Community Health Needs Assessment (CHNA) Implementation Strategy

Fiscal Year 2026

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 25, 2025. 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-reportsor 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 multi-specialty 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

While community health needs assessments (CHNA) and implementation strategies are required by the IRS, Trinity Health ministries have historically conducted CHNAs and developed Implementation Strategies as a way to meaningfully engage our communities and plan our Community Health & Well-Being work. Community Health & Well-Being promotes optimal health for people experiencing poverty or other vulnerabilities in the communities we serve by addressing patient social needs and investing in our communities through dismantling oppressive systems,

including racism, and building community capacity. Trinity Health has adopted the Robert Wood Johnson Foundation's definition of Health Equity - "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

This implementation strategy was developed in partnership with community and will focus on specific populations and geographies most impacted by the needs being addressed. Racial equity principles were used throughout the development of this plan and will continue to be used during the implementation. The strategies implemented will mostly focus on policy, systems and environmental change as these systems changes are needed to dismantle racism and promote health and wellbeing for all members of the communities we serve.

Health and Social Needs of the Community

The CHNA conducted in late 2024, to early 2025 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	• 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. 2021-2023 • 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. 2021-2023
2. Diabetes	• 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 the NYS (11.1%) and the US (12.0%) rate. 2021-2023 • 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)
3. Social Determinants of Health	• The food insecurity rate for Schenectady County is 11.3%, which is lower than the NYS (12.6 %) and the US (12.88%) rates. • Within Schenectady County there are forty-six grocery establishments- a rate of 29.10 per 100,000 population; this is significantly lower than the NYS average of 41.76/ 100,000 population (2024) • 12.77% of Schenectady county households receive Supplemental Food and Nutrition (SNAP) benefits, which is greater than the US average of 11.52%. 2019 • 11.21% of the low-income population in Schenectady County have low food access. The total low-income population in Schenectady

	County with low food access is 4,613. (Low food access is defined as living more than 1 mile (urban) or 10 miles (rural) from the nearest supermarket, supercenter, or large grocery store.). This rate is higher than the NYS rate (7.98%) and lower than the US rate (19.41%). 2019 • In Schenectady County, 25.03% or 38,915 individuals for whom poverty status is determined are living in households with income below 200% of the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status. (2018-2022)
4. Mental Illness including 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. 2022 • 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.
5. Cardiac Conditions including Stroke, Heart Disease and Hypertension	• Within Schenectady County, there were a total of 984 deaths due to coronary heart disease, from 2018-2022. This represents a crude death rate of 126.1 /100,000 population. • The rate of heart disease in the Medicare population in 2022 was 21% in Schenectady County, which was lower than the NYS rate (23%) and the same as the US rate. • Within Schenectady County, 33.2% of adults age 18+, reported having high blood pressure, which is higher than both the NYS and US Average. (2021)
6. Poor Birth Outcomes	• Within Schenectady County, the percentage of women who did not obtain prenatal care until the 7th month (or later) of pregnancy or who did not have any prenatal care was 4.86% overall, which is lower than the national average rate of 6.12%. In addition, Black Non-Hispanic individuals living in Schenectady County have a lower rate of early prenatal care (66.1%) compared to White Non-Hispanic individuals (81.9%). (2019-2021) • The overall rate of premature births (<37 weeks gestation) was 10.6% for Schenectady County, which was slightly higher than the NYS rate. In addition, Black non-Hispanic individuals (13.6%) have a higher rate of premature births, when compared with White non-Hispanic individuals (9.4%) (2019-2022)

	• Within Schenectady County, ninety infants died during the 2015-2021, seven-year period. This represents 7.1 deaths/ 1,000 live births, which is higher than both the NYS and US rates
7. Alcohol and Drug Misuse	• 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% (County Health Rankings, 2021) • 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
8. Childhood Lead Exposure	• 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)
9. 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. 2018-2022 • 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
10. Tobacco Use	• Within Schenectady County, 12.9% of the total population age 18+ are current smokers (2022), which is slightly higher than the NYS rate.
11. Immunization and Related Disease, including COVID-19	• The percentage of deaths in Schenectady County attributed to COVID-19, as of 3/10/23 was 243.97 per 100,00 population, which is less than the NYS average of 391.93 /100,000. • As of September 2022, the percentage of adults fully vaccinated for COVID-19 in Schenectady County was 83.20%, which was lower than the NYS percentage of 84.02%
12. Asthma	• Within Schenectady County, 10.7% of adults age 18+ reported having asthma, which was slightly higher than NYS and US rates. 2022 • Within Schenectady County, asthma hospitalization rates were 2.1 times higher among Black, Non-Hispanic residents than White Non-

	Hispanic residents. 2021
13. 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.
14. Injuries and Falls	• Within Schenectady County, the 2015-2017 three-year total of reported violent crimes was 1,862, which equates to an annual rate of 401.20 crimes per 100,000 people, lower than the statewide rate of 536.90. • Within Schenectady County, the 2018-2022 five-year average rate of death due to motor vehicle crash per 100,000 population was 6.9/ 100,000 population. • The age adjusted falls hospitalization rate in Schenectady County (2020-2022) was 50.6/10,000 population
15. Tick-Borne Disease	• Schenectady County's 2019-2021 Lyme disease incidence rate of 97.3/100,000 population was higher than the NYS rate of 34.8/100,000. • In Schenectady county, the incidence of Lyme Disease increased from 68.7/100,000, in 2016-2018 to 97.3/ 100,000 in 2019-2021.

