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Saratoga Hospital

Community Service Plan 2025–2027

Saratoga Hospital
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Prepared for submission to the New York State Department of Health

Service area: Saratoga County, New York.

This Community Service Plan (CSP) represents an individual plan submitted by Saratoga Hospital in collaboration with a joint regional Community Health Needs Assessment (CHNA) developed by Healthy Capital District (HCDI) in partnership with hospital systems and public health departments serving the six-county Capital Region of New York.

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Data Sources: 2025 Capital Region CHNA (Healthy Capital District) and its appendices, 2024 Capital Region Community Health Survey, and New York State Department of Health (NYSDOH) data.

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Executive Summary

1. Introduction

Saratoga Hospital, located in Saratoga Springs, New York, is a 171-bed acute-care hospital and the sole hospital serving Saratoga County. It provides a full continuum of care, including emergency services, ambulatory surgery, inpatient medical/surgical, intensive care, pediatric, maternity, psychiatric, and comprehensive outpatient services. With more than 450 physicians and medical professionals on staff, Saratoga Hospital offers primary care and a broad range of specialty services to the community and surrounding region.

Founded in 1891 by a group of civic-minded women responding to the community's urgent need for organized medical care, Saratoga Hospital has served the region for more than 120 years. Throughout its history, the Hospital has remained committed to its founding mission—evolving alongside the needs of a growing population while ensuring access to high-quality care close to home.

In 2017, Saratoga Hospital affiliated with Albany Medical Center, becoming part of the Albany Med Health System alongside Columbia Memorial Health and Glens Falls Hospital. The Albany Med Health System is committed to promoting and advancing the value and strength of people from all communities. Our goal is to bring our communities together to ensure that the System is a place where eliminating disparities and inequities is integral to the health and wellbeing of all. Together, these organizations form the region's only locally governed, integrated health system, collaborating to improve healthcare across Northeastern New York.

Today, Saratoga Hospital operates an integrated delivery system that includes hospital-based extension clinics, a freestanding ambulatory surgery center, and multiple outpatient facilities offering diagnostic, treatment, rehabilitation, and specialty services throughout the region.

Mission, Vision, and Values

Mission
To serve the people of the Saratoga region by providing access to excellence in healthcare in a supportive and caring environment.

Vision
Saratoga Hospital will be the preeminent provider of high-quality healthcare for the Saratoga region, delivering exceptional service, innovative care, and convenient access through expanded inpatient and outpatient services. The Hospital will recruit and retain outstanding clinicians, invest in advanced technology, grow strategically to meet community needs, and remain a trusted community partner.

Core Values

Saratoga Hospital's core values are rooted in quality, service, people, and growth. Saratoga hospital is committed to delivering high-quality care through continuous improvement and accountability, providing an exceptional and compassionate experience for patients and families, and fostering a respectful, supportive environment for our employees, physicians, and volunteers.

2. Prevention Agenda Priorities (2025-2030)

As part of the New York State (NYS) Prevention Agenda for 2025-2030, hospitals must develop a CSP based on findings of a CHNA that aligns with the State Health Improvement Plan. These statewide agendas are three-year cycles (2025-2027, 2028-2030) per IRS requirements. A new Prevention Agenda is published every six years.

Through the HCDI, Saratoga Hospital collaborated with regional hospitals, local health departments, and community partners to engage healthcare providers and residents in a coordinated community health assessment and priority-setting process. This collective effort identified the most significant health needs facing the region and established shared priorities to guide action.

Aligned with the New York State Prevention Agenda, Saratoga Hospital's community health efforts address key domains that influence health and well-being. Priorities include:

- **Economic Stability**, with a focus on **Nutrition Security** to ensure individuals and families have reliable access to healthy food
- **Social and Community Context**, emphasizing the prevention and treatment of **Depression**
- **Healthcare Access and Quality**, with a strong emphasis on **preventive services for chronic disease prevention and control**.

Together, these priorities reflect a comprehensive approach to improving health outcomes by addressing clinical, behavioral and social care factors that shape health.

In collaboration with community partners, Saratoga Hospital will focus its efforts on populations at increased risk for poor health outcomes, including individuals living in poverty, those experiencing housing instability or homelessness, and people with untreated mental health conditions. This shared work will also prioritize middle-aged and older adults, who often face higher rates of chronic disease and behavioral health needs. Through coordinated partnerships and aligned resources, Saratoga Hospital and its community partners aim to reduce health disparities, improve access to care, and improve health outcomes across the region.

3. Data Review

Saratoga Hospital's CSP is grounded in a collaborative regional CHNA led by the HCDI in partnership with local health departments, hospitals, community-based organizations, businesses, schools, subject matter experts, and community members. The CHNA was informed by a comprehensive review of public health data from state, local, regional, and national sources—including New York State Prevention Agenda indicators, vital statistics, Behavioral Risk Factor Surveillance System data, U.S. Census data, and other relevant datasets—and supplemented by community input gathered through Capital Region Community Health Surveys. Community Health Prioritization Meetings and facilitated workgroups further reviewed and scored identified health issues using HCDI's Public Health Issue Scoring methodology. Guided by a shared commitment to improving health outcomes and reducing disparities, Saratoga Hospital's priorities and interventions align with the New York State Prevention Agenda 2025–2030 and the 2025 Capital Region CHNA. A more detailed list of primary and secondary data sources is listed in Section 2 of the CHNA Summary of this document.

4. Partners and Roles

The Capital Region Prevention Agenda Work Group (PAWG), supported by the HCDI, led a regional, data-informed process to identify public health needs and align intervention planning across the Capital Region. Community input was gathered through the 2024 Capital Region Health Needs Survey, which assessed residents' health priorities, access to care, mental health, and social determinants of health (SDoH).

Within Saratoga County, Saratoga Hospital led the Prevention Agenda prioritization process, beginning with internal and community partner meetings to review county-level data and survey findings. Through a structured scoring and prioritization approach facilitated by HCDI, stakeholders narrowed key health issues and evaluated them based on need, feasibility, and potential impact. Additional regional collaboration occurred through the Capital Region United Hospital Fund convening, which focused on shared physical, behavioral, and social care needs and opportunities under the Medicaid 1115 Waiver.

By December 2025, Saratoga Hospital finalized its priority areas and selected interventions that align with the Capital Region CHNA while reflecting the organization's strengths and capacity for partnership. The resulting CSP translates these findings into clearly defined objectives, interventions, partnerships, and evaluation metrics for 2025–2030, grounded in a shared commitment to collaboration and improved community health outcomes.

5. Interventions and Strategies

Priority Area 1: Economic Stability – Nutrition Security

As a **featured intervention within the New York State Prevention Agenda**, Saratoga Hospital is advancing a system-level approach to strengthening nutrition security for individuals and families most at risk of food insecurity. This work is being undertaken as part of a **collaborative, health system–wide effort across all Albany Med Health System partners,** ensuring alignment, shared learning, and collective impact across the region. While Saratoga County performs relatively well on several food environment indicators, significant disparities persist within specific ZIP codes and among households with annual incomes below $25,000. Regional data estimates food insecurity rates of approximately 11–12 percent, and demand for food assistance continues to exceed available resources—challenges reinforced during the Capital Region Convening in September 2025, where stakeholders emphasized the need for sustainable funding and improved access models.

Through this coordinated initiative, Saratoga Hospital and its Albany Med Health System partners aim to increase food security among low-income households from 42 percent to 51.1 percent. Standardized screening for nutrition insecurity will be implemented across clinical and community-based settings, with individuals who screen positive connected to state, federal, and local benefit programs and referred to community-based organizations positioned to address food-related needs.

Key interventions focus on strengthening referral pathways and expanding partnerships with food banks, schools, housing agencies, and social service providers. Resources leveraged include emergency food programs, SNAP, WIC, school meal programs, Meals on Wheels, medically tailored meals, and food prescription programs. Progress will be measured through screening volumes, enrollment in nutrition assistance programs, growth in community partnerships, and delivery of nutrition education in schools and community settings. Through this featured, system-level intervention, Saratoga Hospital and its partners are addressing a critical social driver of health while advancing equitable, value-driven improvements in community well-being.

Priority Area 2: Social & Community Context – Depression and Mental Well-Being

Also a featured intervention within the New York State Prevention Agenda, Saratoga Hospital is advancing a focused strategy to improve depression and overall mental well-being across the community. Chronic stress, anxiety, and depression have been identified as significant drivers of poor health outcomes, with regional data showing emergency department visits related to self-injury and behavioral health crises occurring at rates **46 percent higher than the New York State average**. These trends highlight the need for coordinated, accessible, and effective mental health interventions across the continuum of care.

The goal of this initiative is to reduce the prevalence of depressive episodes among adults by improving access to early identification, timely treatment, and continuity of care. To support this objective, Saratoga Hospital will implement a **Collaborative Care Model (CoCM)** that integrates behavioral health into primary care and OBGYN settings. This approach ensures that individuals receive timely, evidence-based care for mental health conditions while fostering stronger coordination among medical providers, behavioral health specialists, and community partners.

Key strategies include routine screening for depression and anxiety, expanding access to behavioral health providers within primary care, and increasing the availability of community workshops and peer support programs. Progress will be tracked through increased screening rates, the number of primary care practices implementing CoCM, provider availability, and participation in community-based mental health programming.

In addition to strengthening early identification and treatment in outpatient settings, Saratoga Hospital will implement a **standardized post-crisis referral and follow-up pathway** for patients discharged from the Emergency Department or Crisis Unit following a behavioral health crisis or self-injury event. This pathway will ensure proactive outreach, timely connection to outpatient behavioral health services, and structured follow-up to reduce gaps in care after discharge.

Together, these interventions create a more seamless system of support — from early identification in primary care to timely aftercare following acute crises — strengthening transitions of care, reducing repeat emergency department utilization, and improving outcomes for individuals experiencing depression and behavioral health challenges.

