ST. JOSEPH'S HEALTH
A Member of Trinity Health

ST PETER'S HEALTH PARTNERS
A Member of Trinity Health

FISCAL YEAR 2025
(JULY 1, 2024 - JUNE 30, 2025)

Community Impact Report

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OUR COMMITMENT TO THE COMMUNITY

We are proud to present the first regional look at the Community Health & Well-Being (CHWB) Impact Report for the 2025 fiscal year (July 1, 2024-June 30, 2025) for both St. Joseph's Health in Syracuse and St. Peter's Health Partners (SPHP) in Albany. We have collaborated to share program ideas and best practices to continue to evolve community benefits in our regions. We are excited to show the full reach of our efforts.

Our aim is to promote optimal health for our overall community, while focusing on individuals experiencing poverty, homelessness, food insecurity, or other unmet social needs – emphasizing the need bring together clinical and social care.

We do this by first addressing patients' social needs and leveraging community resources to meet those needs, along with providing screenings and safety net health centers, and developing sustainable healthy lifestyle programming, among other benefits. We also invest in our communities through shareholder advocacy, local policy changes, and community grants to name a few strategies. In FY25, our community impact in our regions totaled a combined $339.2 million.

Our community members have a voice in determining the types of programs and services that are needed. The transportation specialist position created last year for SPHP OB/GYN patients with transportation issues has been successful in helping 426 patients get to their medical appointments. In Syracuse, we provided 3,633 meals to 120 community members through our Food Farmacy program, allowing consistent access to fresh and healthy food. And together, our diabetes prevention program enrollment increased by 70% from FY24 to FY25.

It is always our priority to live our Mission to serve as a "compassionate and transforming healing presence within our communities." We are grateful to the partners in our robust referral networks as we continue to work together to improve the quality of life for the people we serve.

Sincerely,

Stephen Hanks, MD

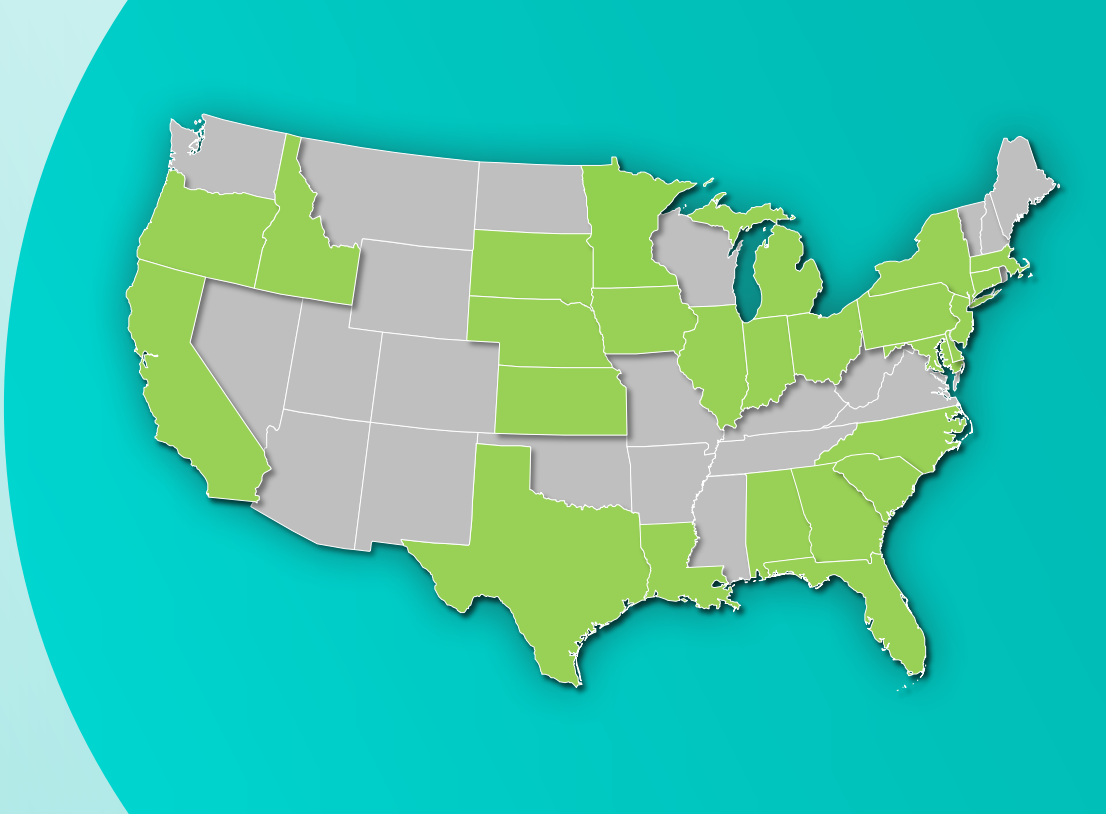
Katherine A. DeRosa

Stephen Hanks, MD
President & CEO
St. Joseph's Health &
St. Peter's Health Partners

Katherine A. DeRosa
Chief Mission Officer and Vice President
Community Health & Well-Being
St. Joseph's Health &
St. Peter's Health Partners

TRINITY HEALTH

ONE OF THE LARGEST CATHOLIC HEALTH SYSTEMS IN THE NATION



25 States

92 Hospitals*

1.1M Attributed Lives

12 Clinically Integrated Networks

$2.9B in Community Impact**

41 Safety Net Health Centers

162 Community Health Workers

11 Diabetes Prevention Programs

*Owned, managed or in JOAs or JVs. **including $1.4B in IRS-defined Community Benefit

OUR MISSION

We, St. Joseph's Health, 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.

OUR CORE VALUES

Reverence

Commitment to Those Experiencing Poverty

Safety

Justice

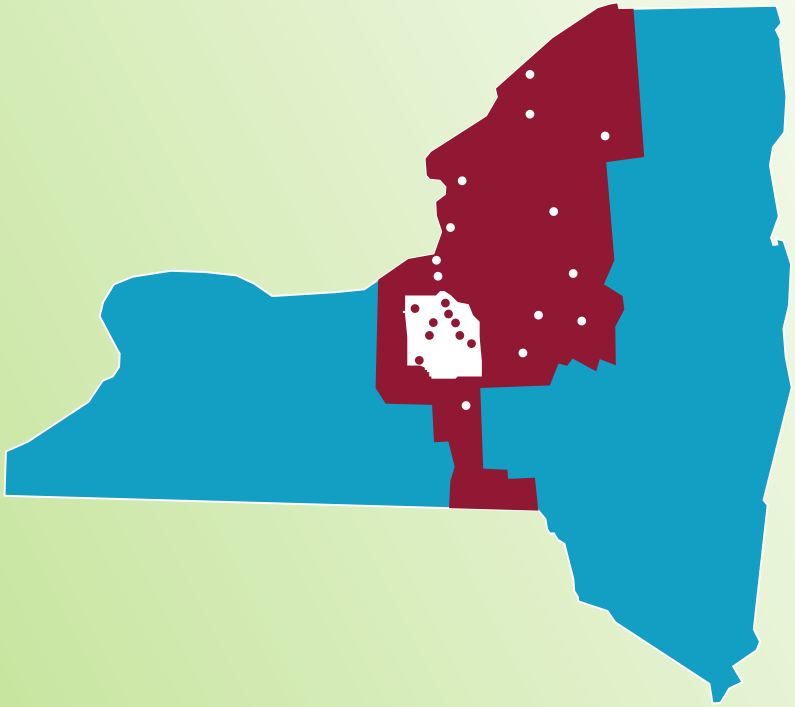
Stewardship

Integrity

OUR VISION

As a mission-driven innovative health organization, we will become the national leader in improving the health of our communities and each person we serve. We will be the most trusted health partner for life.

ST. JOSEPH'S HEALTH
AT A GLANCE



3,391 Colleagues

1 Hospital

423,426 Medical Practice Visits

15,462 Total Surgeries

724,035 Outpatients Visits

54,053 Emergency Visits

17,997 Inpatient Discharges

1,516 Babies Delivered

Community Impact

Our Community Impact includes both our investments in serving patients experiencing poverty and other vulnerabilities and investing in communities that have been, and continue to be, disinvested.

Achieving improvements in health outcomes is not possible until the conditions in the communities we serve are safe and all community members have access to basic needs such as education, health care, affordable housing and healthy foods. Knowing that health care influences only 20% of outcomes, St. Joseph's Health prioritizes the integration of clinical and social care, along with investments in social influencers of health. We are committed to improving community conditions and see measureable progress each year. We continue to track our impact and adjust our strategies to advance health equity.

St. Joseph's Health and Trinity Health are committed to ensuring we comprehensively report all the IRS-defined community benefit that occurs across our system, as well as our total Community Impact, to fully demonstrate the services and support we provide to our communities.

