Community Health Assessment 2022-2024

Community Health Improvement Plan 2022-2024

Tompkins County Whole Health
Cayuga Medical Center, a member of Cayuga Health
Ithaca, New York
December 2022

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Executive Summary

The Tompkins County Community Health Assessment and Improvement Plan is a collaborative process with a focus on promoting health equity. Health equity occurs when every person has fair and just opportunities for optimal health and well-being. The integration of mental, physical, and environmental health allows us to envision a future where every person in Tompkins County can achieve wellness. This vision captures the recent combining of the local health department (LHD) and mental health services into one organization, Tompkins County Whole Health (TCWH). TCWH looks forward to working with partners and the community in this new capacity.

The Prevention Agenda (PA), New York State's blueprint for "the healthiest state," includes five Priorities: Prevent Chronic Disease, Promote a Healthy and Safe Environment, Promote Healthy Women, Infants, and Children, Promote Well-Being and Prevent Mental and Substance Use Disorders, and Prevent Communicable Disease. Each priority is divided into two or more Focus Areas.

Tompkins County selected two Focus Areas in the Prevent Chronic Disease priority, two in Promote Heathy Women, Infants, and Children, and two in Promote Well-Being and Prevent Mental and Substance Use Disorders. Objectives address food security and healthy eating, gaps in cancer screening, equity of care for women and infants, and opportunities to build and strengthen well-being.

Disparities are primarily across wealth and race. Inequity is also evident in housing and access to healthcare, with the latter often due to lack of transportation options. Secondary data shows an income gap between races.

Secondary data for the CHA were primarily sourced from the U.S. Census and the NYSDOH. The DOH pulls data from a variety of sources and compiles key indicators in the PA dashboard and the NYS Community Health Indicator Reports (CHIRS). These same sources have been the references for all editions of the Tompkins CHA.

Primary data was collected directly from the community through a community wide survey in which respondents were asked to rate their own health, identify choices and challenges, and weigh in on what makes a healthy community. Over 1,500 eligible responses to the survey were completed. The results clearly demonstrate the influence that social determinants of health have on an individual's perception of their health.

A Steering Committee was convened to review and coalesce all data, and to propose the PA priorities and Focus Areas most relevant to the Tompkins County community. The committee included representatives from County Whole Health, County Youth Services,

Office for the Aging, Cayuga Health, Health Planning Council, Cornell University MPH Program, and Cornell Cooperative Extension of Tompkins County (CCE-TC).

The array of programs active in Tompkins County to address social determinants of health drive strategies that are evidence-based, promising/pilot programs, and/or programs planning an expansion to serve new constituencies. These activities are aligned with CHIP goals and objectives identified by the steering committee. Promoting chronic disease activities focus on increasing the availability of fruit and vegetable incentive programs, screening for food insecurity, removing structural barriers to cancer screening, and promoting strategies to improve detection of hypertension and prediabetes.

Well-being relates to an individual's physical, mental, and social sense of health and satisfaction, along with the influence that social determinants have on experiences and quality of life. The CHIP outlines strategies to strengthen well-being and promote health equity, including in the home to support parents and young children in families, and support those living with a chronic disease or disability to learn and practice techniques to better manage their disease in a safe, social setting.

It takes a supportive community to build well-being, and the CHIP specifies that Mental Health First Aid (MHFA) courses be taught to an ever-widening audience throughout the county, including at workplaces in all sectors. The CHIP identifies activities to prevent and treat mental and substance use disorders, including increasing access to medication-assisted treatment, access to overdose reversal training and kits, and integrating trauma-informed approaches in training and policy.

Evaluating the impact of the goals, objectives, and interventions presented in this CHIP will take place through 2024. A steering committee will monitor short term process measures that track activities. Community partners will have access to a reporting matrix that will be updated quarterly and on an annual basis submitted to NYS.

Community Health Assessment, 2022-2024

DESCRIPTION OF THE COMMUNITY

The demographics of the population served

TOMPKINS COUNTY, New York covers 476 square miles at the southern end of Cayuga Lake, the longest of New York's Finger Lakes. Tompkins County is on Cayuga Tribal land, part of the Iroquois Confederation.

Positioned in the center of the county at the lake's southern tip is Ithaca, the county seat and only city. Ithaca is 60 miles southwest of Syracuse and 25 miles west of Cortland. It forms a hub for five state highways, though the closest Interstate connection is forty minutes away in Cortland. (Figure 1)

Figure 1

Population

While the U.S. Census Bureau's 2021 estimate population for Tompkins County is 105,162, all data in the following demographic profile is based on the Bureau's 2016-2020 5-year estimates, which marks the county population at 102,237.

The City of Ithaca and the surrounding Town of Ithaca account for nearly half (49.4%) of the county population. The Towns of Dryden and Lansing combined are another quarter (25.2%) of the population total, with the six remaining towns, all with population under 5,829, making up the final 25.4%. (Table 1)

Profile

Tompkins County is home to three institutions of higher education, Cornell University, Ithaca College, and Tompkins Cortland Community College (TC3). Cornell's main campus is on East Hill in the City of Ithaca, and many of its facilities are in the Towns of Ithaca and Dryden. Ithaca College is on South Hill, within the Town of Ithaca. TC3 is in the Town of Dryden. Together, these schools enroll a total of 27,644 undergraduate, graduate, and professional students, 27% of the county population.