This integrated approach reflects Saratoga Hospital's commitment to advancing prevention, reducing disparities, and improving mental health outcomes through collaboration, coordination, and innovation.

Priority Area 3 — Prevention & Management of Chronic Disease

As the third priority area in Saratoga Hospital's Prevention Agenda strategy, this initiative advances the New York State Prevention Agenda focus on **Healthcare Access and Quality** by strengthening preventive services that support early detection, chronic disease prevention, and improved health outcomes. This work emphasizes timely, evidence-based screenings and proactive care for adults at elevated risk for chronic conditions, particularly those associated with obesity, diabetes, and cancer.

Saratoga Hospital is focused on increasing participation in recommended **colorectal cancer screening**, improving rates of **blood sugar testing** among adults, and expanding access to **evidence-based cancer screenings**, including **low-dose CT lung cancer screening** and **breast cancer screening**, consistent

with current clinical guidelines. These efforts respond to regional data showing higher rates of preventable hospitalizations in certain counties and among Black, non-Hispanic populations, as well as elevated smoking prevalence and breast cancer incidence — all signaling opportunities for earlier intervention, more effective chronic disease management, and targeted strategies to address social drivers of health.

Obesity and diabetes remain closely linked challenges in both rural and urban communities, while cancer continues to be the leading cause of death in the region, often influenced by delayed screenings and modifiable risk factors. Increasing access to and utilization of preventive screening services offers a critical opportunity to identify disease earlier, reduce morbidity and mortality, and improve long-term outcomes.

To advance these goals, Saratoga Hospital will partner with community-based organizations to promote awareness, education, and access to preventive and cancer screening services. Clinical interventions will include referrals to nutrition services, point-of-care A1c testing in primary care settings, proactive outreach to patients who are overdue for colorectal, breast, or lung cancer screenings, and patient education regarding eligibility for low-dose CT screening based on smoking history and risk factors.

In addition, Saratoga Hospital will continue to expand the use of **Community Health Workers** — a featured intervention in the New York State Prevention Agenda — through the expansion of the New York State Health Home model. Community Health Workers will play a critical role in care coordination, patient navigation, and addressing social needs that impact access to preventive care and chronic disease management, including transportation, insurance coverage, health literacy, and appointment follow-through.

This work will be supported by a broad network of healthcare, community, and payer partners committed to improving prevention and chronic disease outcomes across the region. Through strengthened partnerships, proactive care models, and a focus on equity, Saratoga Hospital seeks to improve healthcare access and quality, reduce disparities, and advance long-term population health.

Together, Saratoga Hospital's three Prevention Agenda priority areas reflect a deliberate, integrated approach to improving community health through **whole-person care**. By addressing **Economic Stability through Nutrition Security, Social and Community Context through Depression and Mental Well-Being**, and **Healthcare Access and Quality through Preventive Services for Chronic Disease**, Saratoga Hospital is intentionally aligning clinical care, behavioral health, and social supports. This comprehensive strategy recognizes that health outcomes are shaped not only by medical services, but also by access to basic needs, mental well-being, and preventive care. Through system-level collaboration, community partnerships, and a focus on equity and value, Saratoga Hospital is advancing coordinated interventions that support individuals and families across the full continuum of health.

6. Progress and Evaluation

Saratoga Hospital will track progress and evaluate the impact of its CSP through a structured, data-driven approach aligned with the New York State Prevention Agenda. Performance will be monitored using clearly defined process and outcome measures across each priority area, including screening rates, referral and enrollment activity, deployment of evidence-based models, participation in preventive services, and engagement with community-based partners. Evaluation will incorporate internal data sets—such as electronic health record data, quality and utilization reports, population health dashboards, and care management data—alongside regional and state public health data to assess progress and identify disparities.

This evaluation framework is supported by ongoing collaboration with Albany Med Health System partners, community organizations, and regional stakeholders to ensure alignment and shared accountability. Data will be reviewed regularly to inform continuous quality improvement, guide resource allocation, and refine interventions over time. By integrating internal and external data sources, Saratoga Hospital will promote transparency, support value-based care goals, and drive measurable, sustainable improvements in whole-person health outcomes.

The Saratoga PAWG and the HCDI will continue to convene regularly to coordinate implementation, support shared learning, and monitor progress across the service area, ensuring alignment with regional priorities.

2025 Community Health Needs Assessment (CHNA)

Introduction

Saratoga Hospital is a community-based, acute-care hospital serving Saratoga County and the surrounding region, providing a comprehensive range of inpatient, outpatient, emergency, and specialty services. As the sole hospital in Saratoga County, Saratoga Hospital plays a critical role in ensuring access to high-quality, patient-centered care close to home. With a broad network of physicians, clinicians, and outpatient facilities, the Hospital delivers primary care and specialty services designed to meet the evolving needs of the communities it serves.

Assessing and responding to the healthcare needs of the community is an ongoing priority for Saratoga Hospital. The Hospital is actively engaged in partnerships and collaborations throughout its service area with the shared goal of improving health outcomes and quality of life. Community service and community partnerships are integral to Saratoga Hospital's strategic planning and population health efforts.

Saratoga Hospital actively promotes public health through health education, preventive services, and community-based screenings, often in collaboration with local organizations and partners. Physicians, nurses, staff, and volunteers contribute their time and expertise through participation in community organizations, coalitions, and service initiatives that support the health and well-being of the region.

This CSP does not represent an exhaustive inventory of all programs and services provided by Saratoga Hospital, including those offered at free or reduced cost in partnership with other organizations. Rather, it highlights selected priority health needs identified through community health planning efforts and outlines how Saratoga Hospital—working collaboratively with community partners—is advancing strategies to:

- Implement a community health improvement plan
- Promote health equity, particularly for populations experiencing disparities
- Reduce duplication of services and associated costs
- Improve efficiency and effectiveness through collaboration
- Maximize shared resources and community assets

The findings and data from the 2025 Healthy Capital District Initiative's Capital Region Community Health Needs Assessment are integral to this plan and are incorporated by reference.

1. Community Description

Service Area

The communities assessed in the Capital Region CHNA are the counties of Albany, Columbia, Greene, Rensselaer, Saratoga, and Schenectady. They form the common service area covered by the local health departments in Albany, Columbia, Greene, Rensselaer, Saratoga, and Schenectady counties and the primary patient population served by Albany Med Health System affiliates (Albany Medical Center, Columbia Memorial Hospital and Saratoga Hospital), Ellis Hospital, and St. Peter's Health Partners (Albany Memorial Hospital, Samaritan Hospital, St. Peter's Hospital, Seton Health/St. Mary's Hospital, Samaritan Hospital, Sunnyview Rehabilitation Hospital), which are located within the six counties.

The **Saratoga Hospital service area** is composed of all the zip codes in Saratoga County and select zip codes in Warren, Washington, and Schenectady County. Historically, about 86% of Saratoga Hospital's patients resided within this geography. The map included in Appendix A represents the top 80% of zip codes based on patient discharges that are serviced by the Hospital. Patients in the primary service area represent the top 50% of discharges while patients in the secondary service area represent the bottom 30%. Patients listed as "other service area" were outside the 80% but are still considered within the Hospital's service area based on geographic location.

Demographics of Population Served

Saratoga Hospital serves a primarily suburban and semi-rural population within Saratoga County, one of the higher-performing counties in the Capital Region on many health and socioeconomic indicators. The population is predominantly White, non-Hispanic, though racial and ethnic diversity has increased modestly over the past decade. Saratoga County has a comparatively older age profile, with adults aged 65 and older representing a growing share of residents, which has implications for chronic disease prevalence, preventive screening needs, and access to ongoing care. While overall poverty (6.6%) and food insecurity rates (9.5%) are lower than in neighboring counties, the 2025 Capital Region CHNA identifies continued nutrition security challenges among seniors, lower-income households, and residents in rural or seasonal employment areas, underscoring the importance of routine screening and referral for food insecurity within clinical and community settings.

CHNA findings further highlight how Saratoga County's demographic profile intersects with behavioral health and chronic disease prevention priorities. Saratoga County reports the lowest rate of frequent mental distress in the Capital Region at approximately 9.6%, compared to the regional average of 12.8%; however, access to timely behavioral health services remains a challenge,

particularly for older adults, rural residents, and individuals insured by Medicaid. These trends support Saratoga Hospital's focus on expanding depression screening and improving access to behavioral health services within primary care. In addition, while Saratoga County demonstrates lower childhood obesity rates (approximately 16.5%) and favorable chronic disease indicators relative to the region, colorectal cancer screening and diabetes management remain critical priorities due to the county's aging population and rising prevalence of chronic conditions. Saratoga Hospital's CSP emphasizes improving preventive screening rates, strengthening diabetes management, and addressing social factors—such as nutrition security and transportation—that influence long-term disease outcomes, ensuring that favorable county-level averages translate into equitable health outcomes across all populations served.

After careful consideration and review of the 2025 Capital Region CHNA and 2024 Community Health Survey, the Saratoga Hospital internal stakeholders group prioritized the following populations of patients within the service area:

- Individuals living in poverty, with low income, or experiencing housing instability or homelessness
- People with untreated mental health conditions
- Middle-aged and older adults

2. Health Status Description

Data Sources

The 2025 Capital Region CHNA drew on a wide range of data types to capture the full picture of community health for each county. Demographic measures such as age, race/ethnicity, poverty, education, housing, and employment were paired with health outcomes including mortality, chronic disease prevalence, maternal and infant health, and infectious disease. Indicators of health care access and utilization—insurance coverage, primary care, dental visits, hospitalizations, and emergency department use—were examined alongside behavioral and lifestyle factors like nutrition, physical activity, tobacco, alcohol, and drug use. Environmental and social determinants such as housing quality, lead exposure, transportation, and climate resilience were also considered, as were mental health and substance use indicators including depression, anxiety, self-harm, suicide, and opioid and alcohol use.

