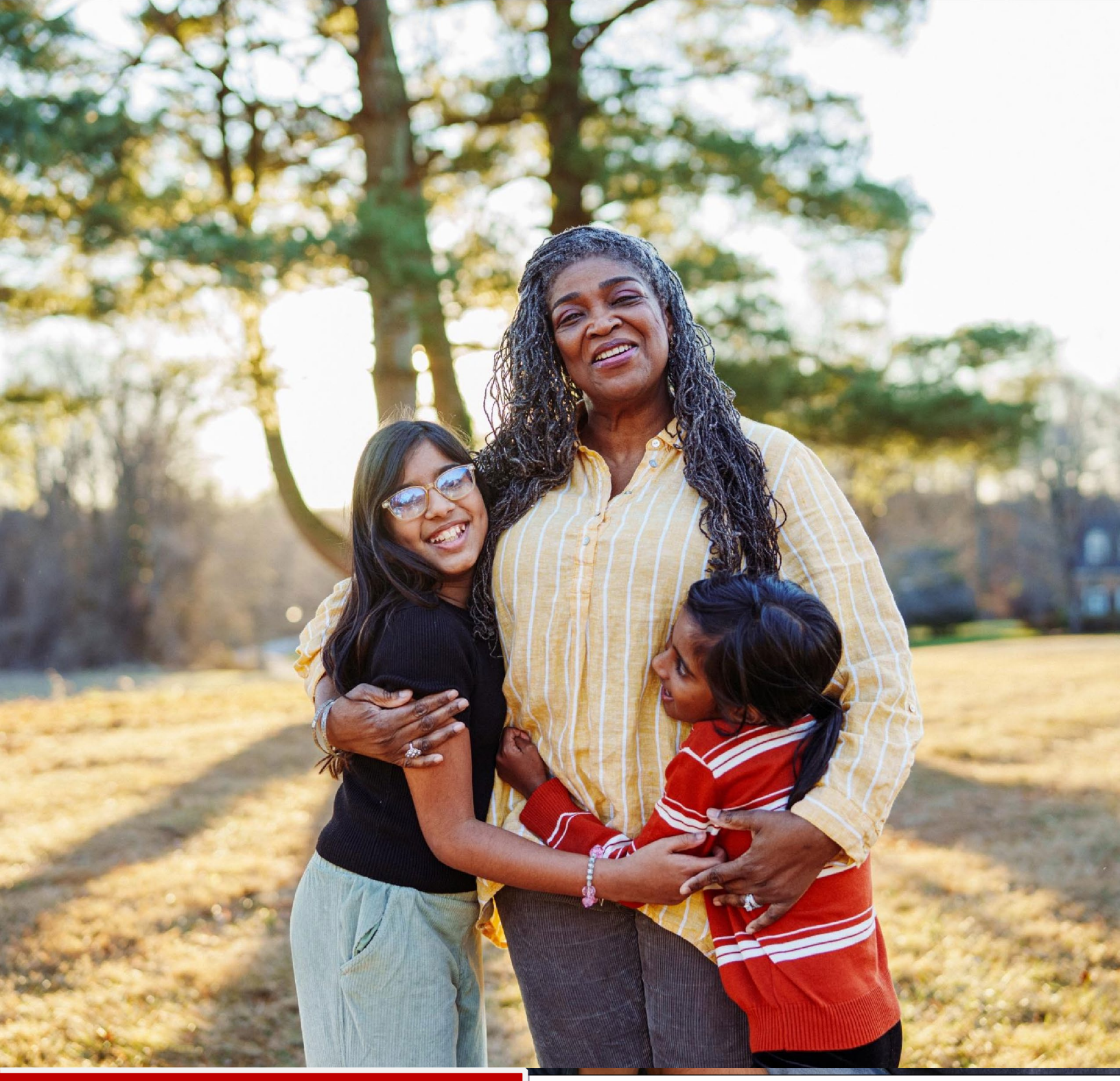

Community Health Needs Assessment (CHNA) Implementation Strategy

Fiscal Years 2027-2029

Sunnyview Rehabilitation Hospital
St Peter's Health Partners
A Member of Trinity Health

Sunnyview Rehabilitation Hospital completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors on April 24, 2026. Sunnyview Rehabilitation Hospital performed the CHNA in adherence with applicable federal requirements for not-for-profit hospitals set forth in the Affordable Care Act (ACA) and by the Internal Revenue Service (IRS). The assessment considered a comprehensive review of secondary data analysis of patient outcomes, community health status, and social influencers of health, as well as primary data collection, including input from representatives of the community, community members and various community organizations.