Our Community Impact
is more than Community Benefit

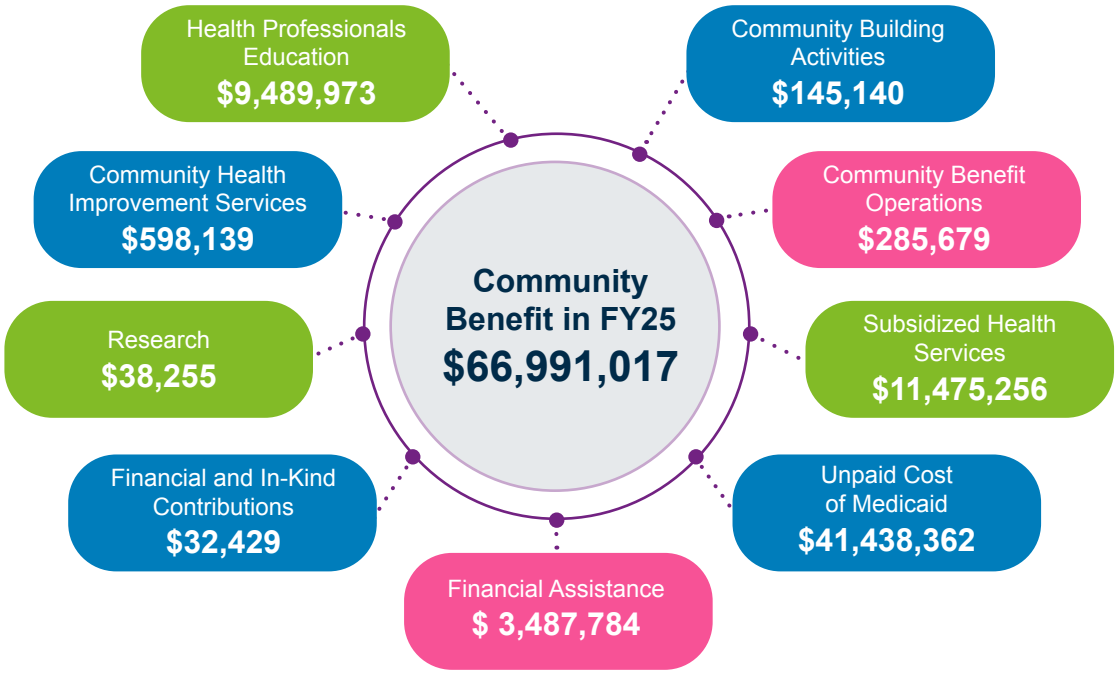
COMMUNITY IMPACT

$66,991,017 in IRS-defined Community Benefit

The IRS has clearly defined standards for reporting community benefit which includes Unpaid Medicaid Financial Assistance and other community benefit programs, including: Community Health Improvement; Health Professions Education; Subsidized Health Services; Research; Cash and In-Kind Contributions; Community Building Activities; and Community Benefit Operations.

$28,422,190 in Community Impact Activities

Community Impact meets the spirit of community benefit and acknowledges the investments made that create an impact in the community that the IRS does not consider.



FINANCIAL ASSISTANCE

Financial Assistance includes insured patients' co-pays, co-insurance, and deductibles for patients with incomes up to 400% of the Federal Poverty Level.

In FY25, St. Joseph's Health provided

$3,487,784 in financial assistance

10,195 patients benefited

Patients can now sign-up for Financial Assistance in MyChart.

Scan here

Integrating Social and Clinical Care

Addressing Patient Social Needs

Only 20% of our overall health and well-being in the United States is affected by the health care we receive. The remaining 80% is related to social influencers of health (housing needs, financial insecurity) and individual behaviors.

St. Joseph's Health goes beyond our hospital walls to serve our communities and our patients, especially to optimize health for people experiencing poverty and other vulnerabilities.

Everyone deserves the opportunity to live their healthiest life. By providing support that considers a wide range of human needs, we contribute to the well-being of the communities we serve.

Social Needs Screening

We are committed to annually asking our patients about their health-related social needs. Identified concerns may impact the health of our patients and could include things that make it hard to be healthy, like problems with work, housing, food, safety, and transportation. This information helps us:

- Understand our patients' needs and their barriers to care
- Connect patients to helpful resources and services specific to their needs

St. Joseph's Health screened nearly 87.58% patients for social needs in primary care settings. If patients identify a need, our teams are able to connect them to community resources through the Trinity Health Community Resource Directory, community health workers, and other social care professionals.

Food Access

Financial Security

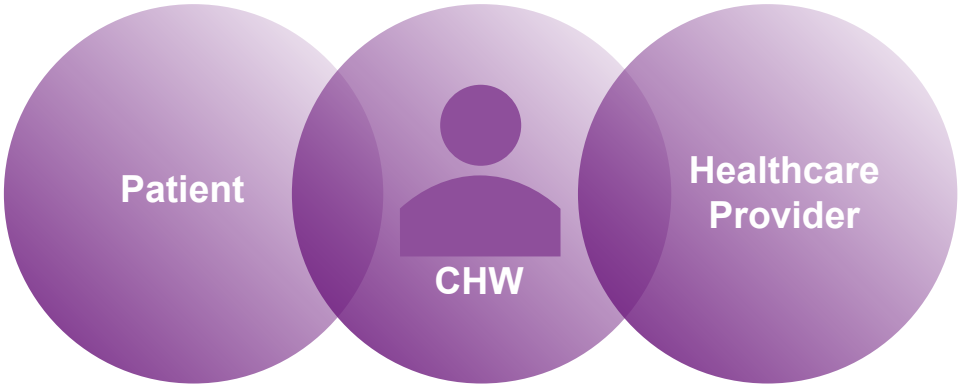
Transportation

Housing

Integrating Social and Clinical Care

Community Health Workers

A community health worker (CHW) is a frontline public health worker who is a trusted member of and/or has a close understanding of the community served. This trusting relationship allows the CHW to act as a bridge between patients, health care providers, and health/social services to increase access to services and improve the quality and cultural competence of service delivery.



CHWs fulfill many skills and functions including:

For example, CHWs can support patients with:

- Home visits to identify social needs and barriers that exist beyond hospital walls.
- Applying for public benefit assistance programs.
- Adopting healthy behaviors through health promotion and education.
- Feeling more confident and capable in managing their health care.

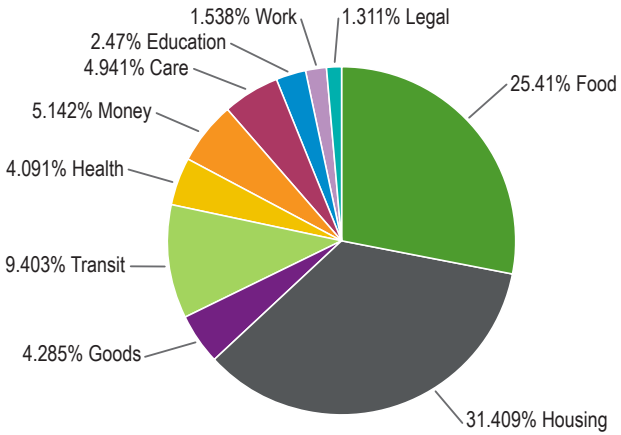
COMMUNITY MEMBERS SERVED

In FY25, two Community Health Workers at St. Joseph's Hospital assisted 434 community members, up from 350 in FY24.

COMMUNITY RESOURCE DIRECTORY

In FY25, 1,734 searches were conducted in the Community Resource Directory (CRD) which includes 1,298 organizations throughout New York state.

Searches by Category 2024-07-01 to 2025-06-30



Integrating Social and Clinical Care

Community Health Worker Success Story

An 81-year-old female patient who lives alone in her home was hospitalized on Jan. 29, 2025, and discharged on Feb. 4, 2025, following treatment for congestive heart failure (CHF). She was later referred to the CHF program by her health coach, Krista Piraino, for continued support in managing her condition.

During her first home visit on March 5, 2025, a safety assessment done by Pam Marion, community health worker, revealed multiple throw rugs throughout the home, which posed a fall risk. With her daughter present, the rugs were immediately removed to reduce hazards. The patient also faced barriers to care, particularly difficulty attending appointments due to weakness and pain. To address this, the accountable care organization (ACO) nurse coach contacted the community loaner closet, which provided both a walker and a transport chair. These resources allowed the patient to move safely within her home and attend appointments with the help of her daughter, who provided transportation.

Collaboration between the CHW, the nurse, the cardiology office, the patient, and her daughter supported ongoing monitoring of weights and medication management. With guidance, the patient began taking a more active role in her care, contacting cardiology directly when she noticed changes in her weight or symptoms. At the time of the initial call in February, the patient weighed 128 pounds. By July 2, 2025, she had reduced her weight to 108.5 pounds and reported feeling much better, with greater ability to complete tasks around her house. In addition, her health coach coordinated with her primary care provider regarding Vitamin B12 injections. Since weekly office visits were difficult, her daughter was trained at the office and is now able to administer the injections at home.

