Introduction and Background

Introduction
New York State Public Health Law 2803-1 requires voluntary not-for-profit hospitals to submit an annual Community Service Plan (CSP) to the New York State Department of Health. As an entity of the State of New York, Stony Brook University Hospital is not required to provide such a report. As an expression of its commitment to the 1.5 million residents of Suffolk County, the hospital has decided to create a CSP for the benefit of the community.

This document represents Stony Brook University Hospital's Community Service Plan. It is the result of a collection of data from a variety of sources, including community partners such as the American Cancer Society and the Suffolk County Department of Health. The CSP is a reflection of Stony Brook Medicine's mission to improve the lives of our community and vision to be a world class academic medical center.

Background and Overview
Stony Brook University Hospital (SBUH), a major academic medical center, serves the healthcare needs of Long Island as the region's only tertiary care center and Level 1 Trauma Center. SBUH is a stroke center, the region's only academic medical center, regional perinatal center, AIDS center, and burn center. Founded in 1980, the hospital is located 60 miles east of New York City and has 603 certified beds. In 2012, SBUH discharged 31,964 patients (excluding newborns), treated 96,021 patients in the Emergency Department, and served 225,793 outpatients. As a premier academic medical center, Stony Brook Medicine is responsible for healing the sick, educating skilled healthcare professionals, uncovering the complexities of disease and discovering new treatments, and reaching out to the community to inform and teach. The hospital fully embraces patient and family centered care, and considers its patients and families to be integral members of the healthcare team.

Suffolk County Demographics[i]

Current Statistics
In 2013, the Suffolk County population is estimated at 1.5 million residents and 502,887 households. The population is 51 percent female and 49 percent male. The 18-44 year age group makes up the largest subset of the population at 33 percent.

The County's ethnicity profile is: 69.9 percent White Non-Hispanic, 17 percent Hispanic, 6.9 percent Black Non-Hispanic and 3.6 percent Asian Non-Hispanic. All other ethnic categories comprise 1.3 percent or less of the total population.

An analysis of Suffolk County's discharges by financial class indicates that 70.3 percent of discharges were Private Direct, ESI, or Exchange, 14.5 percent Medicare and Medicaid dual eligible, 11 percent Medicaid, and 4.1 percent uninsured.

The Suffolk County resident median household income is $82,557.

Demographic Projections
Between 2013 and 2018, we project that the County's population will grow by 1.3 percent to 1,517,063 people, with the greatest growth in the age 45-64 and 65+ cohorts. The number of households within Suffolk County is also projected to grow by 1.6 percent during the same time period.

Demographics Analysis

Suffolk County Households

2013 Households	2018 Households	Growth 2013-2018	% Growth 2013-2018
502,887	510,739	7,852	1.60%

Suffolk County Median Household Income

2013 Median Household Income	2018 Median Household Income
$82,557	$91,130

Suffolk County Population Growth by Age Group

Age	2013 Population	%	2018 Population	%	Growth 2013-2018	% Growth 2013-2018
00-17	345,574	23%	332,173	22%	-14,401	-4.2%
18-44	499,190	33%	494,440	33%	-4,750	-1.0%
45-64	435,236	29%	442,976	29%	30,268	1.8%
65+	217,206	14%	247,474	16%	18,857	13.9%
Total	1,498,206	Total	1,517,063			

Suffolk County Population Growth by Gender

Gender	2013 Population	%	2018 Population	%	Growth 2013-2018	% Growth 2013-2018
Female	761,339	51%	771,193	51%	9,854	1.3%
Male	736,867	49%	745,870	49%	9,003	1.2%

Suffolk County Population by Race and Ethnicity

Race Ethnicity	2013 Population	%
Asian Non-Hispanic	53,544	3.6%
Black Non-Hispanic	102,749	6.9%
Hispanic	268,175	17.9%
Multiracial Non-Hispanic	19,845	1.3%
Native American Non-Hispanic	2,875	0.0%
Other Non-Hispanic	3,187	0.0%
Pacific Islander Non-Hispanic	269	0.0%
White Non-Hispanic	1,047,562	69.9%

I. Mission, Vision, Values

Mission:

Stony Brook Medicine delivers world-class, compassionate care to our patients, advances our understanding of the origins of human health and disease, and educates the healthcare professionals and biomedical investigators of the future, so they can bring the fruits of scientific discovery to our patients.