The complete CHNA report is available electronically at: https://www.sphp.com/about-us/community-benefit/community-health-reports or printed copies are available at: St. Peter's Health Partners, Community Health and Well-Being, 315 South Manning Blvd. Albany, NY 12208

Our Mission

We, St. Peter's Health Partners and Trinity Health, serve together in the spirit of the gospel as a compassionate and transforming healing presence within our communities. CORE VALUES Reverence – We honor the sacredness and dignity of every person. Commitment to Those Experiencing Poverty – We stand with and serve those who are experiencing poverty, especially those most vulnerable. Justice – We foster right relationships to promote the common good, including sustainability of Earth. Stewardship – We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care. Integrity – We are faithful to who we say we are. Safety – We embrace a culture that prevents harm and nurtures a healing, safe environment for all.

St. Peter's Health Partners

St. Peter's Health Partners, a member of Trinity Health, is one of the Capital Region's largest, most comprehensive not-for-profit health care networks. Our full range of services, along with support and care coordination, help people achieve their health goals-centered, integrated care is at the heart of St. Peter's Health Partners (SPHP). With nearly 11,000 employees in more than 185 locations, our breadth of services across the continuum of care uniquely positions us to be the region's leader for quality, efficiency, and innovation in delivering compassionate health care and senior services.

Sunnyview Rehabilitation Hospital

Founded in 1928, Sunnyview Rehabilitation Hospital is a 115-bed hospital specializing in physical rehabilitation. Every year, more than 15,000 individuals come to Sunnyview from across the Northeast. Each one has a dedicated team of physicians, nurses, therapists, and specialists all focused on one goal – helping patients recover from a stroke, traumatic injury, or disabling disease. Sunnyview is the only nationally recognized specialty rehabilitation hospital in upstate New York. Patients travel to Sunnyview from forty counties in New York State, as well as 10 other states, for our expertise, experience and technology and our reputation. Our outcomes show that we help patients attain their greatest level of independence and provide them with the best chance of going home. We're proud that an overwhelming number of former patients say they would recommend us to family and friends.

Our Community Based Services

In addition to our hospitals, St. Peter's Health Partners includes: The Eddy system of continuing care, The Community Hospice and St. Peter's Health Partners Medical Associates, one of the Capital Region's largest multispecialty physician groups with more than 850 physicians and advanced practitioners in more than 130 locations. As a member of Trinity Health, St. Peter's Health Partners' Community Health & Well-being (CHWB) strategy promotes

optimal health for those who are poor and vulnerable and the communities we serve by connecting social and clinical care, addressing social needs, dismantling systemic racism, and reducing health inequities. We do this by:

- Investing in our communities.
- Delivering outstanding care for those who are experiencing poverty and other vulnerabilities.
- Impacting social influencers of health.

St. Peter's Health Partners reinvests in communities through financial support, screenings, education, and research. We provide programs such as PACE, The Butt Stops Here Tobacco Cessation Program, Diabetes Prevention Program, Prescription Assistance, Food Access Programs, the Maternal Obstetrical Mentoring Services (MOMS) program for our prenatal patients, and financial assistance/charity care for those in need.

Our Community

Geographic Area Served

For the purposes of the Community Health Needs Assessment, Sunnyview Rehabilitation Hospital has defined its service area as Schenectady County. As a specialty hospital, it serves a broad geographic area. and, in addition to Schenectady County, serves a significant number of patients from Albany, Rensselaer and Saratoga counties. However, given that the community health needs are being comprehensively addressed by the hospitals (including other SPHP hospitals) located in those counties, it was determined that Sunnyview would work with Ellis Hospital and the Schenectady County Health Department to address the needs in Schenectady County, which represents the home zip codes of 51% of its patients.

