanch Rising project, because it's literally right in the middle of the project.

So, you know, I know there's some concerns. We had some tough budget, fiscal situation, but this is -- the move of this, the facilitation of the move of this health center is going to do the community great wonders, and help provide, continue to provide the great service that we're providing to our residents, and they're looking forward to it. So I hope I can have your support as well.

**CHAIRMAN SPENCER:**

Well, that's the -- that's the point that I think that might be lost. I understand my colleagues' concern with regards to the amount of money that we're spending. And when we were debating the smoking 21 legislation, and we're looking at the cost of loss of taxes to retailers. But when we looked at the impact of health care costs savings, they were astronomical. They were in the amount of billions of dollars over a 20-year period of time.

And when you look at -- when you build, especially in communities, a health care infrastructure, what you do, especially with modern facilities, and I can testify to that from the Dolan Health Care Center, is that when the health care center, you go in and it's -- there are stained ceilings, and cracked floors, and there's a place that is dingy and dark and ugly, it does contribute to just the perception that this is not a great place to be. And when you have people that don't go to the facility, when they don't have the modern machines and the modern processing, it has an impact on health care delivery. And health care delivery and education is essential in terms of prevention and long-term health care.

So, yes, I understand the argument, but we have an opportunity to spend \$14 million in projects, and this DSRIP is really the top issue in terms of how the Federal Government, how the State is looking at distributing health care dollars. We have an opportunity to go out for the taxpayers of this County and get \$14 million to put direct infrastructure, and we have the poorest infrastructure around the country in our roads, and bridges, and in some of our buildings.

And so, yes, we can argue, we can be, you know, a penny wise and a pound foolish, but I believe that this will -- over the future will allow us to provide better health care. I think this will increase productivity in our community, in our workforce. I think this will save us money in terms of treatment for chronic diseases, because it will give us some more opportunity for prevention. And that's what the DSRIP Program is about, and they saw that in order to be able -- and I look at this as President of the Medical Society. I am the current President of the Suffolk County Medical Society, and for us to be able to do this here in Suffolk County -- I think that we're being very myopic if we're looking at this as, "Oh, we don't want to do this now." We have to do this now. This is a great opportunity.

I will be supporting this. I urge my colleagues to support this. So thank you. With that, I'm going to call the vote.

**MR. RICHBERG:**

Mr. Chair.

**CHAIRMAN SPENCER:**

I am going to ask for a motion to take I.R. 1990 out of order, seconded by Legislator Gregory. All those in favor? Opposed? Abstentions? **(Vote: Approved to Take Out of Order 7-0-0-0 - Presiding Officer Included in Vote).**

We have **1990** before us - **Amending the 2015 Capital Budget and Program and appropriating funds for a new Wyandanch Health Center (CP 4088) (Co. Exec.).** I'll -- is Wyandanch in your district, Legislator --

**P.O. GREGORY:**

Yes.

**CHAIRMAN SPENCER:**

No, you're the -- so motion to approve by Legislator Gregory.

**LEG. CALARCO:**

Second.

**CHAIRMAN SPENCER:**

Seconded by Legislator Calarco.

**LEG. TROTTA:**

Motion to table.

**CHAIRMAN SPENCER:**

Motion to table by Legislator Trotta, seconded by Legislator Kennedy. Motion to table takes precedence. All those in favor of the motion to table? Opposed? Opposed. So two in favor -- three in favor of tabling, four against tabling, so motion to table fails. **(Opposed: Spencer, Browning, Calarco and Martinez)**

So motion to approve. All those in favor? Opposed? Opposed. **(Opposed: Trotta, Kennedy and Browning)** Abstentions? Four to three, the motion carries, the motion to approve carries. Presiding Officer is voting. **(Vote: Approved 4-3-0-0/Opposed: Trotta, Kennedy Browning)**

**I.R. 1993 (Amending the 2015 Capital Budget and Program and appropriating funds for a New Patchogue Health Center (CP 4087)(Co. Exec.).** I'll make a motion to take 1993 out of order, seconded by Legislator Martinez. All those in favor? Opposed? Abstentions? **(Opposed: Legislators Trotta and Kennedy)**. We have I.R. 1993. Opposed to taking it out of order (laughter). Guys, come on. **(Vote: To Take Out of Order 5-2-0-0)** All right, so we have two opposed, but it passes to take it out of order.

**I.R. 1993 - Amending the 2015 Capital Budget and Program and appropriating funds for a New Patchogue Health Center (CP 4087)(Co. Exec.).** Motion by Legislator Calarco, seconded by Legislator --

**LEG. TROTTA:**

Motion to table.

**CHAIRMAN SPENCER:**

-- Spencer on the approval. Motion to table by Legislator Trotta, seconded by Legislator Kennedy. Motion to table takes precedent. All those in favor of tabling? **(In favor of Tabling: Trotta, Browning and Kennedy)** Opposed? Opposed to tabling? **(Opposed to Tabling: Spencer, Calarco, Martinez and Gregory)** Motion to table fails 4-3. Those voting to approving table,

Browning, Kennedy and Trotta.

Motion to approve is next. All those in favor? Opposed? Abstention? Motion to approve carries 4-3. Voting against are Browning, Kennedy and Trotta. **(Vote: Approved 4-3-0-0/Opposed: Browning, Kennedy and Trotta)**

So, moving back to the rest of the agenda. Thank you very much for being here. Congratulations. You know, thank you. Happy Holidays.