To collect and interpret this information, the assessment employed multiple methods. Quantitative analysis provided age-adjusted rates, county and ZIP code comparisons, and stratification by race/ethnicity and gender. The 2024 Capital Region Community Health Survey added qualitative insights from 5,415 residents, while public meetings engaged more than 100 organizations in reviewing data, voting on priorities, and contributing to collaborative discussions. Finally, local health departments and hospitals convened workgroups to align findings with the New York State Prevention Agenda, ensuring that community priorities were integrated into a structured, statewide framework.

Primary Sources

- NYS SPARCS (hospitalizations, ED visits, PQIs)
- Vital Statistics (mortality, birth outcomes)
- BRFSS (health behaviors, mental health)
- NYS Dashboards (Prevention Agenda, Cancer Registry, Leading Causes of Death)
- U.S. Census ACS (demographics, socioeconomic data)
- County Health Rankings (University of Wisconsin & RWJF)
- NYS Opioid Data Dashboard & SUDORS
- NYS Education Department Report Card Database
- NYS Department of Environmental Conservation (climate/environmental indicators)

Secondary Sources

- 2024 Community Health Survey (resident perspectives on health priorities, barriers, needs)
- Local Health Department Reports (county-specific prioritization results)
- Community Feedback (input from organizations, businesses, universities, residents)
- Appendices (detailed demographic, mortality, hospitalization, ED visit tables)

Community Engagement

The 2025 Capital Region CHNA was shaped through extensive collaboration across multiple sectors. The Capital Region PAWG, consisting of stakeholders from local health departments and hospitals and supported by HCDI, convened to identify local public health needs and find opportunities for regional alignment in health intervention planning.

The PAWG began by engaging over 5,400 local residents with the 2024 Capital Region Health Needs Survey. The survey offered multiple choice and open-ended response options to learn about Capital Region residents' health needs and priorities, access or barriers to care, mental health, and social determinants of health. Demographic information collected by the survey allowed review of information by county, age, gender, race/ethnicity, income level, health insurance type, parental status, sexual orientation or gender identity.

Once survey reports were shared, four local Work Groups convened to complete health issue prioritization processes including community voices through representatives from community-based organizations that serve low-income residents, the homeless, and other vulnerable populations; federally qualified health centers; advocacy groups; academic institutions; public health departments; providers; and health insurers. Participants were encouraged to share data and observations of their own, and to advocate for the needs of their constituents. HCDI and its stakeholders strategically invited partners with access to medically underserved populations, as well as potential partner organizations who had traditionally not been involved in this process, to align with the updated New York State Prevention Agenda 2025-2030 priority areas.

Relevant Health Indicators

Saratoga County

Chronic Disease

- Saratoga County had the highest prevalence of smoking prevalence among adults with income less than $25,000, among Capital Region counties with 2021 data (BRFSS)
- Saratoga County had the highest stroke mortality rate in the Capital Region in 2022 (NYS Vital Statistics)
- Saratoga County had the second highest rate in the region for breast cancer incidence at any stage in 2021, and ranked among the bottom 10 NYS counties (NYS Cancer Registry)

Healthy and Safe Environment

- Saratoga County had the highest percentage in the Capital Region in 2021 of adults who had reported having experienced at least two adverse childhood experiences (ACEs) (BRFSS)

- Saratoga County had less than 1 in 8 residents living in a certified Climate Smart Community in 2023 (NYS Department of Environmental Conservation)

Infant and Maternal Health

- Saratoga County had the largest disparities in percent of births with early prenatal care between Black, and White, non-Hispanic residents in 2020-2022 (NYS CHIRE) Mental Health and Substance Use Disorder
- Saratoga County had the second highest rate of mental health emergency department visits in the Capital Region, in 2023, where a mental health condition was the primary diagnosis (NYS SPARCS)
- Saratoga County had the highest rate in the Capital Region of binge drinking among adults in 2021 (BRFSS)
- Saratoga County had the lowest buprenorphine prescribing rate in the Capital Region in 2022 (Prescription Monitoring Program Registry) Infectious Disease

Additional details regarding the demographics and health status of Saratoga County and surrounding Capital Region can be found in the HCD 2025 Capital Region Community Health Needs Assessment.

3. Process & Methods Used to Conduct CHNA

The 2025 Capital Region CHNA was conducted using a comprehensive, collaborative process designed to assess population health status, identify disparities, and prioritize community health needs across the Capital Region, including the service area of Saratoga Hospital. The CHNA was coordinated by Healthy Capital District (HCD) and developed in partnership with area hospitals, county health departments, and a broad network of community-based organizations. The assessment adhered to guidance from the New York State Department of Health, the 2025–2030 NYS Prevention Agenda, and applicable federal community benefit requirements.

A mixed-methods approach was used to ensure a robust and data-driven assessment. Secondary data sources were analyzed to describe demographic characteristics, social determinants of health, health behaviors, chronic disease prevalence, and access to care. Key data sources included the Behavioral Risk Factor Surveillance System (BRFSS), NYSDOH SPARCS hospital discharge and emergency department data, County Health Rankings, the NYS Student Weight Status Category Reporting System, Feeding America food insecurity estimates, and Prevention Agenda dashboard indicators. Data were reviewed at the regional and county levels and stratified, where possible, by age, race and ethnicity, geography, and insurance status to identify disparities relevant to Saratoga County and the broader region.

Primary data collection included a regional community health survey administered in 2024, which received more than 5,000 responses from residents across the Capital Region. Survey questions addressed physical and mental health status, access to care, social care needs, health behaviors, and perceived community priorities. Outreach strategies were designed to reach diverse populations, including older adults, rural residents, Medicaid beneficiaries, and individuals from historically underserved communities. In addition, key informant interviews and focus groups were conducted with public health officials, health care providers, educators, social service agencies, and community advocates to provide qualitative context and validate quantitative findings.

CHNA findings were reviewed and prioritized through a structured stakeholder engagement process. PAWGs, hospital internal stakeholder teams—including representatives from Saratoga Hospital—and community partners participated in facilitated discussions to evaluate identified needs. A standardized prioritization framework was used that considered the magnitude and severity of health issues, the presence of disparities, alignment with the NYS Prevention Agenda, feasibility of intervention, availability of evidence-based strategies, and organizational capacity. Community feedback collected through surveys and public meetings was incorporated into the prioritization process to ensure that selected priorities reflected lived experience and local context.

The final CHNA priorities represent both shared regional challenges and county-specific needs, including those unique to the Saratoga Hospital service area. The completed CHNA report was made publicly available and serves as the foundation for the development of CSPs for participating hospitals and local health departments. This inclusive, transparent, and data-driven process ensures that CSP strategies are responsive to community needs and positioned to advance health equity across the Capital Region.

4. Community Assets and Resources

The Capital Region benefits from a strong network of hospitals, health centers, and community organizations that provide a foundation for addressing public health needs. Major health systems such as Albany Med, Ellis Medicine, St. Peter's Health Partners, Columbia Memorial, and Saratoga Hospital deliver comprehensive care, while FQHC's like Whitney Young, Hudson Headwaters, and Hometown Health Centers extend services to underserved populations. Community-based organizations, academic institutions, and insurance partners further strengthen this infrastructure by supporting preventive programs, addressing social needs, and contributing to research and workforce development.

Saratoga Hospital encompasses an integrated delivery system that includes the acute care hospital as well as the following outpatient services:

- Primary Care – Community Health Center
- Primary Care – Malta
- Primary Care – Mechanicville
- Primary Care – Milton
- Primary Care – Saratoga
- Primary Care – Schuylerville
- Primary Care – Scotia/Glenville
- Primary Care – Wilton
- Addiction Medicine – Community Health Center
- Behavioral Health Services
- Dental Services – Community Health Center
- OB/GYN and Midwifery – Malta and Wilton
- Occupational Medicine
- Adult and Pediatric Ophthalmology – Eye care
- Pain Management
- Palliative Care
- Podiatry
- Pulmonary and Sleep Medicine
- Radiation Oncology
- Rehabilitation
- Saratoga Spine Care
- Sports Medicine
- Urgent Care
- Urology
- Wound Health and Hyperbaric Medicine

Other Regional Resources:

Organization	Assets & Resources
Albany Guardian Society	• Hunger and Food Insecurity • Mental Health, SUD, Suicide Prevention • Chronic Diseases • Aging and Caregiving
Albany Med Tobacco Cessation Service	• Prevention Services • Tobacco Use, Vaping
American Foundation for Suicide Prevention - Capital Region NY Chapter	• Mental Health, Suicide Prevention
American Heart Association	• Chronic Diseases • Physical Activity • Hunger and Food Insecurity • Mental Health

Capital District Latinos	• Hunger and Food Insecurity • Mental Health, SUD • Chronic Diseases
Saratoga Regional YMCA	• Physical Activity • Hunger and Food Insecurity • Mental Health • Chronic Diseases
Capital Roots	• Hunger and Food Insecurity • Chronic Diseases
Catholic Charities Care Coordination Services	• SUD • Diabetes
CDPHP	• Obesity • Diabetes • Hunger and Food Insecurity • Mental Health, Suicide Prevention, SUD • Tobacco Use, Vaping • Chronic Disease • Infant and Maternal Health • Asthma • Sexually Transmitted Infections • Childhood Lead Poisoning
Chasing Health Inc.	• Chronic Disease
Clean+Healthy	• Childhood Lead Poisoning
Double H Ranch	• Chronic Disease
Franklin Community Center	• Hunger and Food Insecurity
Health Is Home	• Chronic Disease • Hunger and Food Insecurity
Healthy Alliance	• HRSN Services
Hope House Inc.	• Mental Health, SUD • Tobacco Use, Vaping • Gambling
Logan Strong Foundation	• Cancer Care, Prevention • Serious Illness in Children
MVP Health Care	• Chronic Disease • Cancer • Hunger and Food Insecurity • Mental Health, Suicide Prevention, SUD • Tobacco Use, Vaping • Infant and Maternal Health • Asthma • Sexually Transmitted Infections • Childhood Lead Poisoning • Social Needs Screening and Intervention
NAMI	• Mental Health, Suicide Prevention
NAMI Capital Region NY	• Mental Health, Suicide Prevention, SUD
New Choices Recovery Center	• SUD