Demographics of the Population

US Census Bureau Quick Facts	United States	New York	Schenectady County
Population, Census, April 1, 2020	331,449,281	20,201,249	158,061
Population, Census, April 1, 2010	308,745,538	19,378,102	154,727
Persons under 5 years old	5.5%	5.3%	5.7%
Persons under 18 years old, percent	21.7%	20.2%	21.3%
Persons 65 years old and over, percent	17.7%	18.6%	18.2%
Female Persons, percent	50.5%	51.2%	50.7%
White alone, percent	75.3%	68.5%	74.7%
Hispanic or Latino, percent	19.5%	19.8%	8.3%
Asian alone, percent	6.5	9.7%	6.0%
Black or African American alone, percent	13.7	17.7%	14.0%
Native Hawaiian and Other Pacific Islander alone, percent	0.3%	0.1%	0.3%
Two or More Races, percent	3.1%	2.9%	4.3%
White alone, not Hispanic or Latino, percent	58.4%	54.0%	69.3%
Foreign Born Persons, Percent, 2019-2023	13.9%	22.6%	10.2%
Veteran's, 2019-2023	16,569,149	607,728	7,025
High school graduate or higher, percent of persons age 25+ , 2019-2023	89.4%	87.9%	91.8%
Bachelor's degree or higher, percent of persons age 25+, 2019-2023	35.0%	39.6%	35.1%
Language other than English spoken at home, percent of persons aged 5 years +, 2019-2023	22%	30.6%	8.9%
Owner-occupied housing unit rate, 2019-2023	65.0%	54.3%	63.8%
Median households' income (in 2023 dollars), 2019-2023	$78,538	$84,578	$76,989
Persons in poverty, percent**	11.1%	14.2%	14.0%
Percent with a disability, under age 65 years, percent	9.1%	8.1%	9.6%
Population per square mile, 2020	93.8	428.7	772.6

Source: **US Census Bureau QuickFacts,** www.census.gov

**These geographic levels of poverty and health estimates are not comparable to other geographic levels of these estimates

Our Approach to Health Equity

At Trinity Health, Community Health Needs Assessments (CHNAs) and Implementation Strategies are foundational to advancing the Common Good and strengthening our commitment to health equity. Across our ministries, CHNAs foster meaningful community engagement and inform strategic planning within our Community Health & Well-Being efforts.

Community Health & Well-Being works to promote optimal health for individuals experiencing poverty, marginalization, or other vulnerabilities by addressing social needs within clinical care. Our approach is rooted in a commitment to removing barriers to health and building community capacity to support long-term well-being.

This Implementation Strategy was developed in partnership with community stakeholders and focuses on populations and geographic areas most affected by the identified needs. Principles of fairness, inclusion, and community voice guided the development of this plan and will continue to shape its implementation.

The strategies outlined emphasize policy, systems, and environmental change, recognizing that sustainable improvements in health require transforming the conditions and structures that influence well-being. Through this approach, we aim to foster healthier, more resilient communities for all those we serve.

Health and Social Needs of the Community

The CHNA conducted in late 2025, to early 2026 identified the significant needs for health and social drivers of health within Schenectady County. Community stakeholders then prioritized those needs during a facilitated review and analysis of the CHNA findings. The significant health needs identified, in order of priority include:

1. Obesity and Diabetes	• Within Schenectady County, 34% of adults age 18+ are obese, which is defined as a Body Mass Index (BMI) of 30 or higher, which was higher than both the NYS and US rates. • Within Schenectady County, 22.2% adults age 18+ who have no leisure-time physical activity last month of the total population age 18+. This is slightly lower than the NYS and US rates. • The estimated prevalence of diabetes among adults in the Capital Region is below that of NYS, excluding NYC. Within Schenectady County, 10.2% of adults, age 18 and older have been diagnosed with diabetes, which is less than NYS (11.1%) and the U.S. rate (12.0%). • In Schenectady County, as of 2019, 1,057 or 88% of Medicare enrollees with diabetes have had an annual A1C test, which is a blood test that can measure how well blood sugar levels are managed.
2. Mental Health (including Depression, Anxiety and Stress) and Suicide	• The percentage of adults age 18+ who report 14 or more poor mental health days during the past 30-day period was 16.1 % in Schenectady County, which was higher than both NYS and US rates. • According to the 2022 BRFSS, Schenectady County adults reported a higher than state average incidence of depression (as diagnosed by a health professional) at 20.1%. • From 2018-2022, Schenectady County had a suicide mortality rate of 9.6/ 100,000 population. In addition, the rates of suicide are higher among White/Caucasian individuals, when compared to Black/African American individuals.