**TABLED RESOLUTIONS**

All right. Back to tabled resolution: ***I.R. 1564 - A Local Law establishing a Drug Stewardship Program for Suffolk County (Hahn)***. Per the sponsor, motion to table. Seconded by Legislator --

**MR. RICHBERG:**

Hold on.

**CHAIRMAN SPENCER:**

You need to keep up (laughter). Let us know, Mr. Clerk, when you're with us, please, sir. Thank you.

**MR. RICHBERG:**

I'm ready, Mr. Chair.

**LEG. SPENCER:**

(Laughter) All right. And the motion to table, I offered a motion to table. It was seconded by Legislator Calarco. All those in favor? Opposed? Abstention? Motion is carried to table. **(Vote: Tabled 7-0-0-0)**

***I.R. 1605 - A Local Law to increase awareness of dry cleaning chemical use (Hahn)***. Per the sponsor is the motion to table. I'll offer it, seconded by Legislator Martinez. All those in favor? Opposed? Abstentions? Motion is tabled. **(Vote: Tabled 7-0-0-0)**

**INTRODUCTORY RESOLUTIONS**

***Introductory Resolution, I.R. 1939 - Appropriating funds in connection with the Environmental Quality Geographic Information and Database Management System (CP 4081)(Co. Exec.)***. Motion to approve by Legislator Calarco, seconded by Legislator Trotta.

**LEG. TROTTA:**

No.

**LEG. KENNEDY:**

No.

**CHAIRMAN SPENCER:**

No? I saw your hand go up.

**LEG. TROTTA:**

No.

**CHAIRMAN SPENCER:**

Cosponsor, is that what --

(\*Laughter\*)

Seconded by Legislator Spencer. All those in favor? Opposed? Abstentions?

**LEG. TROTTA:**

Opposed.

**LEG. KENNEDY:**

Opposed.

**CHAIRMAN SPENCER:**

Opposed, Trotta and Kennedy. **(Vote: Approved 5-2-0-0/Opposed: Trotta and Kennedy)**

I.R. -- I'm sorry. Oh, they're here?

**MS. HORST:**

It's okay.

(\*Laughter\*)

**CHAIRMAN SPENCER:**

We can reconsider it, it was approved.

**LEG. CALARCO:**

It's not needed.

**CHAIRMAN SPENCER:**

It's not needed?

**LEG. CALARCO:**

No. Move on.

**CHAIRMAN SPENCER:**

There's two ways to pass resolutions, either wait long enough -- (laughter)

***I.R. 1955 - Accepting and appropriating 100% federal funds passed through the New York State Department of Environmental Conservation to Suffolk County Department of Health Services for the State Pollutant Discharge Elimination System (SPDES) Water Quality Management Planning Program (Co. Exec.).*** I'll make a motion to approve and place on the Consent Calendar, seconded by Legislator Browning. All those in favor? Opposed? Abstentions? The motion is carried. **(Vote: Approved 7-0-0-0)**

***I.R. 1969 - Accepting and appropriating 100% federal and state grant funds passed through the New York State Department of Health to the Suffolk County Department of Health Services for the Women, Infants and Children (WIC) Program.*** Same motion, same second, same vote. **(Vote: Approved 7-0-0-0)**

***I.R. 1970 - Accepting and appropriating 100% state grant funds from the New York State Department of Environmental Conservation for Water Quality Monitoring for pesticides in Nassau and Suffolk Counties (Co. Exec.).*** Same motion, same second, same vote; on the Consent Calendar. **(Vote: Approved 6-0-0-0)**

**1971 - Accepting and appropriating 100% federal grant funds passed through the New York State Department of Health to the Suffolk County Department of Health Services for the Early Intervention Administration and Child Find Program (Co. Exec.).** Again, 100%. Same motion, same second, same vote. **(Vote: Approved 6-0-0-0)**

**I.R. 1972 - Accepting and appropriating 100% state grant funds from the New York State Department of Health to the Suffolk County Department of Health Services for the Tuberculosis Prevention and Control Program (Co. Exec.).** Same motion, same second, same vote; on the Consent Calendar. **(Vote: Approved 6-0-0-0)**

**I.R. 1973 - Accepting and appropriating 100% federal grant funds passed through the New York State Department of Health to the Suffolk County Department of Health Services for the Maternal and Infant Community Health Collaborative (MI CHC) (Co. Exec.).** Again, same motion, same second, same vote; on the Consent Calendar. **(Vote: Approved 6-0-0-0)**

We did 1990. **1991 - Requesting legislative approval of a contract award for Peconic Estuary Eelgrass Assessment Services for the Department of Health Services, Division of Environmental Quality (Co. Exec.).** what's that about?

**MR. NOLAN:**

One person responded to an RFP, and whenever that happens, we have to approve the contract by two-thirds vote of the full Legislature.

**CHAIRMAN SPENCER:**

How much money?

**MR. FREAS:**

Eighty-two thousand.

**CHAIRMAN SPENCER:**

Eighty-two thousand. Any questions or concerns with this particular one? All right. We have a motion to approve, Legislator Calarco, seconded by Legislator Martinez. All those in favor? Opposed? Abstentions? **(Vote: Approved 6-0-0-0)**.

We covered 1993. Two hours from start to finish. Thank you very much. Happy Hanukah, Happy Holidays, Merry Christmas, Happy New Year, Happy Kwanzaa. Thank you.

**(\*The meeting was adjourned at 4:31 p.m. \*)**