Much of the county's demographic profile reflects the college sector. The median age of Tompkins County residents is 31.3

American Community Survey, 5-year est, 2020	Population	Percent of total pop	White alone %	Black or African American alone %	Asian alone %
Tompkins County	102,237		79.6%	4.1%	9.4%
Caroline	3,318	3.2%	86.3%	2.8%	1.5%
Danby	3,387	3.3%	92.0%	6.5%	0.5%
Dryden	14,361	14.0%	90.4%	2.9%	1.9%
Enfield	3,442	3.4%	96.3%	0.3%	0.0%
Groton	5,829	5.7%	92.1%	1.6%	0.9%
City of Ithaca	30,715	30.0%	67.7%	5.9%	17.2%
Ithaca	19,868	19.4%	72.0%	5.2%	13.3%
Lansing	11,492	11.2%	80.2%	2.8%	11.4%
Newfield	5,115	5.0%	96.2%	1.7%	0.5%
Ulysses	4,892	4.8%	94.1%	2.2%	0.6%

Source: U.S. Census, ACS DT5Y2020.B02001, 2022-08-30, RACE

Table 1

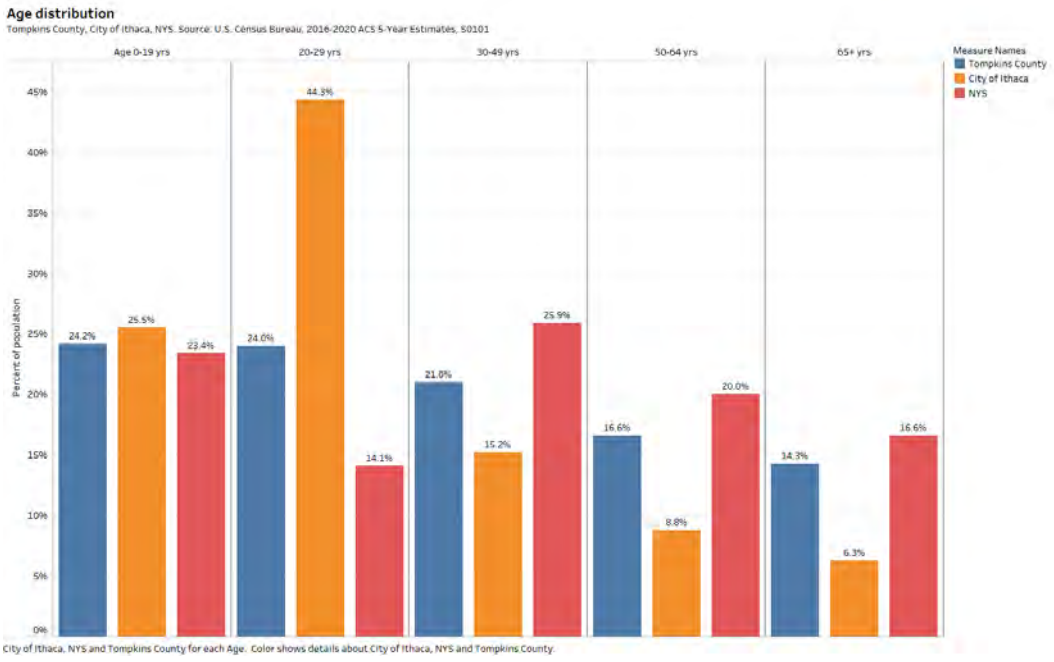

Figure 2

years—the lowest in the state—with 26.6% of residents age 18–24 years. About 1-in-7 Tompkins County residents is age 65 or older (14.3%). (Figure 2)

Tompkins County's population is well educated: 94.4% residents aged 25-plus are high school graduates, 53% have a Bachelors degree, and 29.6% have a graduate or professional degree. Of the civilian population 16 years and over, 16.2% work in educational instruction and library occupations, 11.8% in computer, engineering, and science, and 5.3% in healthcare practitioner and technical occupations. (Figure 3 and Figure 4)