Vision:

Stony Brook Medicine will continue to strive for excellence as:

- A world-class institution, recognized for outstanding, compassionate patient care, biomedical research, and healthcare education
- The first choice of patients for their care and the care of their families
- An academic medical center that attracts educators and students with the desire and ability to provide and receive the highest quality, innovative education
- One of the top-ranked institutions for scientific research and training.

Values:

Integrity – We are honest and ethical in all our interactions.

Compassion - We provide empathic care with attentive listening and affirmation.

Accountability - We hold ourselves accountable to our community, to our organization and to each other for our performance and behaviors.

Respect - We foster an environment of mutual respect and trust, embracing diversity in people and thinking.

Excellence - We set the highest standards for safety, clinical outcomes and service.

II. Service Area

A. Hospital Service Area

As the only tertiary care provider and academic medical center serving Suffolk County, Stony Brook Medicine's leadership broadly considers Suffolk County to be the hospital's service area, particularly with regard to planning the provision of tertiary care services and related public health education/outreach activities. Review of countywide health services demand and utilization data is therefore central to the development of Stony Brook's community service plan.

SBUH also considers the demand for services within its Primary Service Area, defined as the geographic source of the top 50 percent of its inpatient discharges. This service area is particularly relevant to non-tertiary service-related public health education activities.

B. Description of Service Area

SBUH defines its primary market area as the top zip codes that account for half of the hospital's inpatient discharges.

2012 Stony Brook University Hospital Primary Market

III. Public Participation

A. Participants

The voice of our constituents plays an important role in the activities of Stony Brook Medicine. In 2013, more than 300 Suffolk County community based organizations were surveyed electronically as well as on paper about a variety of health topics that impact their constituents. The survey queried respondents on their perception of the biggest health issues impacting their community, screenings and services needed, health issues needing education, sources of health information, and the health of their community. This survey had broad, county-wide participation and had a response rate of 35%.

Additional quantitative data was gathered from a variety of sources, including the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (BRFSS), New York State Department of Health, Statewide Planning and Research System (SPARCS), and the Suffolk County Department of Health.

The Nassau Suffolk Hospital Council facilitated a population health work group (Workgroup) which consists of representatives from each hospital in Suffolk County as well as the local health department. The Workgroup designed and implemented the survey. Stony Brook University's Public Health Program evaluated the data.

B. Meeting Dates

The Workgroup met on 2/14/13, 4/11/13, 4/29/13, 5/30/13, 6/25/13, 7/30/13, 9/18/13, and 10/29/13 to discuss outcomes of the survey, review the NYS Prevention Agenda 2017 priorities and indicators, and strategize how the region was going to select priority areas and meet the needs of the region. Barriers that prevent Suffolk County residents from getting their healthcare needs met include the lack of a reliable public transportation system; lack of affordable housing; improper utilization of emergency departments; cultural differences with regards to perception of cigarette smoking; lack of resources; and a dramatic increase in individuals with limited English proficiency.

C. Public Notification

A variety of community-based organizations, including the Asthma Coalition of LI, Cornell Cooperative Extension, Western Suffolk BOCES and the YMCA, as well as Stony Brook University experts, were invited by the Workgroup to assess the data and present their recommendations.