3. Hunger and Food Insecurity	• 11.3% of people in Schenectady County do not have access to a reliable source of food • As of 2023, estimated program eligibility among food insecure people in Schenectady County is 59%. • Child food insecurity rate is 15.7% in Schenectady County, which is significantly above the national average. • Between 2022-2023, Schenectady County's food insecurity rate increased by 1.3%.
4. **Addiction to Drugs or Alcohol**	• Adults in Schenectady County reported both engaging in excessive drinking, defined as binge or heaving drinking, at 20.2% compared to the NYS average of 19.1% (BRFSS, 2022). The percentage of driving deaths with alcohol involvement was 41% in Schenectady County, which is higher than the NYS rate of 21% • Within Schenectady County there were a total of 208 deaths due to drug poisoning (from 2018-2022), this represents a death rate of 26.5/100,000 population. These rates are similar to the NYS and Us rates. • The 2021 age adjusted rate per 100,000 population of overdose deaths involving any opioid was 27.8/ 100,000 in Schenectady County, which was higher than the NYS rate of 24.6/ 100,000
5. **Cancer**	• Within Schenectady County, the cancer incidence rate per 100,000 population was 492.6/ 100,000, which was higher than both the NYS and US rates. • The Hispanic/Latino population had a higher rate of cancer incidence when compared to all other Racial/Ethnicity groups living in Schenectady County. • Within Schenectady County, there are a total of 1,560 deaths due to cancer from 2018-2022, which is higher than both the NYS and US rate. This represents a crude death rate of 198.9 /100,000 population
7. Tobacco Use and Vaping	• Within Schenectady County, 12.9% of the total population age 18+ are current smokers (2022), which is slightly higher than the NYS rate.

8. Sexually Transmitted Infections	• As of 2022, Schenectady County rates of Early Syphilis (18.3 per 100,000) and Chlamydia (439.0 /100,000) were lower than the NYS Rates of 49.5 per 1000,000 (Early Syphilis) and 553.4 / 100,000) (Chlamydia). • As of 2022, the rates of Gonorrhea in Schenectady County (315.7 per 100,000 persons) were higher than the NYS rate of 230.0 / 100,000.
9. Childhood Lead Poisoning	• Schenectady County's 2016-18 incidence rate of elevated blood lead levels (≥10 µg/dl), 9.1 per 1,000 tested children under 6 years of age, was 1.4 times higher than NYS(6.5).

Source: 2025 Capital Region Community Health Needs Assessment

Hospital Implementation Strategy

Significant health and social needs to be addressed

Sunnyview Rehabilitation Hospital, in collaboration with community partners, will focus on developing and/or supporting initiatives and measure their effectiveness to improve the following needs:

1. Hunger and Food Insecurity – CHNA pages 70-71; 301-305; 398-400; 404-408; 430-432
2. Mental Health (Depression, Anxiety, Stress) and Suicide – CHNA pages 169-; 301-306; 458-459; 471-473; 482-486
3. Obesity and Diabetes – CNHA pages 91-96; 105-109; 301-306; 426-428; 430; 452-453; 455-456

Significant health and social needs that will not be addressed

Sunnyview Rehabilitation Hospital acknowledges the wide range of priority health and social issues that emerged from the CHNA process and determined that it could effectively focus on only those needs which are the most pressing, under- addressed and within its ability to influence. Sunnyview Rehabilitation Hospital does not intend to address the following needs:

- **Addiction to Drugs or Alcohol–** The hospital will provide treatment and education on this health needs as part of our routine care of patients. In addition, the hospital will not address this need through the CHNA Implementation Strategy, as other organizations are addressing this need.
- **Childhood Lead Poisoning –** This need will not be addressed, in order to avoid duplication of efforts because other organizations are addressing the need.
- **Cancer –** This need will not be addressed, in order to avoid duplication of efforts because other organizations are addressing the need, the hospital will provide treatment and education on these health needs as part of our routine care of patients.
- **Tobacco Use and Vaping –** Competing priorities, the hospitals will promote existing cessation programs within the community.
- **Sexually Transmitted Infections –** The hospital will provide treatment and education of this health need as part of our routine care of patients and to avoid duplication of efforts because other organizations are addressing the need.

This implementation strategy specifies community health needs that the hospital, in collaboration with community partners, has determined to address. The hospital reserves the right to amend this implementation strategy if circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the strategic initiatives described.

1

Hunger and Food Insecurity

Goal: Improve consistent and equitable access to healthy, affordable, safe, and culturally appropriate foods.