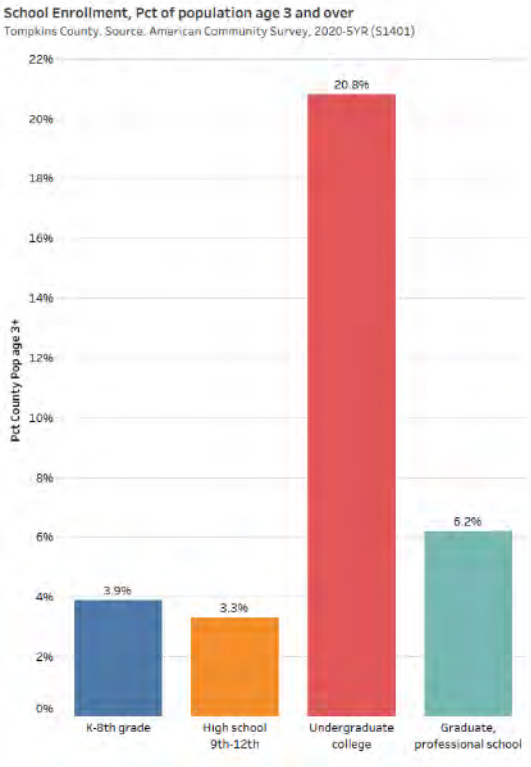

Figure 3

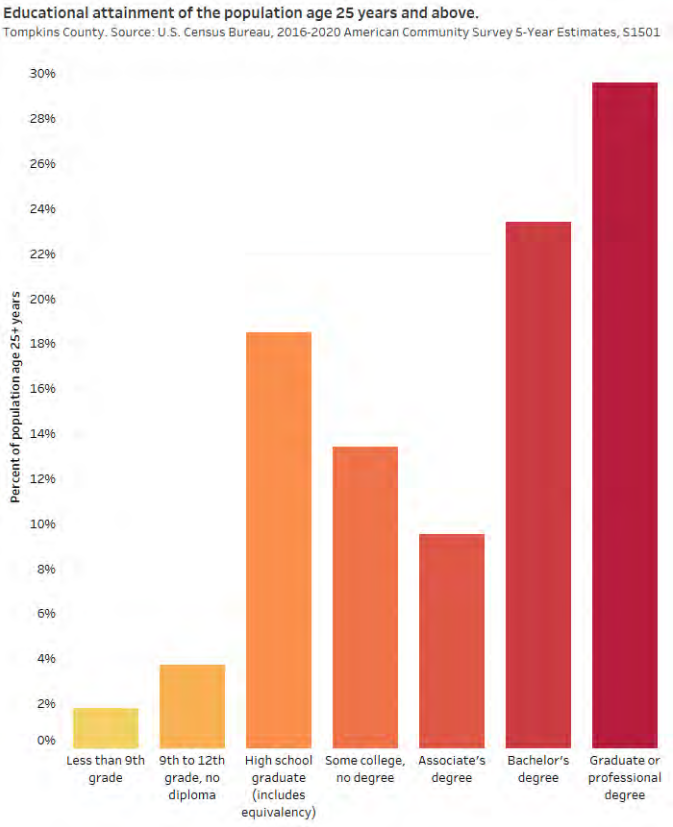

Figure 4

Transience is another characteristic of Tompkins County's student-heavy population. This lack of population consistency challenges efforts to establish a broad awareness of public services for health, housing, and transportation. About 3-in-20 (15.3%) County residents lived outside the county the previous year. In the City and Town of Ithaca, 15.9% and 11.9% of the respective populations moved in from out of state within the past year. (Figure 5)

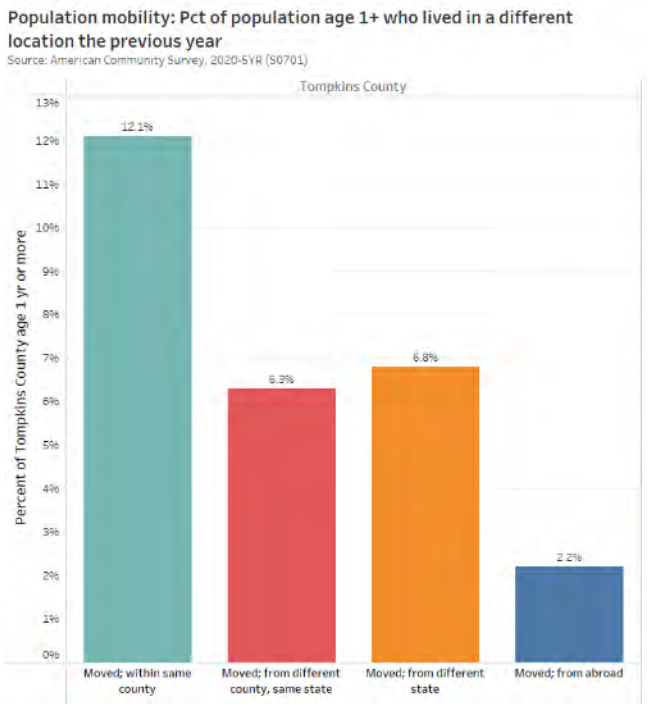

Figure 5

About thirteen percent of county residents are foreign born; about 1-in-20 of those are now naturalized citizens. Among the foreign-born population age 5 and up, 70.3% speak a language other than English, and about 1-in-4 of that group are identified as speaking English "less than very well." That represents about 3,315 residents, not all of whom are post-secondary students. For example, the Ithaca Housing Authority provides its leasing materials in a dozen languages. All public health and public health preparedness service providers must be ready to accommodate these individuals. (Figure 6)