IV. Assessment and Selection of Public Health Priorities

A. Criteria of Public Health Priorities

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Stony Brook University Hospital is an active member of the Population Health Workgroup. The group consists of representatives from each hospital/hospital system in Suffolk County as well as the Suffolk County Department of Health. This group has been charged with identifying two community health priorities for Suffolk County and overseeing the development of action plans to address these priorities. Through monthly meeting discussions with leadership from the SCDOH, area hospitals, community-based organizations, and a thorough review of the NYSDOH's Prevention Agenda 2013-2017 indicators and Suffolk County's performance relative to those indicators, the group has selected the following two focus areas from the chronic disease prevention priorities:

- Reduce obesity in children and adults
- Increase access to high-quality chronic disease preventive care and management in both clinical and community settings

Selected Prevention Agenda Priorities

For several of the chronic disease and health disparities indicators, Suffolk County's results are worse than the NYS 2017 Objective. These include:

Indicator	NYS 2017 Objective	Suffolk County
Percentage of children and adolescents who are obese	16.7	17.5
Age-adjusted heart attack hospitalization rate per 10,000 population	14.0	19.2
Age-adjusted preventable hospitalizations rate per 10,000 – ages 18+ years (ratio of Hispanics to White non-Hispanics)	133.3 (1.38)	148.5 (1.69)

Reducing obesity in children and adults was selected as a priority since Suffolk County has a higher percentage of obese children and adults (17.5 %) than is proposed as the NYS 2017 Objective (16.7%). Because obesity is also associated with increased incidence of many chronic diseases such as heart disease, diabetes and some cancers, members of the Population Health Workgroup agreed that decreasing obesity must be one of the county's Prevention Agenda priorities.

To develop countywide plans addressing the two Prevention Agenda issues, the Workgroup members have identified clinical and administrative leadership from participant hospitals as well as leadership from regional community-based organizations. Action plans and measurements for tracking progress against each Focus Area's goals are being developed.

The second priority area is to "increase access to high quality chronic disease preventive care and management in both clinical and community settings." Areas of focus for Stony Brook are asthma, diabetes, and hypertension. Suffolk County's age-adjusted heart attack hospitalization rate is 19.2 per 10,000, while the NYS 2017 Objective is 14.0 per 10,000. Additionally, according to the most recent data available from SPARCS, 2,546 discharges in Suffolk County had a primary diagnosis of Diabetes in 2011. Approximately fifty percent (50.2 %) of those discharges were from 16 zip codes. Additionally, 33,855 discharges were cardiac (cardiology, open heart and vascular surgery). Of the cardiac discharges, approximately 51% (50.7%) were from 20 zip codes. CVD is a major complication of diabetes and the leading cause of early death among people with diabetes—about 65 percent of people with diabetes die from heart disease and stroke. Adults with diabetes are two to four times more likely to have heart disease or suffer a stroke than people without diabetes.[1]

Utilizing SPARCS and Prevention Quality Indicators (PQIs) data, we have identified 23 zip codes in Suffolk County that account for approximately 53% of total discharges for diabetes, cardiology, open heart and vascular surgery. Of these zip codes, 30% have higher than expected hospital admission rates for diabetes, circulatory, respiratory and acute conditions. These zip codes also have high concentrations of Black and/or Hispanic residents.

[1] National Diabetes Education Program, http://www.ndep.nih.gov/media/CVD_FactSheet.pdf

Stony Brook Medicine's leadership also reviewed Suffolk County's performance against NYSDOH's 2017 Objectives related to injury prevention, healthy women, infants, and children, and health care related infections. For many of the indicators for the NYS 2017 Objectives, Suffolk County's results are worse than the state averages and more importantly, worse than the 2017 Prevention Agenda targets as indicated below:

Indicator	NYS 2017 Objective	Suffolk County
Percentage of cigarette smoking among adults	15.0	17.5
Rate of emergency department visits due to falls per 10,000 – Ages 1-4 years	429.1	524.2
Rate of hospitalization due to falls per 10,000 – Ages 65+	204.6	230.2
Percentage of pre-term births	10.2	12.0
Percentage of infants exclusively breastfed in the hospital	48.1	41.4
Percentage of third-grade children with evidence of untreated tooth decay	21.6	29.6
Rate of occupational injuries treated in ED per 10,000 adolescents - Ages 15-19 years	33.0	48.2
Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month	10.1	13.1

As an institution committed to improving the health of the community we serve and increasing access to care, SBUH has numerous initiatives related to addressing additional Prevention Agenda focus areas/goals namely:

1. Reduce illness, disability and death related to tobacco use and secondhand smoke exposure;
2. Reduce fall risks among the most vulnerable populations
3. Promote maternal and infant health
4. Reduce the prevalence of dental caries among NYS children
5. Reduce healthcare-associated infections.