Northern Rivers, Home Based Crisis Intervention	• Mental Health, Suicide Prevention
Planned Parenthood of Greater NY	• Sexually Transmitted Infections
Refugee and Immigrant Support Services of Emmaus	• Immigration Matters • Hunger and Food Insecurity • Mental Health
Saratoga Senior Center	• Palliative Care • Social Isolation • Social Needs Screening and Intervention
Siena Research Institute	• Data Collection
spina bifida association of NYS	• Disability
St Peter's Health Programs Community Health Programs	• Chronic Disease • Tobacco Use, Vaping • Infant & Maternal Health
St. Catherine's Center for Children	• Hunger and Food Insecurity • Mental Health • Care Coordination • Housing Services
The Food Pantries for the Capital District	• Hunger and Food Insecurity
To Life!	• Cancer Care, Prevention
Upstate New York Poison Center	• Mental Health, Suicide Prevention, SUD • Tobacco Use, Vaping, Cannabis • Childhood Lead Poisoning • Medication Safety
Wellspring	• Mental Health, Suicide Prevention, SUD
Young Parents United Inc.	• Hunger and Food Insecurity • Mental Health, Suicide Prevention, SUD • Infant and Maternal Health • Pregnancy and Parenting • Sexually Transmitted Infections • Childhood Lead Poisoning

Community Service Plan 2025-2027

1. Major Community Health Needs

From the 2025 Capital Region CHNA, Saratoga Hospital and its key internal stakeholders identified the following three regionally aligned priorities that reflect community needs, organizational strengths, collective impact, quality goals, and value-based care metrics:

1. Nutrition Security (Economic Stability)
2. Depression & Mental Well-Being (Social and Community Context)
3. Prevention & Management of Chronic Disease (Healthcare Access and Quality)

The selected priority areas are strongly aligned with community-identified concerns reflected in the Health Priorities survey data. Depression, anxiety, and stress emerged as the top health concern among Saratoga County residents, directly supporting the focus on depression and mental well-being within the Social and Community Context domain. Hunger and food insecurity, while reported at slightly lower levels than some clinical conditions, remain a significant concern and align with the priority on nutrition security and economic stability—particularly for vulnerable populations. In addition, high levels of concern related to cancer, obesity and diabetes, and heart disease underscore the importance of preventive services, early screening, and chronic disease prevention within the Healthcare Access and Quality priority area. Collectively, the selected priorities reflect both the most pressing community concerns and a strategic emphasis on prevention, early intervention, and addressing the clinical, behavioral, and social factors that drive health outcomes.

The disparities to be addressed in the Saratoga Hospital service area by this CSP include the following target populations:

- Individuals living in poverty or low income/unhoused
- People with untreated mental health conditions
- Middle-aged to senior adults

2. Prioritization Methods

a. Description of Health Priority Selection Process

A visual chart of the processes, methods, and internal stakeholders of Saratoga Hospital used to identify priorities for this CSP can be found in Appendix B of this document. The selection of the top health priorities for each local Work Group, including Saratoga County, began with the facilitation of a Public Health Issue Scoring Sheet. The Public Health Issue Scoring Sheet was created by HCDI in 2021 for the 2022 Capital Region CHNA and local Community Health Improvement Plans (CHIPs). It was based on feedback from prior CHNA/CHIP processes that the

health issue prioritization process was difficult due to the multitude of pertinent considerations relating to each health issue. The Public Health Issue Scoring Sheet essentially assigns a score to the most relevant considerations, allowing for the health issues to be ranked and informing decision making.

The Public Health Issue Scoring Sheet method was adapted from a modified version of the Hanlon Method for Prioritizing Health Problems. The Public Health Issue Scoring Sheet quantified considerations regarding both the need to address each health issue and the opportunity to make a positive impact. Opportunity considerations were based on guidance documents from the American Hospital Association, the National Association of County and City Health Officials as well as other public health authority resources. Need considerations included those used in prior prioritization processes, as well as a community priority score derived directly from the contributions of over 5,000 residents in the 2024 Capital Region Community Health Survey. The Public Health Issue Scoring Sheet also included "other" considerations, for both need and opportunity, to address additional factors not included in the sheet and to capture the knowledge and experience of local community partners. More about this scoring sheet and visuals can be found in the 2025 Capital Region Community Health Needs Assessment beginning on page 33.

The Saratoga PAWG met with other regional PAWGs in the Fall of 2024 to review the Public Health Issue Scoring Sheet and provide oversight and guidance during the prioritization process, especially given the recent changes to the structure and focus of the NYS 2025-2030 Prevention Agenda. In the Winter of 2024, HCDI staff consolidated the twenty-five (25) public health issues from the 2022 CHNA/CHIP process into 15 public health issues, based on the updated NYS 2025-2030 Prevention Agenda priority areas. HCDI staff then conducted an internal review of the most recent and relevant available data regarding the 15 identified health issues.

Using publicly available and internal data, HCDI generated five 'data' scores for each of the health issues, based on the number of people affected, rates compared to NYS, excluding NYC, recent trends in rates, disparities between race/ethnicity groups, and the seriousness of health outcomes. HCDI also created 'survey' scores based on results from the 2024 Capital Region Health Needs Survey. Data and survey scores were then visualized in public dashboards and reviewed with each sub-regional Work Group to review. The list of 15 health issues was then shortened based on input from Work Group participants to allow for a more focused discussion at subsequent public meetings.

Local Prevention Agenda Prioritization Work Groups each held in-person or hybrid (virtual and in-person) public meetings to present progress to – and collect input from – local community-based organizations, academic researchers, and members of the public. At the meetings, the health issue scoring method, as well as the data and survey results related to each of the health issues, were reviewed with participants. Then, a discussion was held to answer questions, and individuals shared their understanding and recent observations of the current situation.

Participants were provided with a method to vote on the need and opportunity to address each health issue, as a measurement of the discussion and their own experiences regarding each health issue. Scores for opportunity considerations were self-assessed and were based on criteria including their ability to sustainably devote resources, garner support, and make a measurable impact. Group discussion often coalesced around mental health, food insecurity, and chronic diseases as issues that particularly affect residents' livelihoods, are not fully addressed by existing resources, or are noticeably getting worse or affecting more people. Visual charts of these 15 identified health issues along with the total data, survey, and partner scores can be found in Appendix C of this document.

b. **Community Engagement**

The Capital Region PAWG, consisting of stakeholders from local health departments and hospitals and supported by HCDI, convened to identify local public health needs and find opportunities for regional alignment in health intervention planning. The PAWG began by engaging local residents with the 2024 Capital Region Health Needs Survey. The survey offered multiple choice and open-ended response options to learn about Capital Region residents' health needs and priorities, access or barriers to care, mental health, and social determinants of health. Demographic information collected by the survey allowed review of information by county, age, gender, race/ethnicity, income level, health insurance type, parental status, and sexual orientation or gender identity.

HCDI created several reports which visualized and described results from the 2024 Capital Region Health Needs Survey (see Appendix N of the 2025 Capital Region CHNA). Reports were created for Capital Region residents, overall, and for each county to compare results for their residents to other Capital Region residents. Results for key questions were further broken down for demographic groups of interest. The first question of the survey asked residents which public health issues were most important in their community. The public health priority results from this question were incorporated into the health issue prioritization process. Once survey reports were shared, and results reviewed with the Capital Region PAWG, the group members reconvened into four local Work Groups, each supported by HCDI, to complete separate health issue prioritization processes, with the goal of returning to compare results and find regional alignment.

Each local Work Group's health issue prioritization process included community voices through representatives from community-based organizations that serve low-income residents, the homeless, and other vulnerable populations; federally qualified health centers; advocacy groups; academic institutions; public health departments; providers; and health insurers. Participants were encouraged to share data and observations of their own, and to advocate for the needs of their constituents. HCDI and its stakeholders strategically invited partners with access to medically underserved populations, as well as potential partner organizations who had

traditionally not been involved in this process, to align with the updated New York State Prevention Agenda 2025-2030 priority areas.

c. **Justification for Unaddressed Needs**

While the 2025 Capital Region CHNA identified a broad set of health and social needs—including housing stability, substance use disorders, transportation barriers, injury prevention, maternal and infant health, and economic stability—not all areas could be selected as CSP priorities for this cycle. Saratoga Hospital's Internal Stakeholders used a structured prioritization process that considered magnitude of need, alignment with the NYS Prevention Agenda, feasibility of implementation, existing organizational capacity, and opportunities for regional collaboration. Based on this assessment, the CSP focuses on three priority areas where the hospital and its community partners can make the greatest measurable impact: Nutrition Security, Depression and Mental Well-Being, and Prevention and Management of Chronic Disease. Saratoga Hospital believes these interventions address upstream drivers of health by reducing food insecurity, improving access to behavioral health screening and treatment, and strengthening preventive and chronic disease care pathways—factors that influence multiple health outcomes beyond the selected priority areas.