Through the support of her care team and her daughter, the patient has become stronger, more independent, and increasingly engaged in managing her health. She is now able to care for herself and her home, reflecting the positive impact of collaboration between Community Health & Well-Being, her providers, and her family.

“Through the support of her care team and her daughter, the patient has become stronger, more independent, and increasingly engaged in managing her health.”

Integrating Social and Clinical Care

Food Farmacy

The Food Farmacy continues to address food insecurity and chronic disease by providing eligible patients with three days of nutritious food each week for fifteen weeks, along with personalized counseling from a registered dietitian and access to a community health worker. Each year, 120 patients benefit from the program, receiving both resources and education that support long-term health improvements. In 2025, the Food Farmacy provided 3,633 meals.

In March 2025, the program partnered with the “Just Say Yes to Fruits and Vegetables” initiative to deliver USDA-approved nutrition lessons, cooking demonstrations, and recipes. The Food Farmacy also provides support for colleagues who need pantry items, particularly during food-centered holidays like Thanksgiving.

“Food Farmacy has helped me with food security on numerous occasions. I think community health workers are an important part of a care team. Resources, education, and service are key components that community health workers in the Food Farmacy offer to myself and other participants. Folks who are coming in, need access to resources, and community health workers help connect participants to resources they likely don’t know about and would not know about without having contact with a community health worker. While I am able to use the internet to look things up, I appreciate being able to talk through information with a human being to make finding and getting resources more efficient and in a personalized manner.”

- Damon Jones 7/8/25

Integrating Social and Clinical Care

Healthy Steps

At Primary Care Center (PCC)-Main and PCC-West, the HealthySteps program integrates child development and family support specialists directly into pediatric primary care visits. Parents and caregivers receive personalized guidance on nutrition, literacy, parenting strategies, and mental health resources during routine appointments. By identifying and addressing needs early, HealthySteps strengthens families and improves long-term outcomes for children.

At PCC-Main between 2024–2025, 710 children ages 0–3 were served. So far in 2025, providers have administered 352 developmental screenings and 122 postpartum depression screenings, ensuring both children and caregivers receive the comprehensive support they need.

"My daughter was here (at PCC-West) for her wellness visit and the HealthySteps coach came in and we talked about milestones that she should be reaching. So, we ended up getting her established in occupational and speech therapy. She was really developmentally behind, and now, at only 19 months old, she knows her letters, shapes, and alphabet. She sings songs. Instead of just reaching those milestones that she was supposed to meet, she's well beyond what she was supposed to meet.

The coach placed the referral … and they were able to schedule appointments for us within a few weeks. The process was really easy. I wasn't aware that HealthySteps existed until I came to this office. It's really nice because they check in on me and make sure that she is meeting her milestones. If I have any questions or need help, I know exactly who to call."

- Linette

Linette Garcia, Certified Medical Assistant, and HealthySteps participant and parent, Tiffany, at a wellness visit for Tiffany's daughter

HealthySteps participant and parent, Destiny, with her children

"Originally, PCC-West helped me get a home aid nurse for my oldest, and she came in, checked the baby's weight, and gave toys and books. They helped me get enrolled in HealthySteps, too. And with all my other kids … they helped me get therapy for my two middle kids because they were delayed. And then my oldest son, they helped me with his autism evaluation.

Throughout the eight years I've been in the program, they've helped me keep track of my appointments and provided information about resources I did not know about. They helped me find and contact services like physical therapy, food pantries, and diaper banks.

They helped me get in touch with services and doctors offices. It's been a lot easier because I don't have to go through all these other different contacts to get the help that I need.

HealthySteps is more of a family program. They treat their patients more as family members than just random people that they're just meeting and that walk into their office."

- Destiny

Integrating Social and Clinical Care

National Diabetes Prevention Program

According to the American Diabetes Association, about 38 million people have diabetes, and one in five don't know they have it. People who have diabetes are at higher risk of serious health complications, including kidney disease, eye damage, heart disease, stroke, nerve damage, and amputation.

But type 2 diabetes can be prevented, and diabetes can be managed, with lifestyle changes.

The National Diabetes Prevention Program (DPP) is a 12-month, evidence-based lifestyle change intervention for those with "prediabetes" whose blood sugar levels are higher than normal, but not enough for a type 2 diabetes diagnosis. The goal is to lose a percentage of baseline weight, attend sessions regularly, and engage in 150 minutes of physical activity each week.

Group classes are led by a Centers for Disease Control & Prevention (CDC)-certified lifestyle coach, and are offered in person, through distance learning on a web-based platform, or virtually for individuals needing a different pace.

Integrating Social and Clinical Care

Scale and Impact

The program is made possible through funding from Trinity Health through a cooperative agreement with the CDC to prevent or delay the onset of type 2 diabetes in communities served. It covers participants in both Central New York and the Capital Region. From 2024 to 2025, there were 240 program participants. Since the inception of the program in September 2017, more than 1,128 participants have enrolled.

We continually work to remove barriers to participation in the National DPP program. All patients are screened for health-related needs, including transportation, housing, and food insecurity, and are referred to a community health worker to address any needs. Trinity Health has leveraged its electronic health record to make it easier to identify patients and enroll them into the national DPP.

Diabetes Resource Champion Program

St. Joseph's Health also launched the Diabetes Resource Champion program, an intensive eight-hour training for clinical staff that prepared colleagues to serve as diabetes resources on their units, supporting transitions of care and reducing complications.

Key Community Initiatives

Community Health Needs Assessment and Implementation Strategy

Furthering our commitment to achieving health equity – we are committed to authentically engaging with our community members, organizations, and leaders. Every three years, we conduct a Community Health Needs Assessment (CHNA) which identifies community assets, needs, and the current state of health and social well-being of a community. The process requires input from those who live in the community, on both identifying and prioritizing the needs that will be addressed in the three-year implementation strategy. We are committed to applying a health equity lens to our interventions and decision-making to ensure we are promoting health and healing.

Syracuse CHNA Needs

St. Joseph's Health, in collaboration with community partners, is focused on developing and supporting measurable initiatives and strategies to improve the following health needs:

- Promotion of the Health of Women, Infants, and Children
- Promotion of Well-Being and Prevention of Mental and Substance Use Disorders

Key Community Initiatives

PCC-West Preventative Health Screening Event

St. Joseph's Health Primary Care Center-West (PCC-West) hosted a health screening and resource event that welcomed more than 200 patients and community members. Staff offered health screenings, including blood pressure and body mass index (BMI) checks, assisted with scheduling appointments, and connected individuals with interpreters and resource providers. A complementary meal that included healthy options of chili, fruit, and water was served. The event highlighted the practice's commitment to building personal connections while supporting preventive health and access to solutions for social needs.

Blood Pressure Monitoring

Through a grant from Excellus BlueCross BlueShield, St. Joseph's Health Primary Care Center-West distributed free pill organizers and 84 blood pressure home devices to patients managing hypertension, improving medication adherence and self-monitoring at home.

St. Joseph's Health Primary Care Center-West: Strengthening Care in the Community

St. Joseph's Health Primary Care Center-West (PCC-West) plays a vital role in serving one of Syracuse's most economically challenged neighborhoods. By combining high-quality primary care with outreach events and seasonal activities, the practice creates a welcoming environment where patients and families feel supported well beyond their medical needs. These initiatives address health disparities, foster trust, and strengthen the relationship between providers and the community they serve.

Health, Wellness, and Literacy Night

Colleagues participated in Franklin Elementary's Health, Wellness, and Literacy Night alongside community agencies and first responders. The event hosted approximately 600 participants, including students and family members, to teach them about heart and brain health, nutrition, and literacy through interactive presentations and raffles, making preventive health education engaging and accessible for all ages.

Key Community Initiatives

Clothing and Sock Donations

Colleagues across St. Joseph's Health supported vulnerable neighbors through clothing drives.

Thanks to a drive organized by Nursing Clinical Coordinator Vicki Bugge, RN, at Bryant & Stratton College, St. Joseph's Health Primary Care Center-West was presented with a large donation of clothing. With the help of students, staff, and community members, these donations were distributed to patients in need, furthering the clinic's impact on reducing barriers to health and dignity.

In addition, during "Socktober," employees donated a large box of new socks, one of the most requested but least donated items in homeless shelters. Director of Community Health & Well-Being Eric Stone delivered the socks to Assumption Church.