V. Three year Plan of Action

Serving the community is part of the culture at Stony Brook, and we are committed to helping individuals and organizations access healthcare services. Obesity/weight loss, diabetes, and heart disease/stroke were the top health concerns of responders in both surveys. By partnering with community-based organizations, we strive to improve the health status of the community. Through health information and health promotion/disease prevention lectures, workshops and screenings, we enable people to live healthier lives.

The institution will continue to collaborate with community-based organizations to collectively address health disparities in Suffolk County. Partners in this effort include the Suffolk County Department of Health Services Office of Minority Health and the Latino Health Initiative of Suffolk County. Moreover, the Health Occupations Partnership for Excellence (HOPE) program works with adolescents to diversify the future healthcare workforce. HOPE reaches directly into the region's underserved communities to identify health issues of importance and to set up mechanisms to address healthcare disparities. HOPE educates secondary school students in grades 11-12 from diverse school districts throughout the county about healthcare careers, supports their academic achievement and college entry, and raises their awareness of the issues that affect their own health and that of their communities. Students are provided education about health careers, SAT exam preparation and mentors.

Stony Brook's healthcare professionals will continue to provide a wide variety of free screenings at health fairs and community events throughout Suffolk County. Blood pressure, cholesterol and glucose screenings often reveal the early warning signs of heart disease, stroke and diabetes. We also provide free lectures/talks on more than 100 different topics, free screenings for a variety of ailments such as prostate cancer, oral cancer, vascular disease, and skin cancer. Other outreach to the community includes support groups, and annual events such as the Kids Health & Safety Expo, which raises awareness about health issues such as injury prevention in children, and the Women's Health Day, which raises awareness about health issues affecting women such as cardiovascular disease, diabetes, obesity and cancer.

Strategies for Selected Priorities

A. Prevent Chronic Diseases

Focus Area I: Reduce Obesity in Children and Adults

Strategies:

a. Implement the Children's Weight and Wellness Center which models a Stage 3 Comprehensive Multidisciplinary Intervention for Childhood Obesity.[2] Service is provided for children 5-18 years of age with a Body Mass Index $\geq$ 95 percentile based on CDC BMI curves age-gender. [3]
   b. Continue the Community Roots Community Garden Project in economically distressed communities in Suffolk County
   c. Create nutrient standards for foods sold in public venues throughout Suffolk County by working with local vendors.
   d. Continue the Women Infant & Child (WIC) Nutrition Education and Supplemental Food Program
   e. Continue to participate in the NYS Obesity Prevention in Pediatric Health Care Settings Guidance Team
   f. Partner with the Long Island Health Collaborative to initiate a Walk for Wellness walking program and awareness campaign

Anticipated Outcomes:

- Barriers to access fresh produce in underserved communities in Suffolk County will be minimized, resulting in improved health status of minority communities
- Obese children will have their health needs addressed and will experience a reduction in their BMI
- Participants of the WIC program will continue to receive nutrition education, breastfeeding support, and individualized nutrition support
- Incidence rates of chronic diseases related to obesity and hypertension will decrease over time
- Tools, processes, and evaluation strategies for primary care based pediatric obesity prevention programs will be developed
- Community members will have access to programs, services, and resources available in their local communities

Focus Area II: Increase access to high-quality chronic disease preventive care and management in both clinical and community settings

Strategies:

a. Continue Patient Centered Medical Home model focusing on pediatrics, family medicine, and internal medicine
b. Conduct blood pressure, glucose and cholesterol screenings at community sites
c. Provide nutritional presentations to community-based organizations and worksites
d. Provide diabetes management education to community based organizations
e. Provide diabetes prevention education to parents of school-aged children

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[2] Barlow, S Expert committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report. Pediatrics, 2007.