Several needs were therefore not selected as CSP focal areas, including transportation access, affordable housing and homelessness, opioid and substance use disorders, tobacco use, injury and violence prevention, and maternal and infant health outcomes. These needs were not chosen for this CSP cycle primarily due to limited internal capacity, ongoing initiatives already led by other regional organizations, and alignment with system-wide priorities. For example, substance use disorder services and injury prevention efforts are being addressed through established countywide coalitions and behavioral health agencies with greater specialization and resources. Housing and transportation challenges, while recognized as significant social determinants of health, require multi-sector infrastructure investments beyond the scope of Saratoga Hospital's 2025–2030 CSP. By focusing on areas where the hospital can lead, sustain, and evaluate meaningful change, the CSP maximizes impact while continuing to support regional partners who are better positioned to address these additional needs.

3. Developing Objectives, Interventions, and Action Plan

a. Alignment with Prevention Agenda

In September 2025, the Saratoga Hospital Internal Stakeholders convened to review and apply the NYS Prevention Agenda as a roadmap for the CSP process. During this meeting, the group conducted a comprehensive review of the data provided by HCDI and selected priorities based on the specific needs of the Saratoga Hospital service area. Because the patient demographics and health-related needs in the Saratoga Hospital service area differ slightly from those of the broader Capital Region, the Internal Stakeholders—supported by survey feedback from key partners—

identified priorities that best represent local needs. These priorities are distinct yet complementary to those selected by the other Capital Region PAWGs.

In December 2025, the Internal Stakeholders reconvened to finalize their selection of featured interventions. These interventions align with the broader Capital Region CHNA while also reflecting the unique capacities, resources, and strengths of Saratoga Hospital and its affiliates. Although the interventions included in this CSP differ somewhat from those selected by other hospital groups in the region, together they provide a broader and more comprehensive scope of community service impact. Through this process, we established a shared vision, committed to serving our respective communities, learning from one another, and collaborating in ways we have not previously done.

A description of the rationale, disparities to be addressed, and evidence-based interventions are included in the following action plan section.

4. Action Plan

Priority Area 1: Economic Stability - Nutrition Security

Rationale / data highlights

- CHNA: Capital Region food insecurity estimates ~11–12% for most counties (Saratoga lower), and food environment indices generally in top half statewide — yet localized ZIP codes and low-income households remain at risk. Nutrition and childhood obesity are interlinked and were prioritized regionally.
- Regional Input: Structural and socioeconomic barriers—such as income, geography, transportation, and food cost—limit consistent access to healthy foods for many residents, particularly in low-income, rural, and urban communities. These barriers contribute to nutrition-related chronic disease and unequal health outcomes across the lifespan. Addressing food insecurity and advancing nutrition security are critical to reducing health disparities and supporting overall population health.

Objective Statement

- Increase food security in households with an annual total income of less than $25,000 from 42.0% to 51.1%.

Featured Intervention — Screening & Referral (Year 1–5)

Conduct standardized screening of unmet Nutrition Security needs and provider referrals to state, local, and federal benefit programs and community-based, health-related social needs providers to address unmet needs.

- **Measures**:
  - Number of Saratoga Hospital Medical Group practices that screen for food insecurity and facilitate referrals to supportive services
  - Number of completed screenings
  - Number of closed loop referrals (successful navigation to resource)
- **Partner roles & Resources**:
  - Hospital – Implement standard screening tools and workflows to screen patients.
  - Patient – Complete Screenings
  - Community-Based Organizations – Accept and respond to referrals.

Equity strategy: Prioritize outreach and expanded services in high-poverty ZIP codes, and target programs to households <$25,000 annual income and Medicaid enrollees.

Highlights:

1. Featured Prevention Agenda Intervention
2. System-Level Priority
3. SDoH Intervention
4. Population Focused
5. Community Collaboration

Priority Area 2: Social & Community Context - Depression & Mental Well-Being

Rationale / data highlights

Depression affects a substantial portion of the population and is a significant contributor to poor health outcomes across the lifespan. It often serves as a gateway to other health challenges, including substance use disorders, PTSD, chronic stress, and the worsening of chronic medical conditions. Disparities are most pronounced among individuals with low income and older adults, who frequently face compounded barriers such as social isolation, financial strain, stigma, and limited access to mental health services. Expanding screening and access to timely, culturally responsive treatment is essential to reducing disparities and improving overall population health.

- Frequent mental distress regional average 12.8% (BRFSS 2021)
- Saratoga County had the second highest rate of mental health emergency department visits in the Capital Region in 2023 where a mental health condition was the primary diagnosis (NYS SPARCS).
- Local survey (2024) shows Medicaid-insured and LGBT residents report higher frequent poor mental health and stress/anxiety.

Priority Objective Statement

Reduce the percentage of adults with a major depressive episode during the past year from 6.7% to 5.7%.

Featured Intervention — Screening & Early Intervention

Implement a collaborative care model to ensure that individuals with depression receive treatment.

Implement a standardized, post-crisis referral and follow-up pathway for patients discharged from the ED or Crisis Unit following a behavioral health crisis.

- **Measures**:
    - Implement CoCM in all SHMG Primary Care and Women's Health Practice locations.
    - Reduce the number of major depressive episodes among SHMG patients by 1.0%
    - Improvement in depression and/or anxiety symptoms by 50% as measured by PHQ9 and GAD7 scores among patients enrolled in CoCM.
    - Increase the number of staff trained on post-crisis referral pathways
    - Increase the percentage of individuals with a behavioral health ED/Crisis Unit visit who are contacted within 48 hours of discharge
    - Increase the percentage of individuals with a behavioral health ED/Crisis Unit visit have a follow-up visit within 30 days

- **Partner roles & Resources**:
    - Providers

        - Primary Care provider to identify and refer patients to CoCM through routine screening
        - Diagnose behavioral health conditions and initiate treatment
        - Prescribe and adjust medications based on patient progress and psychiatric input
        - Collaborate with the Behavioral Health Care Manager and Psychiatric Consultant
        - Maintain overall responsibility for the patient's care plan
    - Participant
        - Participate in shared decision-making and goal setting
        - Complete screening and symptom monitoring tools (e.g., PHQ-9, GAD-7)
        - Engage in treatment plans (medication, brief interventions, referrals)
        - Communicate preferences, barriers, and changes in symptoms
        - Identify social, functional, or cultural factors impacting care
    - Behavioral Health Care Manager (BHCM)
        - Conduct comprehensive behavioral health assessments
        - Provide brief, evidence-based interventions (e.g., behavioral activation, problem-solving therapy)
        - Track patient progress using a patient registry and standardized tools
        - Maintain regular contact with patients (in-person, phone, or telehealth)
        - Identify patients not improving and escalate for psychiatric review
        - Coordinate referrals to specialty behavioral health or community supports as needed

Equity strategy: Prioritize areas of high frequent distress, and emphasize access for Medicaid-insured.

Highlights:

1. NYS Prevention Agenda Featured Intervention
2. Population Focused

Priority Area 3: Healthcare Access & Quality - Prevention & Management of Chronic Disease

Rationale / data highlights

Chronic diseases are largely preventable, yet they remain a leading cause of disability, death, and health care costs in New York State—particularly among individuals who face barriers to accessing preventive and ongoing care. Low-income individuals, people experiencing homelessness, and older adults are disproportionately impacted due to challenges such as limited access to primary care, transportation barriers, housing instability, fixed incomes, and social isolation. These barriers contribute to delayed screening, poor chronic disease management, and higher rates of preventable hospitalizations and mortality. Targeted, evidence-based prevention and management strategies that improve access to care and supportive services are essential to reducing disparities and improving health outcomes for vulnerable populations.

- At least 1 in 3 Capital Region adults have obesity, and Saratoga County rates are higher than other counties in NYS, excluding NYC.
- Saratoga County ranked 33rd in the age adjusted percentage of adults who had a test for high blood sugar or diabetes in the past three years. The numbers have also declined from 58% to 48% between 2016 and 2021.
- Percent of adults with a routine health checkup decreased between 2018 and 2021. In the community survey, respondents indicated needing greater access to primary care services.
- Saratoga County had the second highest rate in the region for breast cancer incidence at any stage in 2021, and ranked among the bottom 10 NYS counties (NYS Cancer Registry)
- Saratoga County had the highest stroke mortality rate in the Capital Region in 2022 (NYS Vital Statistics)

Priority Objective Statements

- Increase the percentage of adults aged 35 years and older who had a test for high blood sugar in the past year from 78.1% to 82.4%.
- Increase the percentage of adults aged 45 to 75 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 73.7% to 82.3%.

Featured Interventions — Community Partners, Screening, & Referrals

Expand screening for social care needs among all adults and those with chronic diseases and provide referrals to appropriate community resources and supports.

Partner with community-based organizations to promote access to prevention and screening services.

- **Measures**:

- Number of closed loop referrals for patients within the cohort
- Increase point-of-care (POC) testing for A1c within SHMG Primary Care Practices by 4%
- Increase referrals to nutrition services by 4%
- Initiate active partnerships with 3 community-based organizations (CBOs) serving priority populations (low-income individuals, older adults, people experiencing housing insecurity) and partner on 2 community screening events
- Host at least one low-dose CT lung cancer screening event and at least one breast cancer screening event

- **Partner roles & Resources**:
  - Community-Based Organizations
    - Participate in planning and co-hosting community-based screening and education events (e.g., diabetes, colorectal cancer, nutrition, blood pressure).
    - Assist with outreach and engagement of priority populations, including low-income individuals, older adults, and people experiencing housing insecurity.
    - Support completion of social care screenings and accept referrals through a closed-loop referral process.
    - Provide navigation and follow-up support related to food access, transportation, housing stability, and social connection.
    - Share aggregate data and feedback to inform program improvement and address gaps in access.
  - Primary Care
    - Implement evidence-based screening protocols for diabetes, colorectal cancer, and other chronic disease indicators in clinical and community settings.
    - Conduct point-of-care (POC) A1c testing and ensure timely follow-up and care management for abnormal results.
  - Community Health Workers
    - Support patient engagement, education, and follow-up for individuals with chronic conditions or identified social care needs.
    - Facilitate closed-loop referrals and ensure patients successfully connect to recommended services.
    - Provide culturally responsive, relationship-based support to reduce care gaps and prevent avoidable hospitalizations.
  - Health System & Department Leadership
    - Provide infrastructure, staffing support, and clinical workflows needed to sustain screening and referral activities.
    - Strengthen partnerships with CBOs through formal agreements and shared accountability.