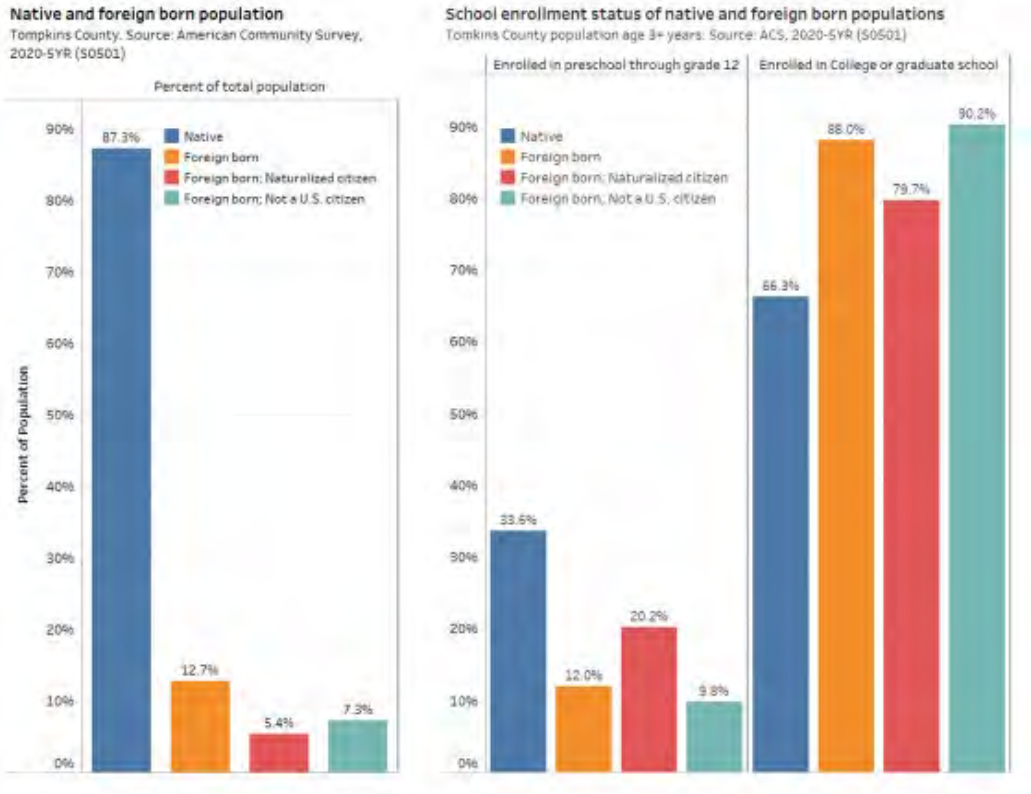

Figure 6

Households

Close to half (47.5%) of Tompkins County households are non-family households. Just in City of Ithaca nearly three-quarters (72%) of households are non-family. Consistent with rates of non-family households and transience, the number of renter-occupied housing approaches half (46%) of all units. In the City of Ithaca, nearly three out of four (74.9%) occupied units are rentals. (Figure 7)

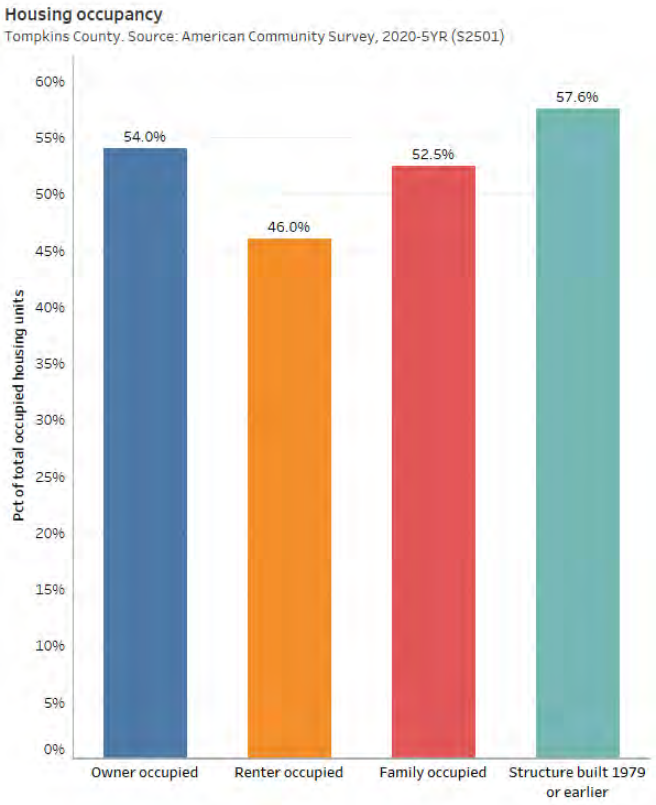

Figure 7

Among all households, owner-, renter-, and family-occupied, a clear majority of the housing stock is old; county-wide, 57.6% of structures were built before 1980. Within City of Ithaca, that number rises to nearly two out of three (62.8%) occupied structures were built before 1980, when lead paint was still in use. Across the county, 8% of occupied units are a mobile home or other type of housing. However, in the towns of Newfield and Enfield on the western side of the county, mobile homes or other housing account for nearly one third of residents' housing (29.1% and 29.9%, respectively).

Median household income is student influenced. In Ithaca city for example, the median for all households is $38,019, while for family households it is $98,542; family households are just 28.6% of all households in Ithaca city. In Tompkins County as a whole, half (52.5%) of all households are families, and the median family income is $87,977. The county median across all households, family and non, is $61,361. (Figure 8)

Poverty

In a college town, the student population that works part time or not at all can skew the poverty rate for non-family households downward.

The overall poverty rate in Tompkins County is 17.5%. For county residents who identify as Black or African American alone, the poverty rate is 40.9%; white alone is 13.7%. Among all residents under age 5, 15.1% are below the poverty level.