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. Obesity and Diabetes– CHNA pages 18-21
2. Social Determinates of Health, Specifically, Food Security– CHNA pages 31-36

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:

- **Mental Illness including Suicide** – the hospital will provide treatment and education of this health need as part of our routine care of patients.
- **Cardiac Conditions, including Stroke, Heart Disease, and Hypertension -** the hospital will provide treatment and education of this health need as part of our routine care of patients.
- **Poor Birth Outcomes**- to avoid duplication of efforts because other organizations are addressing the need.
- **Alcohol and Drug Use**- to avoid duplication of efforts because other organizations are addressing the need.
- **Childhood Lead Exposure**- to avoid duplication of efforts because other organizations are addressing the need.
- **Cancer**- to avoid duplication of efforts because other organizations are addressing the need.
- **Tobacco Use**- Competing priorities, the hospitals will promote existing cessation programs within the community.
- **Immunization and Related Disease**- 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.
- **Asthma**- competing priorities, the hospital will provide treatment and education of this health need as part of our routine care of patients.
- **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.
- **Injuries and Falls**- the hospital will provide treatment and education of this health need as part of our routine care of patients.
- **Tick Borne Disease**- 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. In addition,this implementaion strategy is only for a one-year time line and another implementation strategy will be produced following the full community collaroative Community Health Needs Assessment in 2026. 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 described strategic initiatives. During this year, other organizations in the community may decide to address certain needs, indicating that the hospital should refocus its limited resources to best serve the community.

1 Diabetes and Obesity

Goal: Increase access to healthy lifestyle programing in an effort to reduce the prevalence of diabetes and obesity within the community

CHNA Impact Measures By June 30, 2026:	2025 Baseline	2026 Target
Increase the percentage of adults aged 35+ who had a test for high blood sugar within the past year by 2%, within Schenectady County *(source: BRFSS; Behavioral Risk Factor Surveillance System)*	78.1%	79.6%
Increase the number of adults (aged 35+) who are enrolled in the National Diabetes Prevention Program within Schenectady County	50	100
Increase the prevalence of physical activity among adults age 18+ by 2%, within Schenectady County *(source: BRFSS; Behavioral Risk Factor Surveillance System)*	73.9%	75.3%

Strategy	Timeline Y1	Y2	Y3	Hospital and Committed Partners (align to indicate committed resource)	Committed Resources (align by hospital/committed partner)
Increase prediabetes awareness by promoting diabetes screening, testing and referral to the National Diabetes Prevention Program	X			St. Peter's, Samaritan, and Sunnyview Rehabilitation Hospitals (SPHP)	$260,000 grant funding to screen, enroll and deliver NDPP
	X			Schenectady County Health Department	Staff time and effort promote screening for prediabetes and referral to NDPP
	X			Ellis Hospital	Staff time and effort promote screening for prediabetes and referral to NDPP
	X			Catholic Charities Care Coordination Services	Staff time and effort to screen for prediabetes, enroll and deliver NDPP
	Focus location(s)				**Focus Population(s)**
	City of Schenectady, including high priority zip code: 12307 and priority zip codes: 12303, 12304, 12305, 12308				Black/African American, Latinx and community members age 65+

Strategy	Timeline Y1	Y2	Y3	Hospital and Committed Partners (align to indicate committed resource)	Committed Resources (align by hospital/committed partner)

Scale and spread healthy lifestyle programs such as the National Diabetes Prevention Program (NDPP), an evidence-based intervention for adults (18+) who are at risk for developing diabetes, in accordance with CDC guidelines and Diabetes Self-Management Programing	X			St. Peter's, Samaritan, and Sunnyview Rehabilitation Hospitals (SPHP)	$260,000 grant funding to deliver NDPP; staff time and effort to deliver Diabetes Self-Management Programing
	X			Catholic Charities Care Coordination Services	Staff time and effort to screen, enroll and deliver NDPP
	X			Community Pharmacy Enhanced Services Network (CPESN)	Staff time and effort to screen, enroll and deliver NDPP
	Focus location(s)				**Focus Population(s)**
	City of Schenectady, including high priority zip code: 12307 and priority zip codes of 12303, 12304, 12305, 12308				Black/African American, Latinx and community members age 65+
Strategy	**Timeline**			**Hospital and Committed Partners** (align to indicate committed resource)	**Committed Resources** (align by hospital/committed partner)
	Y1	**Y2**	**Y3**		
Implement a combination of worksite-based and community-based physical activity policies, programs or best practices in an effort to increase the prevalence of physical activity among Schenectady County community members	X			St. Peter's, Samaritan, and Sunnyview Rehabilitation Hospitals (SPHP)	Staff time and effort to implement workplace physical activity initiatives
	X			Ellis Medicine	Staff time and effort to implement workplace physical activity initiatives
	X			Capital District Physicians Health Plan (CDPHP) Cycle Bike Sharing Program	Operation of the Cycle! Bike share program aimed to increase physical opportunities for community members
	X			Capital District Transportation Authority (CDTA)	Cycle Program & Nature Bus, programs aimed to increase physical activity opportunities for community members
				Schenectady County Department of Health	Staff time and effort to implement workplace and community based physical activity initiatives
	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)