CHNA Impact Measures By December 31, 2028:	FY2027 Baseline	FY2029 Target
Increase consistent household food security in households with an annual total income of less than $25,000, by 2%, within Schenectady County (*Data source: NYS Behavioral Risk Factor Surveillance System)*	42%	51.1%
Increase consistent household food security in households by 2% in Schenectady County *(Data source: NYS Behavioral Risk Factor Surveillance System)*	83.4%	85.4%
Increase the number of individuals enrolled in Food as Medicine Programs within Schenectady County *(Data source: St. Peter's Health Partners, Food as Medicine Program)*	300	750

Strategy	Timeline Y1	Y2	Y3	Hospital and Committed Partners (align to indicate committed resource)	Committed Resources (align by hospital/committed partner)
Conduct standardized screening of unmet Nutrition Security needs and provide referrals to state, local, and federal benefit programs and community-based, health-related social needs providers to address unmet needs.	X	X	X	Sunnyview Rehabilitation, and St. Peter's Health Partners Medical Group	In-kind staff time and effort to conduct screening and referrals to food insecurity programs
	X	X	X	Schenectady County Health Department	Staff time and effort to promote screening and referrals to food insecurity programs
	X	X	X	Ellis Hospital	Staff time and effort to promote screening and referrals to food insecurity programs
	X	X	X	Schenectady Food Council	Staff time/effort to plan and facilitate council meetings and collect/report county-wide data
	Focus location(s)				**Focus Population(s)**

	City of Schenectady, including high priority zip code: 12307 and priority zip codes: 12303, 12304, 12305, 12308				Low socio-economic population
Strategy	**Timeline**			**Hospital and Committed Partners** (align to indicate committed resource)	**Committed Resources** (align by hospital/committed partner)
	Y1	**Y2**	**Y3**		
Expand Food as Medicine approaches across the lifespan, especially for populations at a higher risk of nutrition-related health disparities (e.g., medically tailored meals and groceries, produce prescription programs, etc.)	X	X	X	Sunnyview Rehabilitation Hospital	$200,000/yr grant to implement Food as Medicine Programing
	X	X	X	Catholic Charities	Staff time and effort to implement Food as Medicine Programing program.
	X	X	X	Ellis Medicine	Staff time and effort to promote and refer to Food As Medicine programs
	X	X	X	Regional Food Bank	Staff time and effort to promote, implement and monitor Food Access Programs
	Focus location(s)				**Focus Population(s)**
	City of Schenectady, including high priority zip code: 12307 and priority zip codes of 12303, 12304, 12305, 12308				Low socio-economic population with chronic diseases.
	City of Schenectady, including high priority zip code: 12307 and priority zip codes of 12303, 12304, 12305, 12308				Individuals experiencing low socioeconomic status (SES)
Strategy	**Timeline**			**Hospital and Committed Partners** (align to indicate committed resource)	**Committed Resources** (align by hospital/committed partner)
	Y1	**Y2**	**Y3**		
Promote and expand the availability of fruit and vegetable incentive programs.	X	X	X	Sunnyview Rehabilitation Hospital	Staff time/effort to promote/ refer to of Double Up Food Bucks and Farmer's Market's Nutrition coupons programs
	X	X	X	Ellis Hospital	Staff time/effort to promote/ refer to of Double Up Food Bucks and Farmer's Market's Nutrition coupons programs
	X	X	X	Schenectady County Department of Health	Staff time/effort for implementation of Double Up Food Bucks and Farmer's Market's Nutrition coupons programs
	X	X	X	Schenectady Food Council	Staff time/effort for implementation with Double Up Food Bucks, Farm-to-school programs and Farmer's Markets Nutrition Coupon programs
	Focus location(s)				**Focus Population(s)**
	City of Schenectady, including high priority zip code: 12307 and priority zip codes: 12303, 12304, 12305, 12308				Low socio-economic population, racial and ethnic minorities

2

Mental Health (Depression, Anxiety, Stress) and Suicide

Goal: Prevent and address the impact of Adverse Childhood Experiences

CHNA Impact Measures By December 31, 2028:	FY2027 Baseline	FY2029 Target
Reduce the percentage of adults who, as a child, experienced three or more adverse childhood experiences (ACES) (*Data source: NYS Behavioral Risk Factor Surveillance System)*	25.3%	23.8%
Reduce the percentage of Black, non-Hispanic adults who, as a child, experienced three or more adverse childhood experiences (ACES) (*Data source: NYS Behavioral Risk Factor Surveillance System)*	30%	28.4%