Equity strategy: Prioritize neighborhoods and racial groups with highest PQI and preventable hospitalization rates (Black non-Hispanic populations showed PQI rates 50–150% higher than other groups). CHW and culturally adapted interventions will be central.

Highlights:

- Alignment with quality metrics
- Population Focused
- Community Collaboration

5. Partner Engagement

Saratoga Hospital will maintain strong, structured engagement with community partners throughout the duration of the CSP. Partner engagement activities will occur through quarterly meetings convened by Saratoga Hospital in collaboration with Healthy Capital District and other regional PAWGs. These meetings will be used to review shared progress metrics, monitor implementation milestones, and evaluate the effectiveness of selected interventions. Partners—including county public health departments, community-based organizations, schools, behavioral health agencies, primary care practices, and social service organizations—will be encouraged to participate in joint discussion of barriers to implementation and collaborate on strategies to address them.

Saratoga Hospital will also use these quarterly meetings to coordinate cross-sector interventions, align outreach and screening efforts, avoid unnecessary duplication, and leverage combined resources to reach high-priority populations. Data-sharing agreements and standardized reporting formats will support the exchange of actionable information, including screening results, closed-loop referrals, chronic disease indicators, and community program utilization. Through this model, Saratoga Hospital fosters shared ownership of outcomes, strengthens regional capacity, and ensures that CSP activities remain aligned with both community needs and partner strengths.

6. Sharing Findings with the Community

To ensure full transparency and accountability, Saratoga Hospital will publicly share CSP progress and evaluation findings on an annual basis. The complete CSP and subsequent progress reports will be posted on the Saratoga Hospital website and linked through the broader Albany Med Health System and Healthy Capital District websites. In addition to online publication, findings will be disseminated through presentations to local coalitions—including the Saratoga County Public Health Advisory Board, community health collaboratives, food security networks, behavioral health task forces, and other stakeholder groups actively engaged in local health improvement efforts.

Saratoga Hospital will also share results with county agencies, municipal leaders, and community-based organizations to support collective planning and resource alignment. Key findings may be incorporated into community newsletters, social media updates, and public forums to ensure broad public awareness. Where appropriate, Saratoga Hospital will provide data summaries tailored for specific partners (e.g., school districts, senior centers, housing agencies) to support their ongoing program development. This multifaceted dissemination approach ensures that CSP activities remain visible, accessible, and responsive to the communities the hospital serves.

2025-2027 Prevention Agenda Workplan – Saratoga Hospital

Priority Area 1: Economic Stability - Nutrition Security

NYS Prevention Agenda Priority: Economic Stability - Nutrition Security		
Domain: Economic Stability		
Priority: Nutrition Security		
Objective: 3.1 Increase food security in households with an annual total income of less than $25,000 from 42.0% to 51.1%.		
Health Disparity Focus Area/Rationale: Structural and socioeconomic barriers—such as income, geography, transportation, and food cost—limit consistent access to healthy foods for many residents, particularly in low-income, rural, and urban communities. These barriers contribute to nutrition-related chronic disease and unequal health outcomes across the lifespan. Addressing food insecurity and advancing nutrition security are critical to reducing health disparities and supporting overall population health.		
Featured Intervention	**Family of Measures**	**Implementation Partner Roles and Resources**
• Conduct standardized screening of unmet Nutrition Security needs and provide referrals to state, local, and federal benefit programs and community-based, health-related social needs providers to address unmet needs.	• Number of SHMG practices that screen for food insecurity and facilitate referrals to supportive services (April 2026 – December 2027) • Number of completed screenings (July 2026 – December 2027) • Number of closed loop referrals (July 2026 – December 2027)	Hospital • Implement standardized screening tools and workflows to screen patients Patients • Complete screenings Community-Based Organizations • Accept and respond to referrals

Priority Area 2 — Depression & Mental Well-Being

NYS Prevention Agenda Priority: Social & Community Context
Domain: Social & Community Context
Priority: Depression & Mental Well-being
Objective: 7.0 Reduce the percentage of adults, ages 18 and older, with a major depressive episode during the past year from 6.7% to 5.7%.
Health Disparity Focus Area/Rationale: **Depression affects a substantial portion of the population and is a significant contributor to poor health outcomes across the lifespan.** It often serves as a gateway to other health challenges, including substance use disorders, PTSD, chronic stress, and the worsening of chronic medical conditions. Disparities are most pronounced among individuals with low income and older adults, who frequently face compounded barriers such as social isolation, financial strain, stigma, and limited access to mental health services. Expanding screening and access to timely, culturally responsive treatment is essential to reducing disparities and improving overall population health.

Featured Intervention	Family of Measures	Implementation Partner Roles and Resources
• Implement a collaborative care model to ensure that individuals with depression receive treatment.	• Implement CoCM in all SHMG Primary and Women's Health practice locations. • Reduce the number of major depressive episodes among SHMG patients by 1.0% (January 2026 – December 2027). • Improvement in depression and/or anxiety symptoms by 50% as measured by PHQ9 and GAD7 scores among patients enrolled in CoCM (January 2026 – December 2027).	Providers • "Clinical Lead and Prescriber. Identify and refer patients to CoCM through routine screening • Diagnose behavioral health conditions and initiate treatment • Prescribe and adjust medications based on patient progress and psychiatric input • Collaborate with the Behavioral Health Care Manager and Psychiatric Consultant • Maintain overall responsibility for the patient's care plan" Participant • "Participate in shared decision-making and goal setting • Complete screening and symptom monitoring tools (e.g., PHQ-9, GAD-7) • Engage in treatment plans (medication, brief interventions, referrals) • Communicate preferences, barriers, and changes in symptoms

		• Identify social, functional, or cultural factors impacting care" Behavioral Health Care Manager (BHCM) • Conduct comprehensive behavioral health assessments Provide brief, evidence-based interventions (e.g., behavioral activation, problem-solving therapy) • Track patient progress using a patient registry and standardized tools • Maintain regular contact with patients (in-person, phone, or telehealth) • Identify patients not improving and escalate for psychiatric review • Coordinate referrals to specialty behavioral health or community supports as needed

Priority Area 3 — Prevention & Management of Chronic Disease

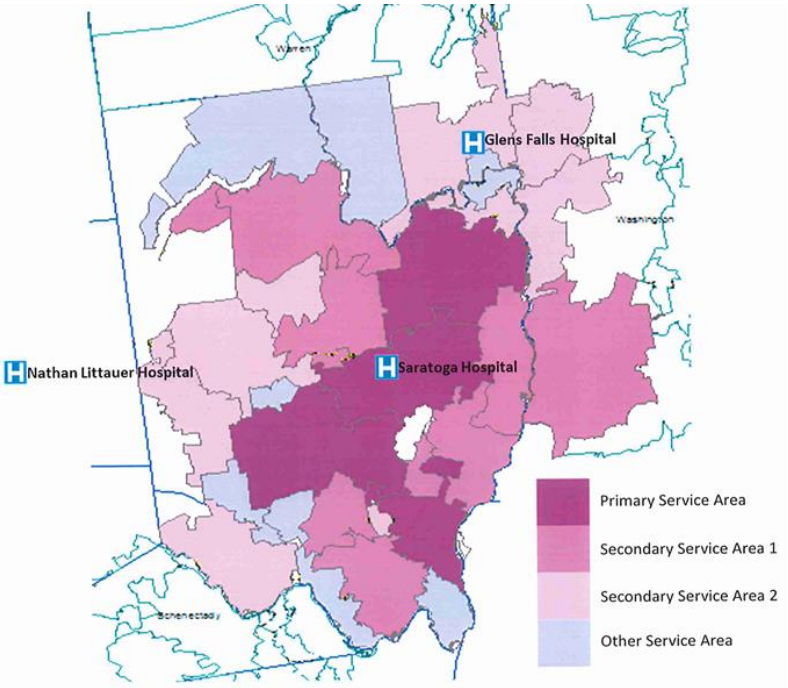
NYS Prevention Agenda Priority: Healthcare Access & Quality		
Domain: Healthcare Access & Quality		
Priority: Preventative Services for Chronic Disease Prevention and Control		
Objectives: Increase the percentage of adults aged 35 years and older who had a test for high blood sugar in the past year from 78.1% to 82.4%. Increase the percentage of adults aged 45 to 75 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 73.7% to 82.3%.		
Health Disparity Focus Area/Rationale: Chronic diseases are largely preventable, yet they remain a leading cause of disability, death, and health care costs in New York State—particularly among individuals who face barriers to accessing preventive and ongoing care. Low-income individuals, people experiencing homelessness, and older adults are disproportionately impacted due to challenges such as limited access to primary care, transportation barriers, housing instability, fixed incomes, and social isolation. These barriers contribute to delayed screening, poor chronic disease management, and higher rates of preventable hospitalizations and mortality. Targeted, evidence-based prevention and management strategies that improve access to care and supportive services are essential to reducing disparities and improving health outcomes for vulnerable populations.		
Featured Interventions	**Family of Measures**	**Implementation Partner Roles and Resources**
Expand screening for social care needs among all adults and those with chronic diseases (prediabetes, diabetes, hypertension, cancer screening), and provide referrals to appropriate community resources and supports. • Increase Point of Care Testing in Primary Care Clinics • Increase referrals to nutrition services Partner with community-based organizations to promote access to prevention and screening services. • Integrate community health workers into health care teams to improve chronic disease management for patients experiencing health inequities.	• Number of closed loop referrals for patients within the cohort (July 2026 – December 2027). • Increase Point of Care Testing for AIC within SHMG Primary Care Practices by 4% (July 2026 – December 2027). • Increase referrals to nutrition services by 4% (July 2026 – December 2027). • Initiate active partnerships with 3 community-based organizations (CBO's) serving priority populations (low-income individuals, older adults, people experiencing housing insecurity) and partner on 2 community screening events (July 2026 – December 2027). • Increase the number of community health workers	Community-Based Organizations • Participate in planning and co-hosting community-based screening and education events (e.g., diabetes, colorectal cancer, nutrition,).Providers • Assist with outreach and engagement of priority populations, including low-income individuals, older adults, and people experiencing housing insecurity. • Support completion of social care screenings and accept referrals through a closed-loop referral process. • Provide navigation and follow-up support related to food access, transportation, housing stability, and social connection. • Share aggregate data and feedback to inform program

