1. The Prevention Agenda priorities for the 2016-2018 reporting period all were within the focus area of Preventing Chronic Disease. The measures pursued were:

- To reduce obesity in children and adults and
- To increase access to high quality chronic disease preventive care and management in both clinical and community settings.

2. The SBH CSP work plan continued to focus on Preventing Chronic Disease. SBH is a member of the DSRIP PPS Bronx Partners for Healthy Communities [BPHC] as are several SBH CSP members. Our intervention interests are aligned with BPHC goals and are data informed.

3. Data sources reviewed for this work plan which confirmed our priorities include:

- The 2014 NY Academy of Medicine’s Bronx Community Needs Assessment
- US Census, American Community Survey 5 year data 2008-2012
- 2011-2012 Medicaid Prevention Quality indicators, NYS Department of Health Office of Quality and Patient Safety, 2014 as reported by the Office of Health Systems Management
- NYC Health Department Community Health Profiles 2015 Bronx Community District 1, 5 and 6
- NYC Department of Health and Mental Hygiene Community Consultations from the Take Care New York 2020
- Vital Statistics Data as of March, 2014, New York State Department of Health-Bureau of Biometrics and Health Statistics
- Bronx County Community Health Survey undertaken in collaboration with Montefiore Medical Center and Bronx Partners for Health Communities

4. Existing and historical partnerships with local community based organizations, institutions; enterprises are listed in the 2016-2018 CHNA/CSP document under Appendix A. We are anticipating establishing stronger faith based organization activities as well as with both the younger adolescents and our geriatric communities.

5. We are engaging the broad community through on-site and community wide outreach activities and in participation at the local government level. The CSP Workgroup supports the local District Public Health Office neighborhoods efforts. The SBH CSP also has participation of local elected officials at the county, city and state level.
6. Some examples of the specific strategies and activities utilized are: workshops in the community, untraditional open-space community locations, use of mobile mammography vehicle, and including hosting subject specific on campus meetings all of which are based on earlier successes.

7. Our goals as we closed out this reporting period were:

   To engage and empower the general community in physical activity through access and programmed use of the campus green and safe environment; promoting a healthier lifestyle by providing a safe and verdant respite that promotes physical activity and mental relaxation;

   Creating an environment that promotes and supports healthy beverage and food choices for the community and for staff;

   Offering culturally relevant diabetic self-management education including food shopping and meal preparation to improve healthy eating while recognizing financial constraints; and

   To ensure a continuum of diabetic care that is trackable and integrated with the institution’s overarching reduction in re-admission rates.

   We look forward to an updated Community Health Needs Assessment for 2019 and along with our CSP partners, establishing our plans for 2019-2024 initiatives.