Strategy	Timeline Y1	Y2	Y3	Hospital and Committed Partners (align to indicate committed resource)	Committed Resources (align by hospital/committed partner)
Strengthen community partnerships to support education, case coordination, and referrals of at-risk families to local health departments, hospitals, and other community-based organizations to increase participation in home visiting programs.	X	X	X	Sunnyview Rehabilitation Hospital	In-kind staff time to attend/plan coalition meetings, data collection and reporting
	X	X	X	Ellis Hospital	In-kind staff time to attend/plan coalition meetings, data collection and reporting
	X			Schenectady County Health Department	In-kind staff time to attend/plan coalition meetings, data collection and reporting
	X			Schenectady Coalition for a Healthy Community	In-kind staff time to attend/plan coalition meetings, data collection and reporting
	Focus location(s)				**Focus Population(s)**
	City of Schenectady, including high priority zip code: 12307 and priority zip codes of 12303, 12304, 12305, 12308				Individuals experiencing low socioeconomic status (SES), access to healthcare and supportive services, access to housing; women and children, racial and ethnic minorities

Strategy	Timeline			Hospital and Committed Partners (align to indicate committed resource)	Committed Resources (align by hospital/committed partner)
	Y1	Y2	Y3		
Identify Adverse Childhood Experiences (ACES) and other types of trauma in primary care settings through screening and referrals.	X	X	X	Sunnyview Rehabilitation Hospital	St. Peter's Health Partners primary cares will institute screening of ACES upon entry intake to the primary care
	X	X	X	Ellis Hospital	Ellis primary cares will institute screening of ACES upon entry intake to the primary care
	X	X	X	Schenectady County Health Department	Staff time and effort to screen for access to primary care and refer community members to primary care settings
	Focus location(s)				**Focus Population(s)**
	City of Schenectady, including high priority zip code: 12307 and priority zip codes: 12303, 12304, 12305, 12308				Individuals experiencing low socioeconomic status (SES), access to healthcare and supportive services, access to housing; women and children, racial and ethnic minorities.

Strategy	Timeline			Hospital and Committed Partners (align to indicate committed resource)	Committed Resources (align by hospital/committed partner)
	Y1	Y2	Y3		
Integrate principles of trauma-informed approach in workforce development, training, and practices within agencies and across communities to promote a trauma-informed culture.	X	X	X	Sunnyview Rehabilitation Hospital	In-kind time/effort for providing Mental Health First Aid programming to staff
	X	X	X	Ellis Hospital	In-kind time/effort for providing Mental Health First Aid programming to staff
	X	X	X	Schenectady County Department of Health	Staff time/effort for the promotion and referral of community members to Mental Health First Aid programming
	X	X	X	Schenectady Coalition for a Healthy Community	In kind time and effort of coalition members to develop trauma informed care practices within community agencies
	City of Schenectady, including high priority zip code: 12307 and priority zip codes: 12303, 12304, 12305, 12308				Individuals experiencing low socioeconomic status (SES), access to healthcare and supportive services, access to housing; women and children, racial and ethnic minorities

3

Obesity and Diabetes

Goal: Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases.

CHNA Impact Measures By December 2028:	FY2027 Baseline	FY2029 Target
Increase the percentage of adults aged 35+ who had a test for high blood sugar in the past year *(Data source: NYS Behavioral Risk Factor Surveillance System)*	78.1%	82.4%
Increase the percentage of younger adults ages 35-44 who had a test for high blood sugar in the past year within Schenectady County *(Data source: NYS Behavioral Risk Factor Surveillance System)*	62.4%	65.5%
Increase the number of participants in Diabetes Prevention Programs within Schenectady County *(Source: St. Peter's Health Partners Diabetes Prevention Program)*	60	180
Reduce the prevalence of obesity among adults (age 18+) within Schenectady County *(Data source: NYS Behavioral Risk Factor Surveillance System)*	34%	32%
Reduce the prevalence of diabetes among adults (age18+) within Schenectady county *(Data source: NYS Behavioral Risk Factor Surveillance System)*	10.2%	8.2%