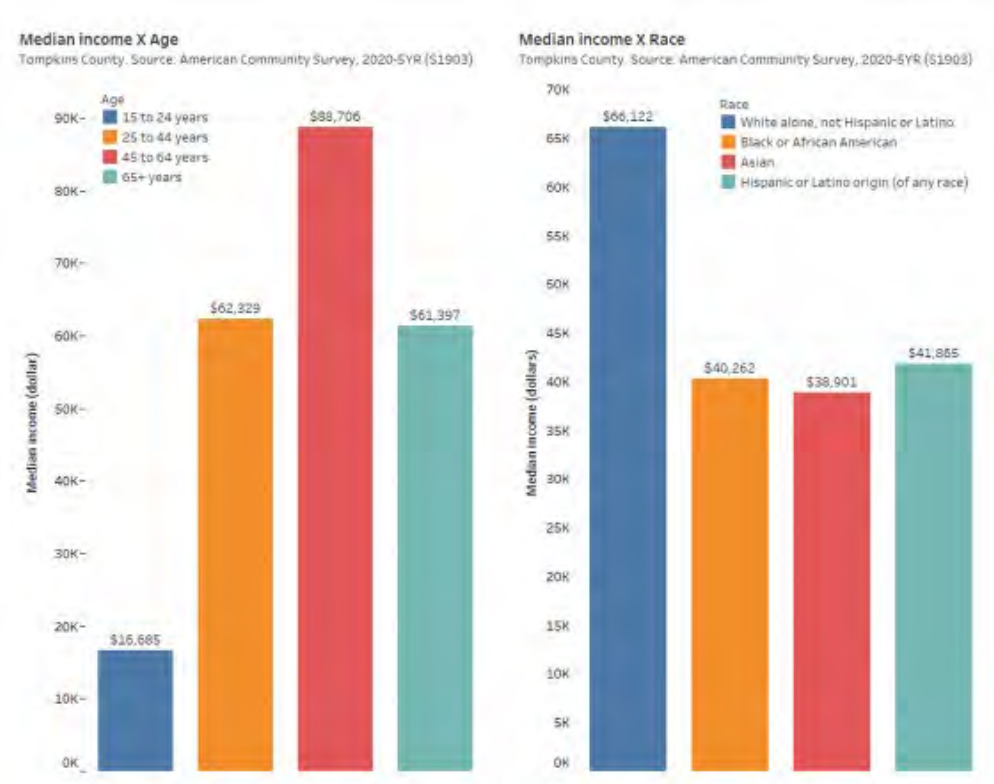

Figure 8

The City of Ithaca has the highest poverty rate in the county, 37.4% among all residents. The rate for city residents who identify as Black alone is 70%; for white alone, 30.6%; for all individuals under age 5, 15.5%. The Town of Dryden has the highest poverty rate for individuals under age 5, 36.3%. The Town of Caroline has the lowest overall poverty rate, at 3.3%. (Figure 9)

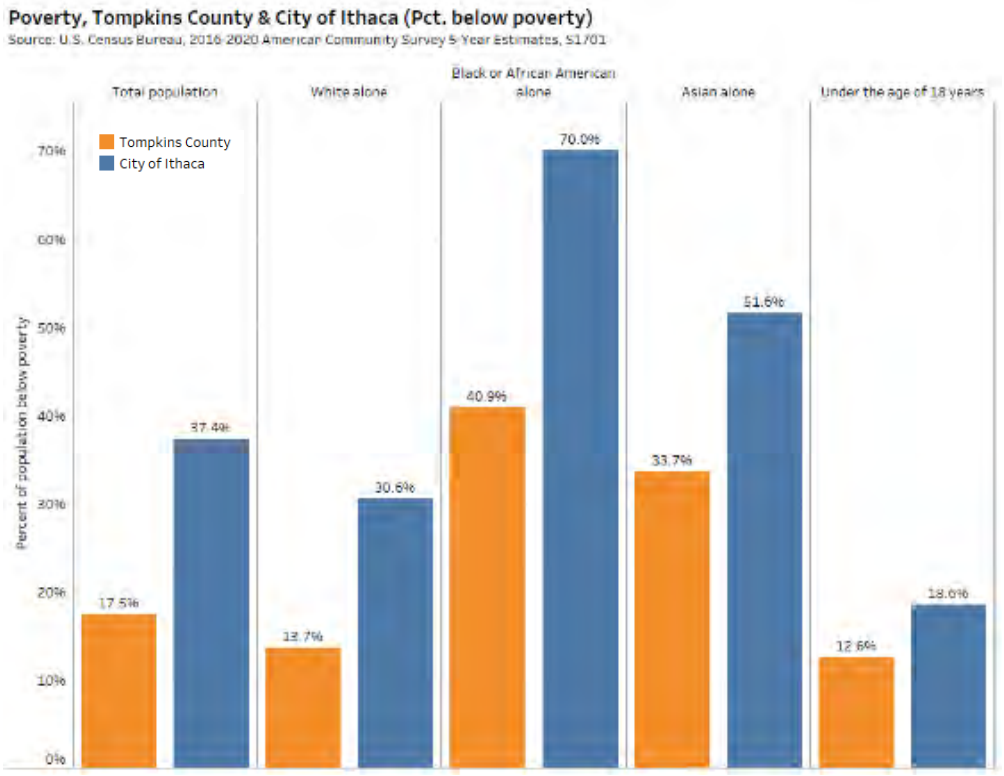

Figure 9

Among all households in Tompkins County, 52.5% are family households, of which one-in-twenty (5.5%) are below the poverty level. Narrowing the population to families with a female householder, no spouse present, and related children under age 5, over a quarter (26.4%) of those Tompkins County families are below the poverty rate. In the City of Ithaca, 19% of family households are below the poverty level. (Figure 10)