Community Outreach Pop-Ups

A series of Community Outreach Pop-Up events connected residents with vital resources outside Emergency Services. Teams from St. Joseph's Health—including Mobile Crisis Outreach, Peer Bridger Services, Health Homes, the College of Nursing, and the Food Farmacy—partnered with Fidelis Care and Onondaga County Department of Social Services (DSS) to provide behavioral health support, insurance enrollment, winter clothing, and snacks. Volunteers donated knitted items, and a community member contributed a sign that read: "Thanksgiving is for gratitude. Thanks for the good being done, ex. the food and the coats!" These events demonstrated the impact of meeting people where they are and reducing barriers to care.

Key Community Initiatives

Heart Saver Event

The Heart Saver Event included an educational component for attendees, teaching the importance of performing hands-only CPR. To demonstrate the impact of this lifesaving technique, the event honored survivors of out-of-hospital cardiac arrest and the individuals who saved them. Survivors and their families shared their experiences, while emergency medical personnel, hospital colleagues, and community members who performed hands-only CPR were recognized for their quick and lifesaving actions. The event highlighted the power of rapid intervention and the importance of community readiness.

Heart Walk

The American Heart Association's Heart Walk is always an impactful event for St. Joseph's Health, reflecting our role as both a financial supporter and a community leader in heart health. Hundreds of colleagues, patients, and families joined together to walk, dance, and celebrate wellness, demonstrating the deep connection between our ministry and the community. The College of Nursing staffed an information table, and St. Joseph's Health shared resources on cardiovascular health and nursing education. CPR demonstrations were offered by a trained colleague educator, equipping attendees with lifesaving skills and outlining the importance of prevention and preparedness.

During the Heart Walk, PCC-West patient Zamika Rogers was honored with the American Heart Association's Lifestyle Change Award. Nominated by her care team, Zamika shared how consistent support from her providers helped her transform her habits and reclaim her health.

Community Investing

In June, 2025, St. Joseph's Health contributed financial gifts to support food justice and health care access in Central New York. These gifts align with the mission to improve the health of the communities served, especially the vulnerable and underserved.

Supporting Access to Health Care Through Assumption Church

Also in June, 2025, St. Joseph's Health contributed $5K to Assumption Church's Poverello Health Center in Syracuse to help vulnerable populations without insurance or with limited insurance connect to health screenings and other needed health care services. The gift helped fund blood pressure cuffs, glucose meters and supplies, continuous glucose monitoring devices, educational materials, and lab costs. The gift was used to expand community outreach both at the church's clinic site and in other community locations.

Contributions to the InterFaith Works of Central New York

St. Joseph's Health contributed $11,350 to InterFaith Works of Central New York in Syracuse to aid in enhancing programming and access related to food justice efforts. The gift was given as a community benefit to support two large healthy food giveaways, educational programming on food access, and promotion of InterFaith Works' Food Justice Program. Focus was placed on the critical work of food pantries, especially during times of increasing financial stressors on individuals and families.

Eric Stone presents checks to support community programs at InterFaith Works of Central New York (top) and Assumption Church (bottom).

Community Investing

Community Grants and Collaborations

American Heart Association
Assumption Church
Autism Speaks, Inc.
Boys & Girls Club of Syracuse
Brady Faith Center
Catholic Charities of Onondaga County
Dunbar Association
Food Bank of Central New York
InterFaith Works of Central New York
NAMI Syracuse
Oswego Health Center
Sarah House, Inc.
The ALS Association
The Salvation Army
Westcott Community Center
YWCA of Syracuse & Onondaga, Inc.

Workforce Development

Student and Career Pathway Partnerships

St. Joseph's Health strengthened the future workforce by partnering with local schools and colleges to offer clinical rotations, mentorship, and career exposure. These opportunities encouraged students to pursue health careers while preparing them with practical experience.

Professional Etiquette Program

More than 120 colleagues, both clinical and non-clinical, completed the Professional Etiquette Program, designed to improve workplace skills, retention, and career progression. The initiative helped colleagues develop communication, professionalism, and leadership capabilities.

Caring Gene® Career Pathways Training Program

Another opportunity we offer our colleagues is the Caring Gene® Career Pathways Training program. This program covers the FULL cost of tuition and books in any of 13 approved fields, including nursing. To qualify for the program, students are required to fullfill a three-year service commitment with a health care, behavioral health, or social care network provider in New York state that serves a patient population of at least 30% Medicaid-reliant or uninsured individuals. Additionally, students must complete their degree by spring 2027 and fulfill the service requirement by 2031.

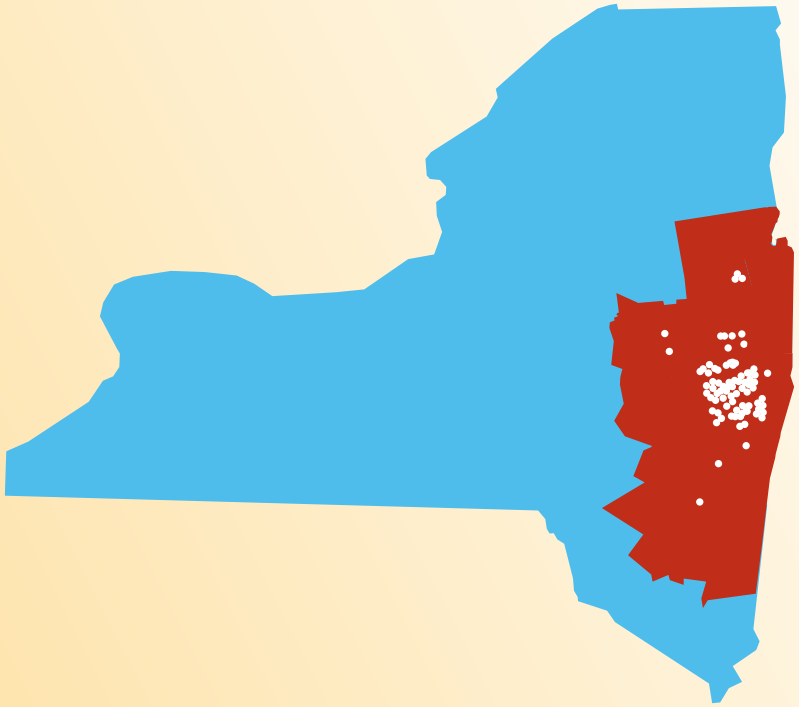
Although students don't have to return to St. Joseph's Health, we still offer the program to benefit them financially, knowing we are helping to better the workforce in our community. Through the Caring Gene program, students can study at most other nursing schools in New York state.

Preserving our Legacy

Expanding Access to TAP Blocks

St. Joseph's Health secured $14,000 in Trinity Health funding to purchase new Transversus Abdominis Plan (TAP) Block probes for use in our Labor & Delivery department. These probes allow clinicians to provide safer, more effective post-operative pain management for cesarean patients. With approximately 1,775 deliveries each year–30% via cesarean section–this investment ensures that more mothers, including the 73% who are Medicaid recipients, have equitable access to advanced, lower-intervention recovery options regardless of ability to pay.

ST. PETER'S HEALTH PARTNERS
AT A GLANCE



11,116 Colleagues

3 Hospitals

423,626 Medical Practice Visits

24,518 Total Surgeries

666,246 Outpatients Visits

115,741 Emergency Visits

38,821 Inpatient Discharges

3,762 Babies Delivered

Community Impact

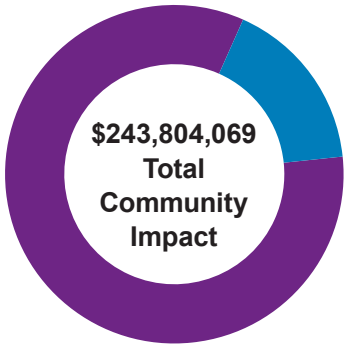
Our Community Impact includes both our investments in serving patients experiencing poverty and other vulnerabilities and investing in communities that have been, and continue to be, disinvested.

Achieving improvements in health outcomes is not possible until the conditions in the communities we serve are safe and all community members have access to basic needs such as education, health care, affordable housing and healthy foods. Knowing that health care influences only 20% of outcomes, St. Peter's Health Partners prioritizes the integration of clinical and social care and investments in social influencers of health. We are working to improve community conditions. Each year, we see measurable progress in our communities and continue to track and inform strategies for further growth in positive outcomes for health equity.

St. Peter's Health Partners and Trinity Health are committed to ensuring we comprehensively report all the IRS-defined community benefit that occurs across our system, as well as our total Community Impact to fully demonstrate the services and supports we provide to our communities.