Strategy	Timeline			Hospital and Committed Partners (align to indicate committed resource)	Committed Resources (align by hospital/committed partner)
	Y1	Y2	Y3		
Expand screening for social care needs among all adults and those with chronic diseases (prediabetes, diabetes, hypertension, cancer screening)	X	X	X	Sunnyview Rehabilitation Hospital, St. Peter's Health Partners Medical Group	Staff time/effort to provide screening of individuals during primary care and walk in visits for chronic diseases

and provide referrals to appropriate community resources and supports.	X	X	X	Schenectady County Department of Health	Staff time/effort to provide screening cards, and information regarding prediabetes and diabetes at outreach events
	X	X	X	Ellis Hospital	Staff time/effort to provide screening of individuals during primary care and walk in visits for chronic diseases
	Focus location(s)				**Focus Population(s)**
	City of Schenectady, including high priority zip code: 12307 and priority zip codes: 12303, 12304, 12305, 12308				Low socio-economic population, racial and ethnic minorities
Strategy	**Timeline**			**Hospital and Committed Partners** (align to indicate committed resource)	**Committed Resources** (align by hospital/committed partner)
	Y1	**Y2**	**Y3**		
Expand the number of health care providers who provide chronic disease self-management education in areas with high chronic disease burden.	X	X	X	Sunnyview Rehabilitation Hospital, St. Peter's Health Partners Medical Group	Staff time/effort to implement Diabetes Prevetion and Diabetes Management Programming
	X	X	X	Ellis Hospital	Staff time/effort to provide education and implement programs
	X	X	X	Schenectady County	Staff time/effort for creating workgroup with focus on diabetes/obesity
	X	X	X	Schenectady Coalition for a Healthy Community	Staff time/effort for creating workgroup with focus on diabetes/obesity
	Focus location(s)				**Focus Population(s)**
	City of Schenectady, including high priority zip code: 12307 and priority zip codes: 12303, 12304, 12305, 12308				Individuals experiencing low socioeconomic status (SES), access to healthcare and supportive services, access to housing; women and children, racial and ethnic minorities
Strategy	**Timeline**			**Hospital and Committed Partners** (align to indicate committed resource)	**Committed Resources** (align by hospital/committed partner)
	Y1	**Y2**	**Y3**		
Improve diagnosis of prediabetes and referrals to the National Diabetes Prevention Program (DPP) lifestyle change programs among high burden NYS adults.	X	X	X	Sunnyview Rehabilitation Hospital,	Implement workflows to increase testing for prediabetes and diabetes at annual wellness visits, in the primary care setting
	X	X	X	Ellis Hospital	Implement workflows to increase testing for prediabetes and diabetes at annual wellness visits, in the primary care setting
	X	X	X	Schenectady County	Staff time/effort for creating workgroup with focus on diabetes/obesity

	Focus location(s)	Focus Population(s)
	City of Schenectady, including high priority zip code: 12307 and priority zip codes: 12303, 12304, 12305, 12308	Individuals experiencing low socioeconomic status (SES), access to healthcare and supportive services, access to housing; women and children, racial and ethnic minorities

Strategy	Timeline			Hospital and Committed Partners (align to indicate committed resource)	Committed Resources (align by hospital/committed partner)
	Y1	Y2	Y3		
Partner with community-based organizations to promote access to prevention and screening services.	X	X	X	Sunnyview Rehabilitation Hospital, St. Peter's Health Partners Community Health and Well-being Dept	Staff time/effort to attend community outreach events to promote access to primary care and preventative screenings
	X	X	X	Ellis Hospital	Staff time/effort to attend community outreach events to promote access to primary care and preventative screenings
	X	X	X	Schenectady Coalition for a Healthy Community	Staff time and effort to plan community outreach events to promote/refer to organizations that provide preventative health screenings
	Focus location(s)				**Focus Population(s)**
	City of Schenectady, including high priority zip code: 12307 and priority zip codes: 12303, 12304, 12305, 12308				Individuals experiencing low socioeconomic status (SES), access to healthcare and supportive services, access to housing; women and children, racial and ethnic minorities

Adoption of Implementation Strategy

On April 24, 2026, the Board of Directors for St. Peter's Health Partners met to discuss Fiscal Year's 2027-2029 Implementation Strategy for addressing the community health and social needs identified in the FY 2026 Community Health Needs Assessment. Upon review, the Board approved this Implementation Strategy and the related budget.

5/5/2026

Steven Hanks, MD, MMM, FACP, FFSMB; President and CEO [Date]