[3] Center for Disease Control- CDC Growth Charts. http://www.cdc.gov/growthcharts/cdc_charts.htm

f. Continue to provide a support group to patients with heart disease and their families
g. Continue to provide low/no cost breast, oral, prostate and skin cancer screenings to the community
h. Continue to provide support groups and other resources to individuals impacted by cancer
i. Continue to provide an annual Breast Cancer Update for the Community
j. Participate with the NYS Health Homes to ensure patients access care management services

Anticipated Outcomes:
- The community will have opportunities to receive health education and screenings pertinent to their health
- Health issues related to heart disease and stroke will be prevented or identified earlier
- Risk factors and signs of stroke and heart attack will be communicated to the public
- Strategies for achieving and maintaining cardiovascular health will be communicated to the community
- The community will have increased opportunities to receive information and screenings related to the prevention and early detection of cancer
- Community members will be educated on the risk factors associated with cancer
- Earlier diagnoses of cancer
- Support group participants will have more resources available to them
- The community will have information on lifestyle choices that impact their health
- Parents will be educated on the importance of good nutrition as it relates to childhood obesity, Type II diabetes, and other health issues
- A decrease in the rate of overweight and obese children and adults over the long term

Focus Area III: Reduce Illness, disability, and death related to tobacco use and secondhand smoke exposure

Strategies:
a. Collaborate with the American Lung Association and Asthma Coalition of Long Island to improve the health of Suffolk County Residents
b. Continue to provide Opt-to-Quit program to parents of pediatric patients
c. Continue to provide smoking cessation programs and resources to staff and the community
d. Continue to utilize resources available from partners such as the American Cancer Society, Suffolk County Department of Health, and Tobacco Action Coalition
e. Continue to enforce Stony Brook Medicine’s smoke-free policy
f. Conduct research to evaluate a new method to help World Trade Center disaster responders with PTSD symptoms quit smoking

Anticipated Outcomes:
- The prevalence of tobacco use in Suffolk County will be reduced
- Exposure to environmental tobacco smoke will be reduced
- Healthcare costs related to tobacco use and environmental tobacco smoke will be reduced
- Smokers with PTSD will quit smoking successfully

B. Promote a Healthy and Safe Environment

Focus Area IV: Injuries, Violence, and Occupational Health

Strategies:

a. Collaborate with the Suffolk County Department of Health Services, SafeKids Suffolk and other community organizations to create a community outreach plan
b. Create low literacy health education booklets, posters, calendars and other materials designed to prevent falls in the elderly
c. Perform pre and post testing of community members to ensure increase in knowledge about falls and fall risks
d. Provide educational campaign of providers and community members via community presentations, newsletters, distribution of materials and outreach in shopping centers and other locations frequented by senior citizens
e. Develop data subcommittee that will analyze pertinent data regarding demographics and high-risk areas
f. Continue to provide the Kids Health & Safety Expo, a free community event promoting the health & safety of children
g. Collaborate with the Elsie Owens Health Center at Coram, Safe Kids Suffolk, and other community-based organizations to educate parents about health and safety of children
h. Support Complete Streets policy
i. Promote prevalence of safer, more walkable communities

Anticipated Outcomes:

- The community and the target population will be educated on the risk factors resulting in falls and strategies for preventing falls
- Healthcare providers (physicians, pharmacists, nurses, home health agencies etc.) will be educated on prevention strategies as well as the risk for falls in the elderly
- Parents and other caregivers will learn how to properly install car seats, prevent house fires and drowning
- Parents and children will receive blood pressure and other screenings.
- The community will have increased opportunities to receive information related to tobacco control, injury prevention, nutrition, physical activity and other relevant health/wellness topics.