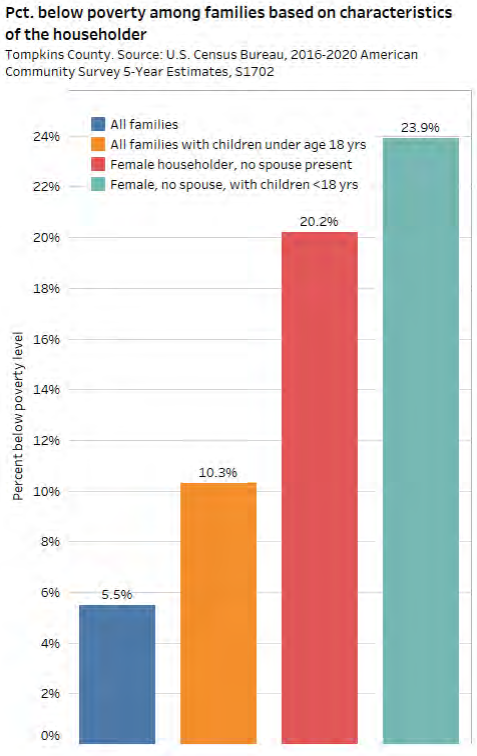

Figure 10

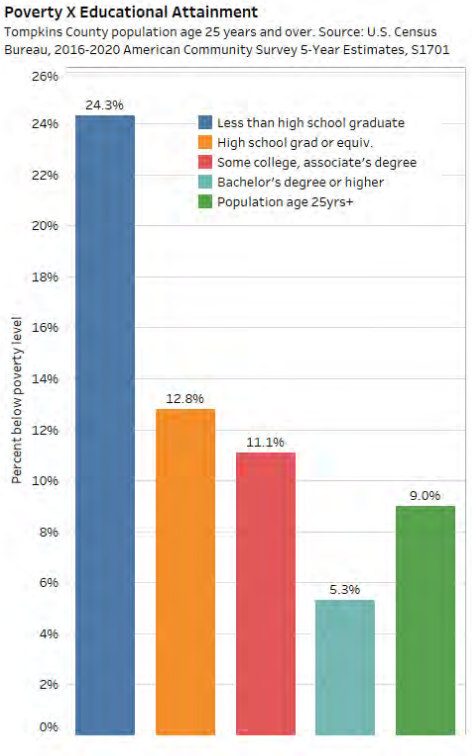

Figure 11

Participation in the Supplemental Nutrition Assistance Program (SNAP) and medical assistance (Medicaid) programs are also key poverty indicators. Nearly one-in-ten Tompkins County households (9.3%) receive SNAP benefits, totaling 3,783 households. About one third of those households include one or more people aged 60 years and over (31.2% of SNAP recipients, or 1,179 households). (Figure 12)

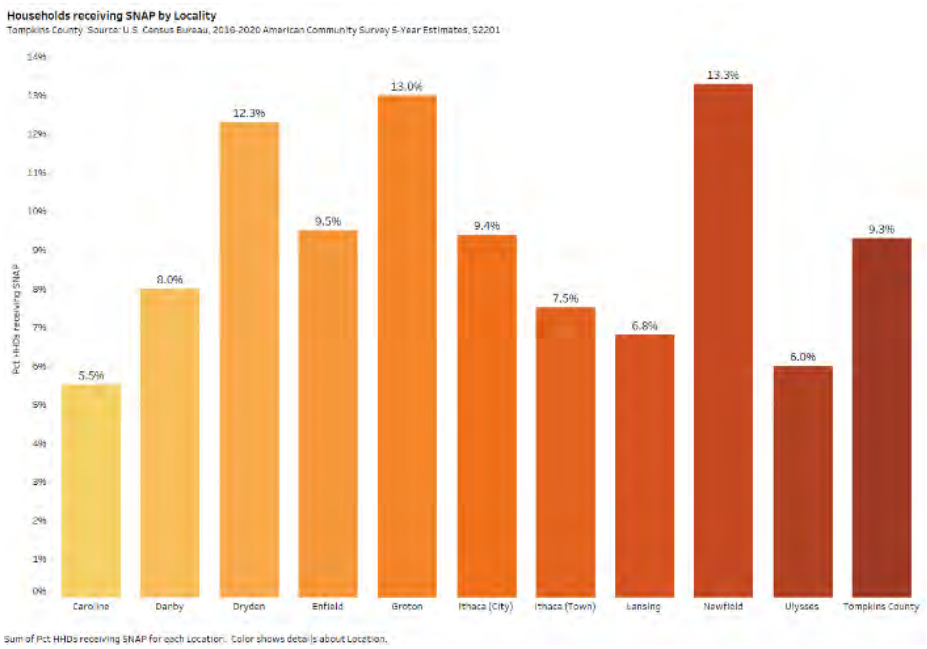

Figure 12

Free and reduced lunch utilization is another often-used indicator of poverty. Across all districts, 40% of students grades K–12 were eligible to receive free or reduced-price lunch during the 2017-2018 school year. This is an increase from 36% in 2009. (Table 2)