2

Social Determinants of Health; Specifically, Food Security

Goal: Improve access to affordable and healthy food options to community members regardless of socioeconomic status

CHNA Impact Measures By June 30, 2026:	2025 Baseline	2026 Target
Sunnyview Rehabilitation Hospital will increase the rate of social needs screenings by 3% from baseline *(source: Trinity Health Social Needs Screening Dashboard)*	91%	94%
Increase enrollment in Food as Medicine Programs within Schenectady County	275	303
Increase the food security rate in Schenectady County *(source: BRFSS; Behavioral Risk Factor Surveillance System)*	88.7%	89.7%

Strategy	Timeline Y1	Y2	Y3	Hospital and Committed Partners (align to indicate committed resource)	Committed Resources (align by hospital/committed partner)
Utilize Community Health Workers (CHWs) to screen and address Social Determinants (Influencers) of Health, including food insecurity and other basic social needs, through the collaborative care model	X			St. Peter's, Samaritan, and Sunnyview Rehabilitation Hospitals (SPHP)	Salary of 3.0 FTE CHW
	X			Ellis Hospital	Time and effort of employed CHWs
	X			Schenectady County Health Department	Promotion of CHWs services
	X			Catholic Charities Care Coordination Services	Time and effort of employed CHWs
	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)

Strategy	Timeline Y1	Y2	Y3	Hospital and Committed Partners (align to indicate committed resource)	Committed Resources (align by hospital/committed partner)
Increase the number of patients and community members screened and referred to community resources through the Community Resource Directory (findhelp.org) and the Unite Us Platform (Healthy Alliance)	X			St. Peter's, Samaritan, and Sunnyview Rehabilitation Hospitals (SPHP)	Staff time and effort for screening/referral
	X			Ellis Hospital	Staff time and effort for screening/referral
	X			Healthy Alliance	Provide ongoing training to Community Health Workers and Care Coordination staff to increase

					utilization and operational support for use of the Unite Us platform
	X			Findhelp.org	Provide ongoing training to Community Health Workers and Care Coordination staff to increase utilization and operational support for use of Community Resource Directory.
	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)
Strategy	**Timeline**			**Hospital and Committed Partners** (align to indicate committed resource)	**Committed Resources** (align by hospital/committed partner)
	Y1	**Y2**	**Y3**		
Serve on and collaborate with the NYS Food as Medicine (FAM) Coalition to advocate for policy change and institutionalize funding for FAM programs into NYS Mediciad	X			St. Peter's, Samaritan, and Sunnyview Rehabilitation Hospitals	Staff time and effort to serve on FAM council and subcommittees
	X			Ellis Hospital	Staff time and effort to serve on FAM council and subcommittees
	X			The Regional Food Bank	Staff time and effort to serve on FAM council and subcommittees
	X			Food Pantries of the Capital District	Coordinates the NYS Food As Medicine Project
	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 food insecurity
Strategy	**Timeline**			**Hospital and Committed Partners** (align to indicate committed resource)	**Committed Resources** (align by hospital/committed partner)
	Y1	**Y2**	**Y3**		
Increase participation in Food as Medicine Programs among individuals that are experiencing food insecurity and have been diagnosed with a chronic condition (such as diabetes or hypertension).	X			St. Peter's, Samaritan, and Sunnyview Rehabilitation Hospitals	$200,000 in grant funding to operate the SPHP Food as Medicine Program, yearly
	X			Catholic Charities	Staff time and effort to operate Food Farmacy (Food access Programming)
	X			Schenectady County Health Department	Staff time and effort to screen and refer to Food as Medicine/Food Farmacy programing
	X			Ellis Hospital	Staff time and effort to screen and refer to Food as Medicine/Food Farmacy programing
	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 food insecurity

Adoption of Implementation Strategy

On July 25, 2025, the Board of Directors for St. Peter's Health Partners met to discuss Fiscal Year 2026 Implementation Strategy for addressing the community health and social needs identified in the 2025 Community Health Needs Assessment. Upon review, the Board approved this Implementation Strategy and the related budget.

_____	08/08/2025
[Name of President/CEO and or CFO]	[Date]