C. Promote Healthy Women, Infants, and Children

Focus Area V: Maternal and Infant Health

Strategies:

a. Continue to participate in the NYS DOH Perinatal Quality Collaborative Continue to encourage participation of Perinatal Quality Collaborative program to affiliated hospitals
b. Continue to participate in National Initiative for Children's Healthcare Quality (NICHQ)'s Best Fed Beginnings project
c. Continue to work toward NICHQ's "Baby-Friendly" status to promote breastfeeding
d. Commit to the success of NYS DOH's Great Beginnings NY program at Stony Brook
e. Continue to provide breastfeeding support group
f. Initiate Centering Pregnancy program
g. Continue to provide NYS DOH and American Congress of Obstetricians and Gynecologists (ACOG) Safe Motherhood initiative to prevent maternal death
h. Continue to provide Code Noelle program which includes protocols, simulations and drills to promote readiness of staff for emergency hemorrhages
i. Continue to provide Code SUB (Sudden Unexpected Birth) program, which provides obstetrical and NICU services including specialists and equipment for persons delivering outside of the Labor & Delivery Suite

Anticipated Outcomes:

- Decrease in the rate of elective deliveries at less than 39 weeks' gestation
- Increased support for mothers who choose to breastfeed
- Increase in the duration of breastfeeding
- Increase in the exclusive breastfeeding rate
- Pregnant women will be empowered to choose health-promoting behaviors
- Increase in staff readiness for maternal hemorrhages
- Decrease in adverse maternal outcomes and deaths
- Improvement in maternal and newborn outcomes

Focus Area VI: Child Health

Strategies:

a. Utilize medical home model to increase the number of children receiving comprehensive primary care
b. Continue to offer Give Kids A Smile and Give Kids A Healthy Smile programs, which provide free exams and sealants to children
c. Continue to provide mobile dental clinic to underserved communities

Anticipated Outcomes:

- The number of children receiving comprehensive well-child care in accordance with American Academy of Pediatrics guidelines will increase
- Dental caries in Suffolk County children will decrease

D. Promote Mental Health and Prevent Substance Abuse

Focus Area VII: Prevent Substance Abuse and Other Mental, Emotional and Behavioral Health Disorders

Strategies:

a. Provide clinical liaison to OB-GYN to help pregnant women and new mothers who have difficulties such as substance abuse and post-partum depression, and plan to do the same with Family Medicine, the Cancer Center and other ambulatory settings to ensure improved access to behavioral health services.
b. Continue to collaborate with Quannacut Addiction Services at Eastern Long Island Hospital and expand group therapy services at SBUH for people with co-occurring substance abuse and mental health disorders.
c. Collaborate with Southampton Hospital to increase availability of behavioral health services for communities on the South Fork.
d. Continue to collaborate with the Suicide Prevention Coalition of Long Island to provide annual training for professionals in suicide prevention.
e. Recruit dynamic and experienced leaders to direct the Division of Child and Adolescent Psychiatry and the Adult Inpatient Service in improving access to care, clinical outcomes and patient experience.
f. Support the implementation of a substance abuse screening and education protocol across the institution.
g. Implement a model of physical and mental health integration within both SBUH and the community.

Anticipated Outcomes:

- There will be a decrease in the number of adults abusing substances through screening and early identification
- There will be a decrease in the number of suicides in our community
- There will be improved access to behavioral health treatment in medical and primary care settings.

Focus Area VIII: Strengthen Infrastructure Across Systems

Strategies:

a. Greater involvement with the leadership of Suffolk County and Office of Mental Health to participate in the development of solutions to system-wide issues.
b. Expand the SBUH focus on behavioral health to promote excellence in research, education and clinical services, while providing both hospital and community providers with timely information on new research findings, clinical trials and best practices.
c. Continue to add new non-physician professional clinical staff in our outpatient services to increase access and enhance the interdisciplinary perspective on the care of our patients and education of our residents and fellows.
d. Recruit additional physicians in the CPEP to ensure that there is adequate coverage at all times, continue to reduce levels of restraint use and maintain a vigorous program of suicide assessment and prevention.
e. Promote responsive collaborative relationships between inpatient and outpatient services and between psychiatric and other hospital medical services.
f. Establish a new Center for Mood Disorders within the Neurosciences Institute and recruit an accomplished clinician and researcher in mood disorders to lead it.

Anticipated Outcomes:

- Reduction in suicides in the healthcare setting
- Increased interdisciplinary perspective on care of patients of clinicians with mental, emotional, and behavioral health needs

VI. Dissemination of the Report to the Public

Public Information

A summary of this Community Service Plan as well as information on public health programs and the availability of financial assistance will be posted on the hospital's website (www.stonybrookmedicine.edu) and distributed at community events for a limited period of time.