Free or reduced school lunch, pct, 2019

	Tompkins County	NYS
Students eligible for free or reduced price lunch (CHIRS 329)	40.3%	55.2%

Source: NYS Community Health Indicator Rpts, CHIRS #329, 2019

Table 2

HEALTH STATUS OF THE POPULATION AND DISTRIBUTION OF HEALTH ISSUES

Aggregated Data

A significant amount of data for health indicators is available in databases curated by the New York State Department of Health (NYSDOH). These include the Community Health Indicator Reports (CHIRS) and the Prevention Agenda (PA). Because these are core indicators that are pulled from many data sources and tracked consistently over years and across the state, they are the predominant source for data cited in this report.

The Prevention Agenda (PA) for 2019-2024 is "New York State's health improvement plan, the blueprint for state and local action to improve the health and well-being of all New Yorkers and to promote health equity in all populations who experience disparities." (health.ny.gov/prevention/prevention_agenda/2019-2024.) It is categorized by the five PA priorities:

- Prevent Chronic Disease,
- Promote a Healthy and Safe Environment,
- Promote Healthy Women, Infants, and Children,
- Promote Well-Being and Prevent Mental and Substance Use Disorders, and
- Prevent Communicable Disease.

Within each Prevention Agenda priority, the structure is: Priority > Focus Areas > Goals > Objectives > Interventions. County status and progress on PA priorities are tracked through 44 indicators in the PA dashboard. Visit the 2019-2024 PA dashboard at health.ny.gov/preventionagendadashboard. Click on the "County" tab to see Tompkins-specific data.

The CHIRS is close to 350 data points organized into 15 categories, including cancer, cardiovascular disease, child and adolescent health, injury, occupational health, health status, and tobacco, alcohol, and other substance abuse. Much of the CHIRS data available for this 2022 revision of the CHA is for years 2017 through 2019.

Comparing data with peer counties, or state and national averages is a common practice for understanding health status and setting realistic health goals. Often, these peer comparisons are made among contiguous counties and a statewide number. In NYS, statewide data are typically provided for "Entire State" and /or for "NYS Except NYC."

The latter, also referred to as the “Rest of State” or ROS, is the most common point of comparison in this year’s CHA.

Community Survey

A Community Health Survey of Tompkins County residents was conducted via Qualtrics over July of 2022. Those who identified as age 18 or over and living in Tompkins County were eligible; there were 1,569 eligible respondents.

Of the total respondents, the largest cohorts were from those aged 55-64 (30%) and aged 55-64 (19%). Respondents by race was: White (86.8%), Black (2.4%), Asian (1.8%), Hispanic (3.4%).

Residents from every municipality participated, with the City of Ithaca drawing the most responses (24%). Consistent with the county’s population distribution, the next highest representation was Town of Ithaca (19%), Dryden (13%), and Lansing (11%). Nearly all respondents identified either as female (68%) or male (27%). A majority of respondents reported that they have private health insurance, alone or in combination with another insurance (68%). Nearly one quarter (23%) had Medicare alone or in combination with another insurance.

The foundation of the Community Survey analysis are the crosstabs for the question at the start of the survey, “How do you rate your health in the following categories?” Categories of health were Physical and Mental. Ratings were: 1-Poor, 2-Fair, 3-Good, 4-Very good, 5-Excellent.
Across all respondents the average rating for both physical health and mental health was 3.5 on the scale of 1 (poor) to 5 (excellent). Seventeen percent of respondents rated their mental health either fair or poor, while 14.2% ranked their physical health at one of the two unfavorable levels. Over half of respondents (53%) rated their physical health either very good or excellent. The proportion was the same for mental health: 53% gave them self either a very good or excellent rating.

Priorities, Focus Areas, and Goals

The CHIP Steering Committee reviewed the PA Priority Areas and Focus Areas (each PA Priority includes multiple Focus Areas) and provided recommendations about which areas should be investigated further during the CHA process and review of data. These recommendations were used to structure the CHA and to determine what data from secondary sources would be reviewed and highlighted in the narrative for this *Health Status* section of the CHA. The review of existing community reports and stakeholder input were also aligned with the Focus Areas.

PREVENTION AGENDA PRIORITY: PREVENT CHRONIC DISEASE

Focus Area 1: Healthy Eating and Food Security

Goal 1.1: Increase access to healthy and affordable foods and beverages
Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices
Goal 1.3: Increase food security

Healthy eating has a major impact on preventing chronic disease, a Prevention Agenda priority. High rates of obesity (BMI 30+) and overweight (BMI 25+) among adults and children has been widely recognized over the last three decades, and ready access to healthy foods such as fresh fruits and vegetables is commonly tracked as a related intervention.