Our Community Impact

is more than Community Benefit



COMMUNITY IMPACT

$143,339,460 in IRS-defined Community Benefit

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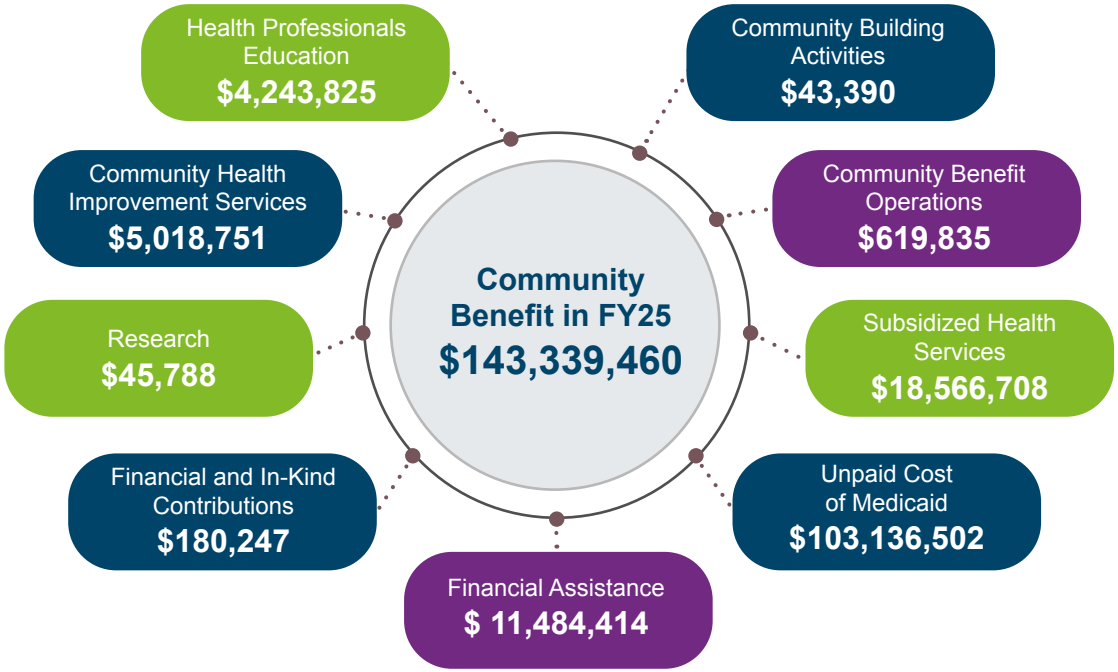
$100,464,609 in Community Impact Activities

Community Impact meets the spirit of community benefit and acknowledges the investments made that are making an impact in the community that the IRS does not consider.



FINANCIAL ASSISTANCE

Financial Assistance expanded in early 2025 to include insured patients' co-pays, co-insurance, and deductibles for patients with incomes up to 400% of the Federal Poverty Level.

In FY25, St. Peter's Health Partners provided

$11,484,414 in financial assistance

41,280 patients benefited

Scan here

Patients can now sign-up for Financial Assistance in MyChart.

Integrating Social and Clinical Care

Addressing Patient Social Needs

Only 20% of our overall health and well-being in the United States is affected by the health care we receive. The remaining 80% is related to social influencers of health (housing needs, financial insecurity) and individual behaviors.

St. Peter's Health Partners goes beyond our hospital walls to serve our communities and our patients, especially to optimize health for people experiencing poverty and other vulnerabilities.

Everyone deserves to live their healthiest life. And, a healthy life means so much more than receiving care in a health care facility.

Social Needs Screening

We are committed to annually asking our patients about their health-related social needs. These include things that make it hard to be healthy, like problems with work, housing, food, safety, and transportation. This information helps us:

- Understand our patients' needs and their barriers to care
- Connect patients to helpful resources and services specific to their needs

St. Peter's Health Partners screened nearly 88.26% patients for social needs in primary care settings. If patients identify a need, our teams are able to connect them to community resources through the Trinity Health Community Resource Directory, community health workers, and other social care professionals.

Food Access

Financial Security

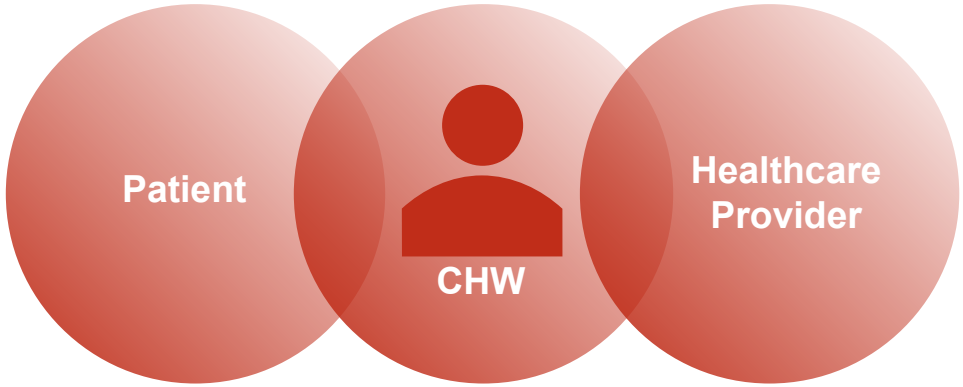
Transportation

Housing

Integrating Social and Clinical Care

Community Health Workers

A community health worker (CHW) is a frontline public health worker who is a trusted member of and/or has a close understanding of the community served. This trusting relationship allows the CHW to act as a bridge between patients, health care providers, and health/social services to increase access to services and improve the quality and cultural competence of service delivery.



CHWs fulfill many skills and functions including:

For example, CHWs can support patients with:

- Home visits to identify social needs and barriers that exist beyond hospital walls.
- Applying for public benefit assistance programs.
- Adopting healthy behaviors through health promotion and education.
- Feeling more confident and capable in managing their health care.

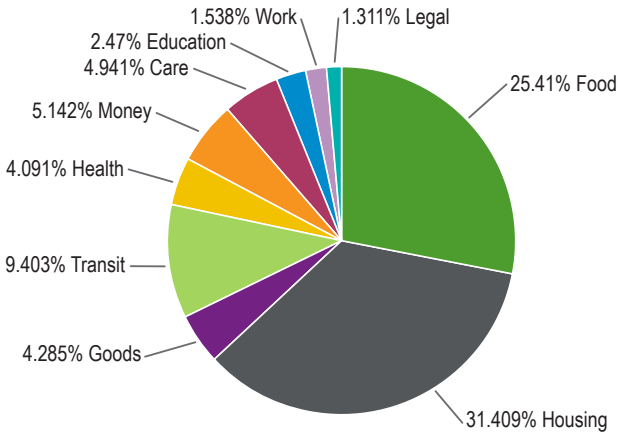
COMMUNITY MEMBERS SERVED

In FY25, six community health workers assisted 2,200 community members, up from 1,800 in FY24.

COMMUNITY RESOURCE DIRECTORY

In FY25, 6,277 searches were conducted in the Community Resources Directory (CRD) which includes 1,298 organizations throughout New York state.

Searches by Category 2024-07-01 TO 2025-06-30



Integrating Social and Clinical Care

Meeting Victoria Keir, Community Health Worker

Victoria Keir, CHW, has been with St. Peter's Health Partners for 17 years, with 11 months dedicated to being a community health worker. One of the things that drew her to this program is the collaborative model of care she feels is extremely important.

"We help a patient problem-solve their barriers by literally meeting them where they are at in life … their home. We become innovative to help make their own and their medical teams' goals happen," said Victoria. "We can connect several physicians at once when there is a communication breakdown and get immediate answers rather than months of individual appointments or weeks of phone calls."

Victoria also likes the amount of time she gets to spend with patients at home.

"While a physician may meet with a patient for 30 to 40 minutes on average, we're able to visit them for one or a few hours so they really feel heard and gain our trust," she said. "They talk to us about how they manage things like mobility, medications, and affording groceries, and we learn what they need help with so their doctors can better customize a treatment plan."

"Often, patients won't engage with a physician as much as they want to because they are nervous of not speaking at the same level and sounding unintelligent," she continued. "I absolutely love working with our physicians and providing insight it might have taken six appointments to uncover or never be uncovered. Something as simple as a patient misunderstanding something or not taking a medication because of a conflict; the patient doesn't realize how significant this change affects them and never mentions it. Together we can upgrade a patient's quality of life and that is life changing for all of us!"

Victoria's patient load varies, but averages around 30-40 patients per month. Most stay with her for six months, but it can be longer depending on the circumstances. If a patient needs extended help, Victoria can connect the patient with a resource who can help long term.

Victoria says teaching patients to advocate for themselves brings big rewards.

"I absolutely love the idea that I am empowering people to be more successful for themselves, whether it be for a day, a month, or a lifetime, there is nothing more rewarding than engaging people and connecting. We are helping patients become leaders in their health journey."

Victoria Keir, CHW, presented at the National Association of Community Health Workers (NACHW) Conference and Workshop in Columbus, Ohio, and described her role in the Social Care for Congestive Heart Failure program, a system-wide initiative supporting dually enrolled patients with heart failure. Victoria shared her experience meeting patients in their homes and her tactics to share back her insights with the patient's provider.