VII. Maintaining Engagement

The Population Health Workgroup in Suffolk County has merged with its counterpart in Nassau County and formed the Long Island Health Collaborative. The LIHC is comprised of representatives from every hospital on Long Island, both local health departments, community-based organizations, faith-based organizations, schools, etc. This group will continue to meet on a regular basis for the foreseeable future. LIHC is addressing obesity on Long Island by creating public awareness of the issue, promoting walking to increase physical activity and decrease obesity, and organizing series of walks in a variety of communities.

A Universal Metric Tool has been created for use with assessing an individual's understanding of their health status and lifestyle. This tool will be used by all members of LIHC in their healthy living (weight/physical activity/chronic disease management) programs. The tool is currently being piloted and will be reviewed in January 2014. LIHC is seeking grant funding from the NYS Health Foundation to implement its work over the next two years.

Appendix

External Community Partners related to CSP

American Lung Association
Asthma Coalition of LI
Babylon Village Chamber of Commerce
Bay Shore Wellness Alliance
Brookhaven Hospital
Catholic Charities
Comsewogue Public Library
Coram Civic Association
Cornell Cooperative Extension
Eastern Long Island Hospital
Eastern Suffolk BOCES
Family Service League
F.E.G.S.
Good Samaritan Hospital
Greater Port Jefferson Chamber of Commerce
John T. Mather Memorial Hospital
Long Island Men's Center
Long Island Youth Mentoring
Mastic Moriches Shirley Community Library
Middle Island Civic Association
Miller Place Fire Department
Montauk Library
Moriches Elementary School
Nassau-Suffolk Hospital Council
North Brookhaven Chamber of Commerce
North Shore – LIJ Health System
Northport-East Northport Public Library
Patchogue Medford Library
Port Jefferson Ambulance
Port Jefferson Board of Education
Port Jefferson Free Library
Port Jefferson Volunteer Ambulance
Port Jefferson Fire Department
St. Catherine of Sienna Medical Center
St. Charles Rehabilitation Hospital
St. James Rehabilitation and Healthcare Facility
St. John's University
St. Joseph's College
SBPWN
South Fork Community Health Initiative
Southampton Hospital
Suffolk County Community College
Suffolk County Department of Health Services
Suffolk County Office for the Aging
Suffolk County Office of Emergency Management
Sunrise Senior Living
The Learning Connection

The Longwood Alliance
Three Village Meals on Wheels, Inc.
Village of Patchogue Community Development Agency
William Floyd School District

External Community Partners related to SBUH Initiatives

AME Bethel Church
American Cancer Society
American Heart Association
American Lung Association
Asthma Coalition
Boys & Girls Club
Brentwood Union Free School District
Civic Association of Setaukets and Stony Brook
Colette Coyne Melanoma Awareness Coalition
Elsie Owens Health Center
Emma Clark Public Library
First Baptist Church of Riverhead
Head Start
Hope Missionary Baptist Church
Longwood Central School District
March of Dimes
Make a Wish Foundation
Middle Country Public Library
National Institute for People with Disabilities
New York Organ Donor Network
Riverhead Central School district
Rotary International
Safe Kids Suffolk
SCOPE
Stony Brook Volunteer Ambulance Corps
Stony Brook University Hospital Auxiliary
Suffolk County Latino Health Initiative
Suffolk County Office of Minority Health
Suffolk County Police Department
United Way of Long Island
VIBS
Witness Project
Women in the Courts
Wyandanch Union Free School District

Internal Committees with External Membership
Cardiac Community Advisory Board
CEO's Community Leaders Roundtable
Compliance and Audit Committee of the Governing Body
ehealth Network of Long Island
Medical Center Development Council
Partners in Caring
Quality Assessment Review Board (including Quality Subcommittee)

Run for Children
School Re-Entry Program
Volunteer Firefighters Burn Center Fund
Walk for Beauty

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[i] Solucient