	• Initiate targeted outreach campaigns to Medicaid and/or Dual Eligible populations in need of preventive screenings (July 2026 – December 2027). • Number of care gaps closed (July 2026 – December 2027). • Number of low-dose CT lung cancer screening • Number of breast cancer screening events	improvement and address gaps in access. Primary Care • Implement evidence-based screening protocols for diabetes, colorectal cancer, and other chronic disease indicators in clinical and community settings. • Conduct point-of-care (POC) A1c testing and ensure timely follow-up and care management for abnormal results. Community Health Workers • Support patient engagement, education, and follow-up for individuals with chronic conditions or identified social care needs. • Facilitate closed-loop referrals and ensure patients successfully connect to recommended services. • Provide culturally responsive, relationship-based support to reduce care gaps and prevent avoidable hospitalizations. Health System & Department Leadership • Provide infrastructure, staffing support, and clinical workflows needed to sustain screening and referral activities. • Strengthen partnerships with CBOs through formal agreements and shared accountability.

Appendices

Data Tables and Charts from HCDI and 2025 Capital Region CHNA

- Appendix A: Saratoga Hospital Service Area

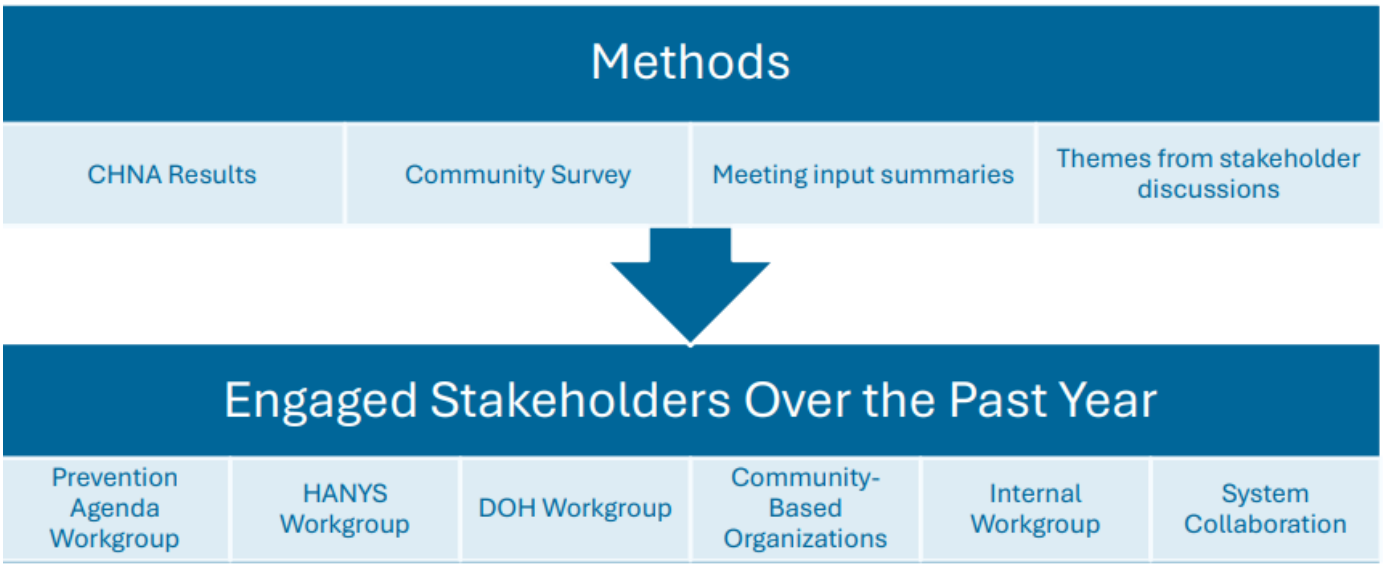


Saratoga County ZIP Code Groups

ZIP Code Group	Neighborhood/Region	
Ballston Spa	Ballston Spa	12020
Burnt Hills/Galway	Ballston Lake	12019
	Burnt Hills	12027
	Galway	12074
	Hagaman	12086
	Round Lake	12151
Clifton Park West	Clifton Park West	12065
	Rexford/Vischer Ferry	12148
North East Saratoga	Gansevoort	12831
	Schuylerville	12871
	Stillwater	12170
North West Saratoga	Corinth	12822
	Greenfield Center	12833
	Hadley	12835
	Middle Grove	12850
	Porter Corners	12859
	Rock City Falls	12863
Saratoga Springs	Saratoga Springs	12866
South Glens Falls	South Glens Falls	12803
Waterford/ Mechanicville	Mechanicville	12188
	Waterford	12118