Integrating Social and Clinical Care

National Diabetes Prevention Program

According to the American Diabetes Association, about 38 million people have diabetes, and one in five don't know they have it. People who have diabetes are at higher risk of serious health complications, including kidney disease, eye damage, heart disease, stroke, nerve damage, and amputation.

But type 2 diabetes can be prevented, and diabetes can be managed, with lifestyle changes.

The National Diabetes Prevention Program (DPP) is a 12-month, evidence-based lifestyle change intervention for those with "prediabetes" whose blood sugar levels are higher than normal, but not enough for a type 2 diabetes diagnosis. The goal is to lose a percentage of baseline weight, attend sessions regularly, and engage in 150 minutes of physical activity each week.

Group classes are led by a Centers for Disease Control & Prevention (CDC)-certified lifestyle coach, and are offered in person, through distance learning on a web-based platform, or virtually for individuals needing a different pace.

Scale and Impact

The program is made possible through funding from Trinity Health through a cooperative agreement with the CDC to prevent or delay the onset of type 2 diabetes in communities served. It covers participants in both Central New York and the Capital Region. From 2024 to 2025, there were 240 program participants. Since the inception of the program in September 2017, more than 1,128 participants have enrolled.

We continually work to remove barriers to participation in the National DPP program. All patients are screened for health-related needs, including transportation, housing, and food insecurity, and are referred to a community health worker to address any needs. Trinity Health has leveraged its electronic health record to make it easier to identify patients and enroll them into the national DPP.

Integrating Social and Clinical Care

Diabetes Prevention Program Success Story

Daisy Cherotich, RN, St. Peter's ICU, finds success in St. Peter's Diabetes Prevention Program, lowering her A1C from 5.7% to 5.4% in just one month, and losing more than 12 lbs. so far.

When Daisy Cherotich found out she was prediabetic last year after an annual physical, she kept looking at an email at work about St. Peter's Diabetes Prevention Program (DPP). When she took stock of her eating habits at home, she realized she had one of the biggest … and smallest … reasons in the world to do something about it.

"The main reason I decided to participate in the program is because of my daughter. I want to be a better role model for her," said Daisy. "I gained most of my weight post-partum, and we had reached a milestone where she started eating solids. I wanted to be able to offer her better, nutritious food and for her to be able to eat what I'm eating. This brought awareness to how much unhealthy food I had been consuming. Not to mention, I love sweet items, and I realized she, too, was starting to favor sweet foods."

Daisy says the facilitators, especially Kaitlin Kozman, made the program interesting and were welcoming with a nonjudgemental tone and approach that doesn't make you feel bad about yourself and gives you hope for change. Her biggest takeaway is setting short, specific goals and celebrating small wins instead of focusing on a long-term goal that would often derail her if she had a setback.

"Before, if I had a lapse and ate something unhealthy, I would proceed to eat unhealthily all day with the plan of 'starting a fresh tomorrow' which would then turn into a lifestyle," remembers Daisy. "But now if I have something unhealthy, I can decide to make a healthier decision for the next meal. This has changed my life as I am now more conscious of the small decisions I make every day and how they impact my life. Little things, like measuring the honey instead of just pouring it, serving smaller portions, not forcing myself to finish a plate, and waiting a few minutes after eating to see if I really want more food or something sweet."

Daisy is most appreciative of the facilitators and the slower pace of the program, equipping participants with tools and a mindset to change their overall outlook and lifestyle for the long term.

"The staff has been nothing short of amazing! I highly recommend this program and encourage anyone who may be hesitant to just start and take it one step at a time. Once you start, you'll realize how reasonable and attainable goals are, and you'll be looking forward to the following week because of the one tiny win you had that week. I am grateful for this program and hope to use what I have learned to positively change my life and that of my loved ones."

Diabetes Prevent Program community outreach at the 2025 Tulip Festival in Albany, New York

Integrating Social and Clinical Care

Food Farmacy: Food is Medicine

Access to healthy food is a vital part of improving health equity, lowering health care costs, and addressing the economic burdens of poor nutrition. The Food Farmacy at Samaritan Hospital-Albany Memorial Campus addresses the health issues and food insecurity needs that our community members experience.

The Food Farmacy Program is provided at no cost and supplies healthy food sourced from the Regional Food Bank of Northeastern NY to food-insecure patients who also have chronic diseases such as type 2 diabetes, gestational diabetes, and obesity. Our goal is to teach patients to make healthy choices, educate them on the benefits of eating nutritious food, and provide them with the tools to help manage their chronic conditions through healthy eating for immediate and long-term success.

To participate in the Food Farmacy, a patient must:

- Screen positive for food insecurity.
- Have a diagnosis of type 2 diabetes, gestational diabetes, or pediatric obesity.
- Be willing to participate in education sessions; 12 weeks for most participants.

Patients are usually referred to the program by their primary care physician or health care specialist, such as endocrinology or maternal-fetal medicine, as part of their care plan. Food bags are picked up at the Food Farmacy once a week or delivered to participants who don't have access to transportation. The bags include recipes to use with the food products. Participants are also given supplies like cutting boards, peelers, pans, etc., if they are in need.

In FY25, there were 311 participants in the program – 758 including family members – from the counties of Albany, Rensselaer, Saratoga, and Schenectady. The average A1C declined from 8.8% to 7.3% with an average weight loss of 9.2 lbs.

Matt Senko and Faith Rescott assemble Emergency Food Assistance bags in St. Peter's Food Farmacy.

EMERGENCY FOOD ASSISTANCE PROGRAM

The Emergency Food Assistance Program is another component of the Food Farmacy Program. It provides hospital inpatients or emergency room visitors who have expressed food insecurity with a bag of three days' worth of healthy, shelf-stable food to take home with them upon discharge. They will also be asked to complete a referral form and, if they wish, will be linked to additional resources to help combat their food insecurity needs in the long term. This program also aids in emergency room and readmission avoidance by promoting healthy habits to result in less sickness and fewer visits.

In FY2025, 920 emergency food assistance bags were distributed to patients.

Integrating Social and Clinical Care

Food Farmacy Success Story

Rick Hlavac receives his weekly groceries from St. Peter's Food Farmacy

When you receive a phone call from a health care provider on a Saturday at 5 p.m., the news is not often good. For 61-year-old Rick Hlavac of Watervliet, New York, who had blood tests earlier that day, it was a directive to get to the emergency room because his sugar (blood glucose) was at 800 mg/dL (fasting blood glucose goals according to the American Diabetes Association are 80-120 mg/dL); and his A1C was at 13.6% (which should be at 7%). He had diabetes and was in acute danger. He spent days in the hospital addressing his sugar levels and learning how to test them and administer insulin.

Before being discharged, a staff member at St. Peter's told Rick about the Food Farmacy Program and how it could help him get his health back on track with a great support system.

"I was gung-ho right from the start to focus on my nutrition. They give you a book that shows all the fruits and calories, sugar, and carb counts," said Rick. "Everything I had I gave away or thew out and started over. It's hard to figure out what you can and can't eat, but they helped me out a tremendous amount. They are very dedicated. I really can't say enough."

So how successful was Rick?
At the time of this article, his sugar was between 60-120 mg/dL and his A1C was down to 5.7%, which is within range even for someone without diabetes. His insulin started at 60 units and was down to 20, and he says he may be able to get off it entirely if his progress continues.

What's next? He's had one knee replaced already and is waiting for the second replacement.

"Once all of this is done, hopefully I'll be able to do more exercise. But I'm managing my weight and keeping up on my numbers through my nutrition," said Rick. "I live on the second floor so every day I have to do stairs and that helps. I'm a lot stronger now. I feel better. I have more energy. I can see better. Everything is just healing. And I can keep up with my sugar on my own."

Community Health & Well-Being team members volunteering at the Regional Food Bank

Integrating Social and Clinical Care

Prescription Assistance Program

Therese O Callaghan, Prescription Assistance Specialist, St. Peter's Health Partners Prescription Assistance Program

As a program specialist for the St. Peter's Health Partners (SPHP) Prescription Assistance Program, which started in 2006, Therese O'Callaghan helps patients, colleagues, and community members obtain essential medications, which they would otherwise be unable to afford. This is done through drug manufacturer patient assistance programs and/or free trial coupons, discounted cash prices, and if needed and within program guidelines, accessing patient financial assistance using one of our outpatient pharmacies at St. Peter's or Samaritan Hospital.

In addition, Therese works closely with providers and pharmacists within SPHP to determine which medications are in highest demand among our more vulnerable populations and then researches available avenues for assistance. She also works with patients and providers to come up with alternatives when a patient is prescribed an expensive medication. Therese has found the most commonly requested medications are prescribed to treat diabetes, asthma, and cardiovascular disease.

During FY25, Therese assisted 1,217 individuals in obtaining 3,912 prescriptions overall, which had a retail value of approximately $195,000. FY25 saw a 5% increase in the number of patients assisted from FY24.

"I've worked in health care for 40 years and have always worked in advocacy of some kind. I've never seen a program like this. I'm usually dealing with patients who are really frustrated on the other end of the phone. I'm a cancer survivor myself, and I'm a diabetic, so I know how much this stuff costs. I love helping patients. We have a lot to juggle these days … worrying about paying for medications shouldn't be one of them.

Our ability to assist our patients is always a team effort. The SPHP Outpatient Pharmacy staff, case managers, and I are committed to making sure patients have their essential medications at discharge. Without continued access to medications and community health care providers, our program's patients won't get better. SPHP is unique to have the resources available to succeed in this goal. The next step is finding solutions to long-term access for these medications, especially for our patients experiencing homelessness and other vulnerabilities."

Integrating Social and Clinical Care

Healthy Families of Rensselaer County

Laurie McBain, LCSW-R, Health Families Program Manager

Healthy Families of Rensselaer County is a home-visiting program designed to support expecting families with prenatal care and education, or help new families by offering developmental screenings, helping them meet milestones, and other types of parenting support until children are five years old.

Many participants have a personal history of trauma or mental health challenges, are at risk of becoming unhoused, or are first-time parents who are anxious about parenting.

The voluntary program is provided at no cost for participants and includes identifying resources to assist parents in better meeting the family's needs. It also offers certified lactation consultants for both English- and Spanish-speaking families.

Starting 25 years ago, and accredited with the Healthy Families of America, there are now programs in Albany, Schenectady, Saratoga, Columbia, and Montgomery counties.

Results show the program improves birth outcomes with a 48% reduction in low birth weight deliveries among individuals enrolled before the 31st week of pregnancy; prevents child abuse and neglect with a drastic reduction in child protective services (CPS) reports for first-time parents as well as those with previous CPS reports; and improves success in school with fewer grade repeats and more children scoring above grade level, among other results.

"As an evidence-based program, we are able to see the positive impact the program has on families," said Laurie McBain, LCSW-R, program manager. "It is very satisfying to work with a program that you know makes an impact."

HEALTHY FAMILIES OF RENSSELAER COUNTY

During FY25, Healthy Families served 142 families and completed 2,926 home visits.

Key Community Initiatives

Community Health Needs Assessment and Implementation Strategy

St. Peter's Health Partners (SPHP) assesses and addresses the community's most critical needs. This analysis is completed using the triennial Community Health Needs Assessment (CHNA), a comprehensive process conducted in collaboration with local not-for-profit hospitals, health departments, and community-based organizations. CHNA involves active participation from community members and stakeholders to evaluate the overall health status of our community. These insights guide our initiatives and resource allocation, ensuring that SPHP addresses the most pressing health issues in our community. We are committed to applying a health equity lens to our interventions and decision-making to ensure we are promoting health and healing.

SPHP, in collaboration with community partners, is focused on developing and supporting measurable initiatives and strategies to improve the following health needs:

- Obesity and Diabetes
- Social Determinants (Influencers) of Health, Specifically Food Insecurity

Community Health & Well-Being's Annual Health and Wellness Fair and Farmer's Market (September 2024). Community members are provided with health education information from community programs; wellness services, such as chair massage and therapy dogs; and have access to free produce provided by St. Peter's Health Partners.

Key Community Initiatives

Transportation Specialist and Safety for Precious Cargo

Since the inception of the St. Peter's transportation program, Transportation Specialist Jill Sharp has helped 426 patients get back and forth to medical appointments.

But Jill's talents don't stop there. She has also been certified by Safe Kids Worldwide as a Child Passenger Safety Technician (CPST). She has performed 27 car seat safety checks to ensure babies are safe while traveling after leaving our hospitals.

Not every new parent can afford a new car seat. In those cases, Jill will refer them to appropriate resources to attain a car seat, including our own SPHP Child Passenger Safety Grant. She will then meet up with the mom at their OB-GYN provider's office to go over the safety points of the car seat and educate her how to properly buckle the baby in the seat. Jill then provides education and guidance while the mom installs the seat in her car, ensuring it is done properly and showing mom how to make adjustments when needed.

So, what does Jill find most rewarding about this aspect of helping new moms?

"There isn't really one thing; it's the whole experience working with the caregivers," said Jill. "I'm an old school 'it takes a village' kind of person. Being able to spend however long it takes to share knowledge and resources, maybe provide the extra 'you got this!' to the caregivers, is truly a wonderful feeling."

Jill must renew her certification as a CPST every two years by completing safety checks on a variety of car seat styles while being observed by a certified instructor or a technician proxy. She also has to participate in at least one community education event involving car seat safety/education and earn at least six continuing education units (CEUs).

Jill Sharp (left) completes another successful child car seat safety check.

Key Community Initiatives

Mom and Son Benefit from Car Seat Safety Instruction

Dana Cruz-Cooper, 38, of Schenectady, was a participant in the Maternal Obstetrical Mentoring Services (MOMS) program at St. Peter's Health Partners just a few months into her pregnancy. She was a single mom in a difficult situation, living in an RV. The program was instrumental in connecting Dana with the confidence and services she needed to find stable housing and have a healthy pregnancy with a bright future. But she still didn't own a car. So she was introduced to Transportation Specialist Jill Sharp.

"She was a lifesaver because at the time, I couldn't think about how I was getting to any of my appointments. She would call and set up appointments to get me to from here to there and also found some programs for me to get support from," said Dana.

Five months after baby Micah was born, he needed a new car seat which was gifted to Dana by the MOMS program.

"Oh, my goodness, I almost cried. It's expensive right now to buy a car seat. I didn't have the funds to buy one that would fit my son because he's growing like lightning."

Jill met with Dana to teach her how to safely secure Micah in the new car seat and install it correctly in her car.

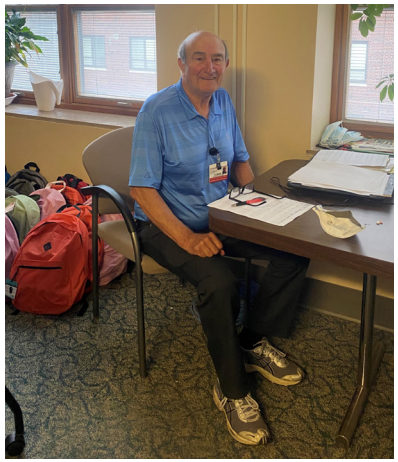
"I definitely don't know what I'm doing when I'm putting the car seat in! So, I feel a lot more secure and safe that he's going to be in there properly and safe in the car."

"It's remarkable how much help I'm still receiving after giving birth to my son … he's a really happy kid. Oh, it's such a blessing!"

The Maternal Obstetrical Mentoring Services (MOMS) is provided at no-cost and offers education and support to pregnant women regardless of age, insurance, or immigration status. Services include: pregnancy education, nutrition counseling, one-on-one childbirth and breastfeeding education, supportive counseling and referrals to community services, and assistance completing health insurance applications, obtaining baby supplies, and coordinating transportation to and from medical appointments.

Key Community Initiatives

The Patient Companion Connection to Needed Services



Jose Santos, Patient Visitor with SPHP Community Health & Well-Being

Joe Santos spent 35 years teaching and coaching in South Colonie, New York, but today, he's putting those skills to new use.

After retiring, Joe took a job in the Community Health & Well-Being department at St. Peter's Health Partners to make a difference in people's lives. He noticed many patients were lonely, so he requested to be a patient companion at St. Peter's Hospital, and his wish was granted.

Every day, Joe visits patients in the hospital. The conversation goes where the patient wants. Everything from worries and concerns to traveling or sports.

"They've been by themselves. They're tired of being poked and prodded and just want some companionship," said Joe. "Other times they express concerns about their social needs. Things like, 'I'm in the hospital and not working so how will I pay my bills?' or 'I have a problem with drinking and need help.' I can bring those concerns forward and help to link them to community services that can help them. We develop a relationship and it's comforting to them."

Sometimes Joe sees patients who are nervous about having major surgery. He reassures them and says he'll see them after surgery, and when they open their eyes and see him, they say, "Oh! I thought you were kidding!" They appreciate the familiar face.

Many patients he sees are hospitalized for an extended time. He visits daily, encouraging them to report a little improvement every day, just like a coach would tell his athletes. They look forward to conversations about a rosy future.

One former patient Joe spoke with regularly found himself in St. Peter's Palliative Care program. The patient kept asking about "Joe Santos" and wanted to reach out to him. They were reconnected by phone and made plans to meet up. By chance, Joe was in a hospital elevator when the doors opened, and he recognized that same patient in a wheelchair from the back. Joe visited him and his wife in his room, and she said, "Because of you, he turned to religion, and he got baptized!" She pulled the baptismal certificate from her purse, and it said, "Godfather: Joe Santos."