- Appendix B: Process for Selecting CSP Priorities for Saratoga Hospital

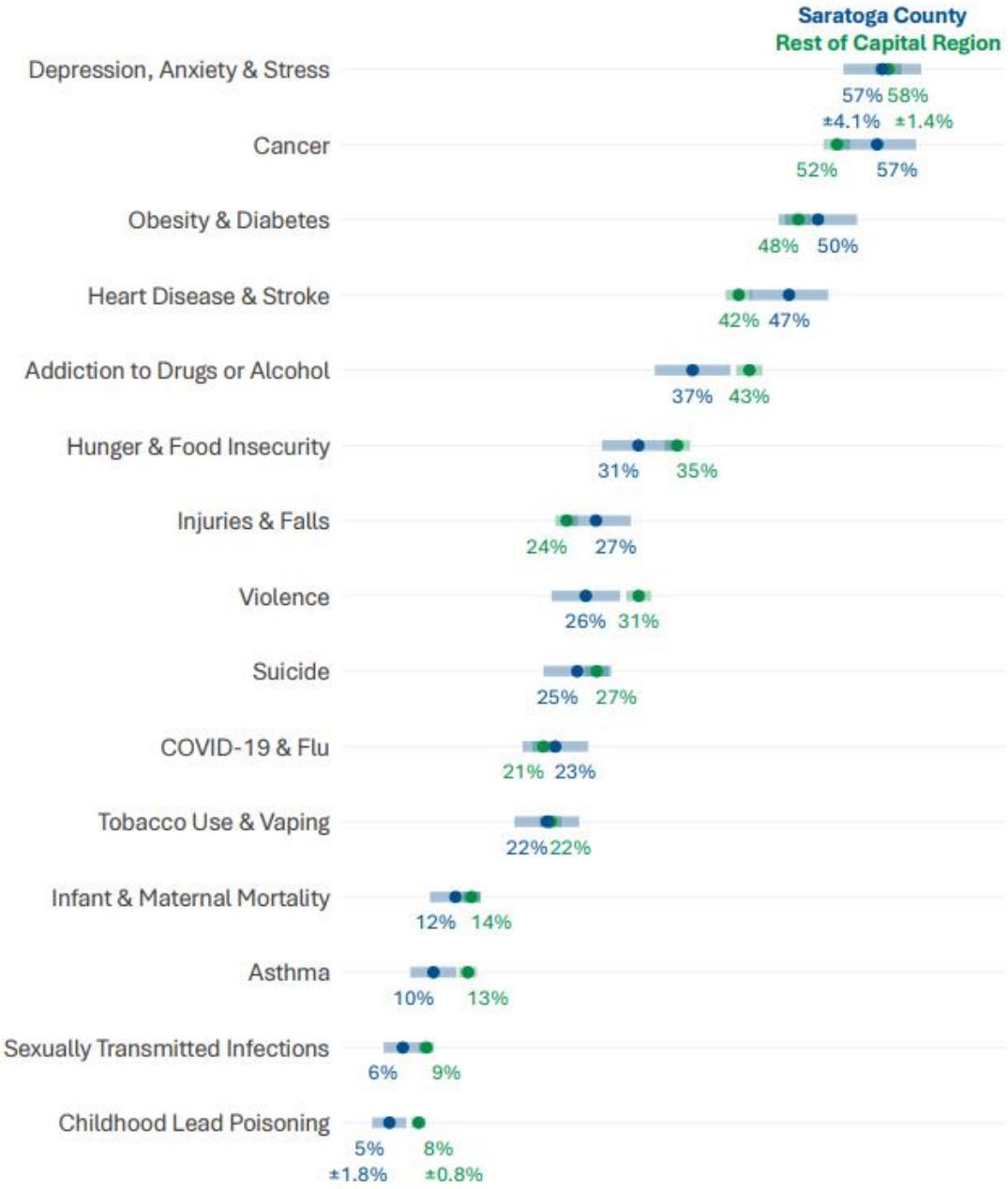
Process for Selecting Priorities



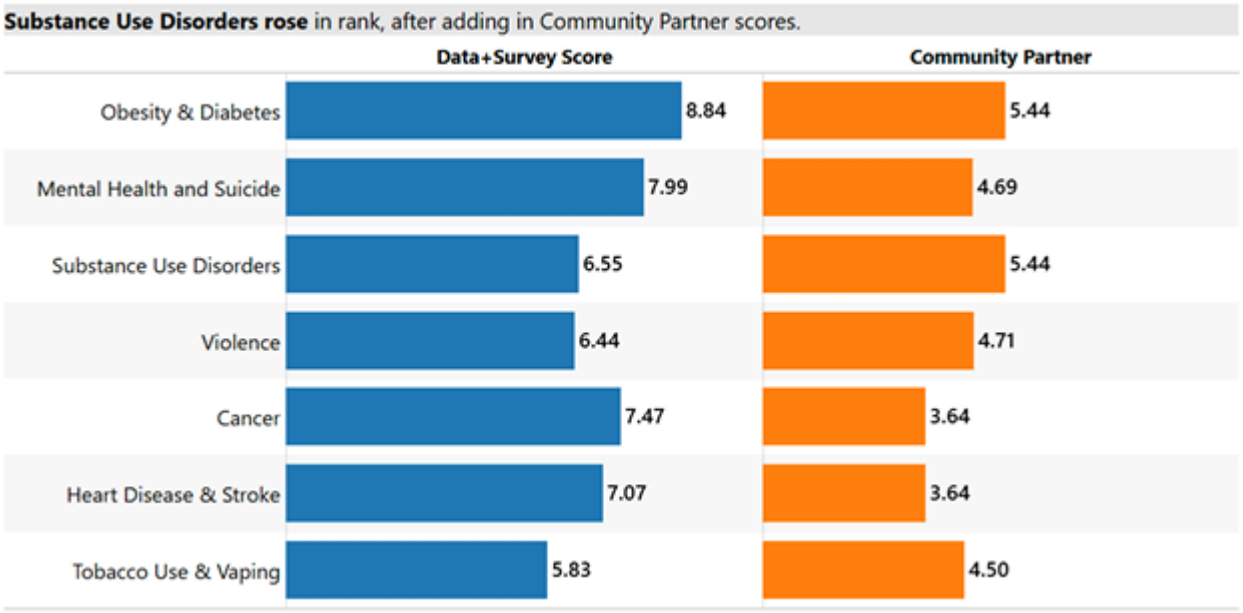
- Appendix C: Results from 2024 Community Health Survey Results – Saratoga Hospital

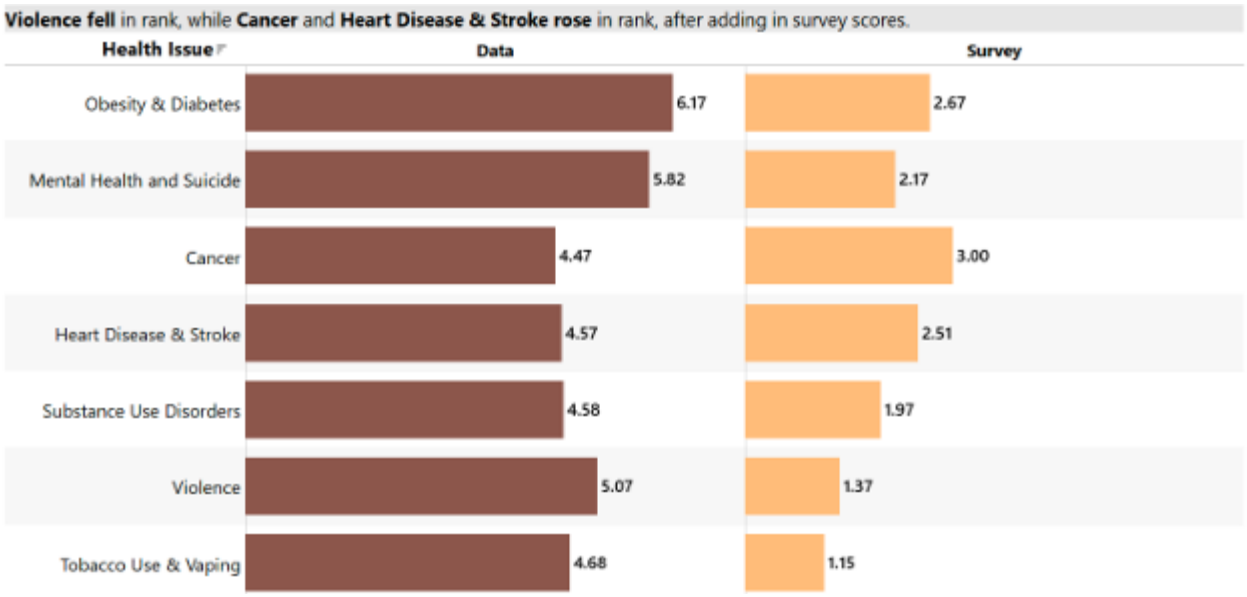
Health Priorities

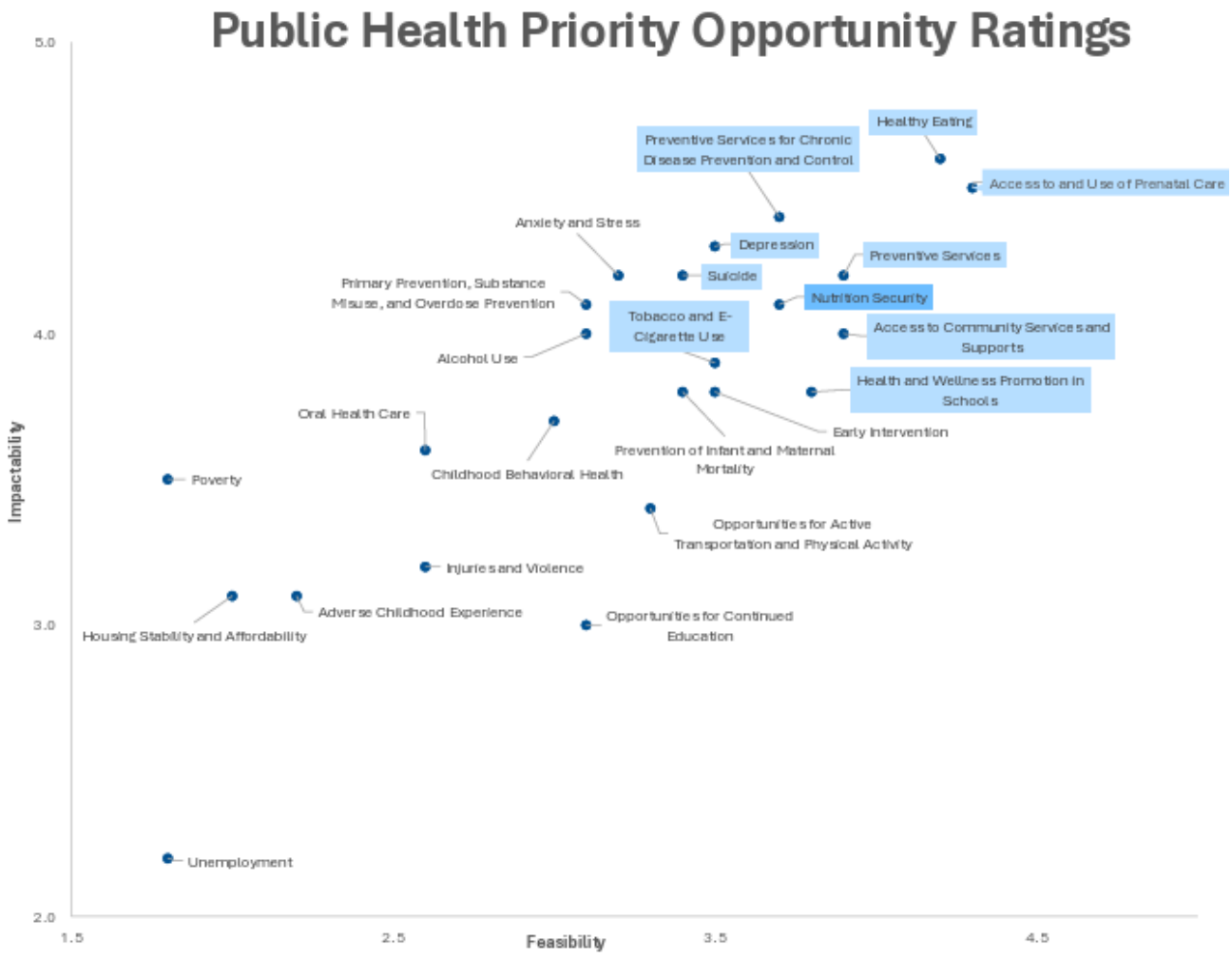
1) In your community, which health issues are you most concerned about?



Saratoga Hospital Total data, survey, and community partner scores




Violence fell in rank, while Cancer and Heart Disease & Stroke rose in rank, after adding in survey scores.
Health Issue
Data
Survey
Obesity & Diabetes
6.17
2.67
Mental Health and Suicide
5.82
2.17
Cancer
4.47
3.00
Heart Disease & Stroke
4.57
2.51
Substance Use Disorders
4.58
1.97
Violence
5.07
1.37
Tobacco Use & Vaping
4.68
1.15


Public Health Priority Opportunity Ratings
Impactability
Feasibility
5.0
4.0
3.0
2.0
1.5
2.5
3.5
4.5
Healthy Eating
Preventive Services for Chronic Disease Prevention and Control
Access to and Use of Prenatal Care
Anxiety and Stress
Depression
Preventive Services
Suicide
Primary Prevention, Substance Misuse, and Overdose Prevention
Nutrition Security
Tobacco and E-Cigarette Use
Access to Community Services and Supports
Alcohol Use
Health and Wellness Promotion in Schools
Oral Health Care
Early Intervention
Prevention of Infant and Maternal Mortality
Childhood Behavioral Health
Poverty
Opportunities for Active Transportation and Physical Activity
Injuries and Violence
Adverse Childhood Experience
Housing Stability and Affordability
Opportunities for Continued Education
Unemployment