"You go in there, just to talk to people, not knowing you can have a tremendous influence by the words you say or how you present yourself," said Joe. "There's a lot of need throughout the hospital. Many patients tell me my visit is the best thing that's happened to them all day, and I'm happy I can help."

Key Community Initiatives

Centering Pregnancy

In 2024, Capital Region Midwifery partnered with the Centering® Healthcare Institute and began the Centering model of empowering prenatal care, combining expert health care with group support. Participants experience 10 interactive and fun group appointments with other pregnant individuals at similar gestational ages. Centering has clinically proven better health outcomes, such as reduced risk of preterm birth, and includes more hours of prenatal education so participants feel ready and confident to birth and care for their babies.

During a previous session in the spring of 2025, participants were gifted donated supplies to kick-start the best care for their babies.

Capital Region Midwifery's first two cohorts of the Centering Pregnancy Program gather to celebrate the births of their babies and talk about their birth experiences through the Centering Pregnancy program.

Community Investing

Addressing Food Insecurity for Students in Need

Some students at the Capital District Educational Opportunity Center (EOC), a division of Hudson Valley Community College (HVCC) in Troy, New York, are getting more than a career opportunity … they are getting much-needed groceries at the program's food pantry.

St. Peter's Community Health & Well-Being (CHWB) donated $15K to the Regional Food Bank in June 2025, earmarked for the EOC which will use these funds to purchase items to stock their student food pantry.

This donation aligns with the Mission of St. Peter's Health Partners and Trinity Health to be a compassionate and transforming healing presence within our communities by addressing the social need of food insecurity in our primary service area. It is the second year CHWB has contributed to this vital program, topping last year's donation of $10K.

Alton Campbell (left), Sheilah McCart (center), Dori McDannold (right) of St. Peter's Community Health and Well-Being pack food bags for students at the Capital District Educational Opportunity Center

The EOC also offers education and training programs at no cost for qualified students who are working to earn their high school equivalency diploma, prepare for college, or train for a new career in many fields, including building trades, cosmetology, culinary arts, natural hair styling, nursing assistant, pharmacy technician, welding, and more.

Between the program dates of October 2024-June 2025, more than 500 food bags were filled, serving the needs of more than 140 students directly, which is 14% of the student population. Three-quarters of the bags were picked up and used by requesting students, while the rest were placed on the Student Lounge Food Pantry shelves to be shared with any students who needed food.

Community Investing

Community Grants and Collaborations

Alzheimer's Association

BirthNet

Boys and Girls Club of the Capital Area

Circles of Mercy

Educational Opportunity Center of Hudson Valley Community College

Food Pantries of the Capital District

Healthy Capital District

Homeless and Travelers Aid

Ignatian Volunteer Corps

Independent Living Center of the Hudson Valley

Interfaith Partnership for the Homeless

Jewish Family Services NENY

Maria College

NYS Dental Association

Regional Food Bank of Northeastern NY

South End Children's Café

The Captain John J. McKenna IV Courtesy Room at Albany International Airport

Walking with Moms in Need, Roman Catholic Diocese of Albany

Whitney M. Young, Jr. Health Center

Advocacy Successes

Doula Care at SPHP

A doula is a professional who receives specialized training and certification in the physiological, emotional, and spiritual needs of pregnant moms. A doula helps a pregnant mom make informed birth choices and advocates for her plan with the clinical team.

St. Peter's Hospital started a doula program in 2024, and expanded it to Burdett Birth Center in early 2025.

Certified birth doula Terry Messina, RN, FCN, CEAS, SANE-A, FCN, CD, said it is well-documented that birthing individuals who feel safe and loved have better health outcomes, including fewer unplanned C-sections and complications.

"The birthing process can be very scary, and for some, they may feel alone and unequipped with lack of control," said Messina. "I am always humbled to witness their fear dispelled, and see the metamorphosis of a courageous, fearless, strong birthing woman, bringing into the world her own miracle of new life."

Terry Messina, RN, FCN, CEAS, SANE-A, FCN, CD, Certified Birth Doula

PATIENTS ASSISTED BY DOULAS

Burdett Birth Center (Jan. – June 2025) 55 patients | **St. Peter's Hospital** (FY25) 122 patients

Workforce Development

Workforce Development at St. Peter's Health Partners (SPHP) is tasked with sourcing, hiring, and retaining colleagues at SPHP and then removing barriers to help them receive certifications, go back to school, prepare for promotions, get to and from work if they don't own a vehicle, and more. The programs help colleagues transition into new roles, empowering them to advance their education without financial burdens. Many of these goals are achievable through the formation of community partnerships, grants, and scholarships.

LPN Scholarship

A key role of Workforce Development is to assist with sourcing and hiring the nurses who care for our patients. Often times, the best candidates come from within the walls of SPHP.

The SPHP LPN Scholarship was started in March of 2022 with a goal of reaching 15 applicants – and ending up with 78. It was clear there was a need and interest. To date, 54 colleagues have graduated from the program and more than 35 have completed their certifications and are currently LPNs.

The program is open to any SPHP colleague who is interested in nursing. If applicants are accepted into the program, which is offered through Maria College in Albany, they will be enrolled for 12 to 18 months, depending on how many credits they may be bringing with them. The cost of tuition is covered in full ($800 per credit hour, resulting in a savings of up to $9,500 per semester, per student), leaving colleagues to pay for only books, uniforms, and any other fees. In return, the student guarantees SPHP three years of employment upon graduation.

Workforce Development

LPN Scholarship Recipient

“Since being granted the LPN scholarship from SPHP, I have been telling all of my coworkers and friends who are interested in the field to look into it! If it wasn't for this scholarship, I would not have been able to attend nursing school. That was the only thing holding me back for so long. Finances," said Nicole Whiting, LPN.

"I am now living my dream of being a nurse in our Emergency Department as an LPN. I am currently receiving the Caring Gene Grant through NYS and chasing my dream of obtaining my RN to be able to one day work in the NICU. I am forever grateful to SPH for supporting me and believing in me.”

-Nicole Whiting, LPN, St. Peter's ED

Nicole Whiting, LPN, St. Peter’s ED

“Every now and then I bump into one of the LPNs in the hospital or we connect in email on another topic and they’ll say ‘by the way, thank you for allowing me to participate in the program, it’s been so amazing!’ And it’s great to see. They work hard and they deserve it.”

-Stephanie Castro
Project Management Specialist

Caring Gene® Career Pathways Training Program

Another opportunity we offer our colleagues is the Caring Gene® Career Pathways Training program. This program covers the FULL cost of tuition and books in any of 13 approved fields, including nursing. To qualify for the program, students are required to fullfill a three-year service commitment with a health care, behavioral health, or social care network provider in New York state that serves a patient population of at least 30% Medicaid-reliant or uninsured individuals. Additionally, students must complete their degree by spring 2027 and fulfill the service requirement by 2031.

Although students don’t have to return to St. Peter’s, we still offer the program to benefit them financially, knowing we are helping to better the workforce in our community. Through the Caring Gene program, students can study at Maria College, St. Peter’s schools of nursing, and most other nursing schools in New York state.

Workforce Development

Transportation - CDTA Navigator Cards

St. Peter's Health Partners (SPHP) is proud to partner with the Capital District Transportation Authority (CDTA) to provide all SPHP colleagues with universal access to the entire CDTA route network. The program allows SPHP colleagues to ride with CDTA **FREE OF CHARGE** with just a swipe of a Navigator card. Unlimited ridership opportunities across CDTA's service network includes CDTA's STAR paratransit service, FLEX On Demand Transit, along with the Northway and Thruway Express services, as well as access to the CDPHP Cycle! bike-sharing program.

CDTA Navigator Program Helps SPHP Colleague

Mia Willis, MSW, SPHP, is grateful for the CDTA Navigator Program

Mia Willis, MSW, moved to Albany from New York City for graduate school and didn't have a car because she wasn't sure how long she'd be here. Now a social worker at St. Peter's Health Partners for two and a half years, she is still opting for public transportation in the Capital District through the CDTA Navigator program.

"Before this program came to my attention, I was spending a chunk of money on monthly passes for transportation. Now, I can get around without having to worry about allocating money every month for a bus pass," said Willis.

Willis uses the bus to go to work, to run weekend errands, and sometimes to meet up with local friends. She says it offers affordability, ease of travel, accessibility, and comfort, among other benefits.

"I'm extremely appreciative that the weight of not having a car to get around Albany and existing areas has been lifted from my mind," continued Willis. "I would 100% recommend this program to other colleagues because this is not a program that is readily available to just anyone. This program allows colleagues to have an opportunity to travel to work and to other destinations no matter the location. For those who are in also difficult circumstances, this program is of great benefit and support."

FISCAL YEAR 2025

Community Health & Well-Being Impact Report

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