The obesity rate for Tompkins County adults (24%) is lower than for the ROS (30%). The statewide PA 2024 objective for obesity is 24% of the adult population. The comparison is similar for overweight adults and for diabetes indicators. Among Tompkins adults, 57% are overweight, about 7 points below the ROS. Physician diagnosed diabetes includes 7% of Tompkins adults; the ROS rate is 9%. (Figure 13)

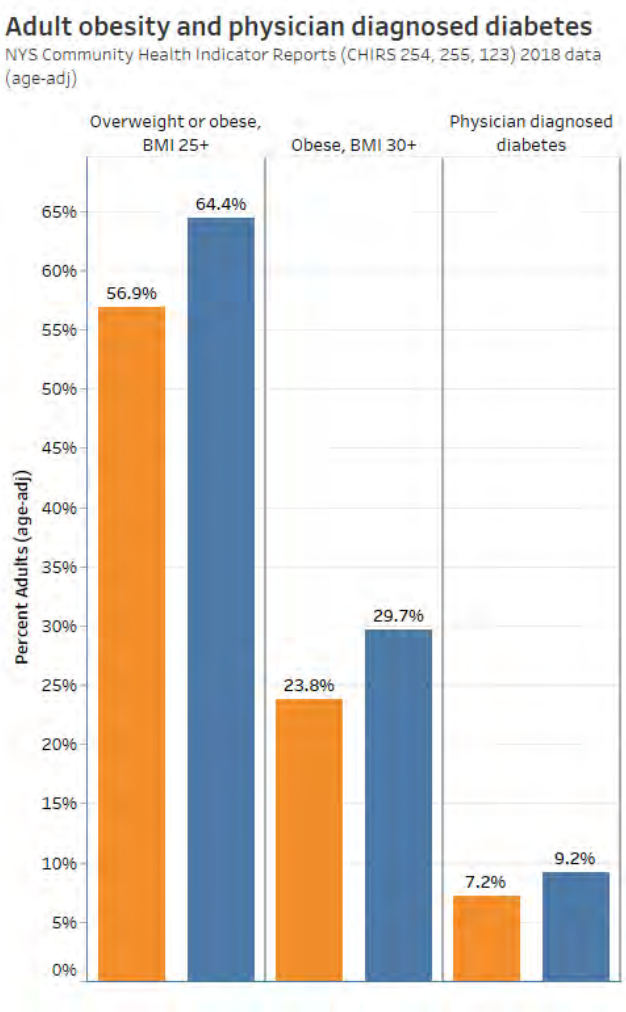

Figure 13

Youth obesity indicators are reported by schools, therefore available by grade level (elementary and combined middle and high school) and by district. Overall, fewer Tompkins elementary students are obese (14%) than throughout the rest of the state (16%). The rate for middle and high-school students is almost one-in-six (17%), where the ROS rate is nearly one-in-five (19%). The obesity rate among WIC children ages 2-4 years is 15%, about equal to the ROS rate. (Figure 14)

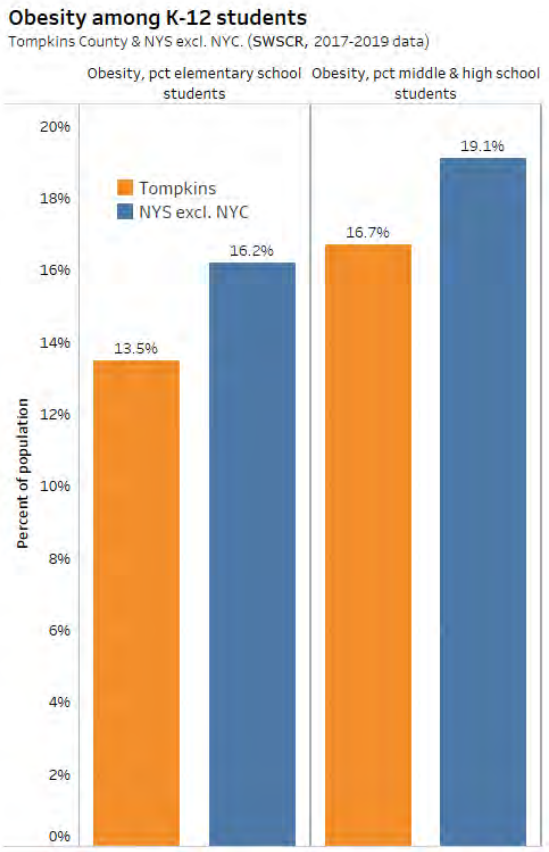

Figure 14

Prevention Agenda sub-county data for student obesity rates is compared among school districts according to quartile distribution; their relative standing as compared with all ROS districts. Quartiles are similar to a median value — the midpoint in a group of data where half the values are higher than the median, and half are lower — but divided four ways. The fourth quartile represents values higher than three-quarters of all values, and the third is the range between half the values (median) and the fourth quartile.

Among the Tompkins County school districts, student obesity rates in Ithaca, Trumansburg, and Lansing are in the first and second quartiles, or better than half of all ROS districts in the sample. Student obesity rates in the Groton and Newfield districts fall in the third quartile, while Dryden is in the fourth quartile for student obesity. These obesity data from NYS are for the years 2017-2019. (Figure 15)

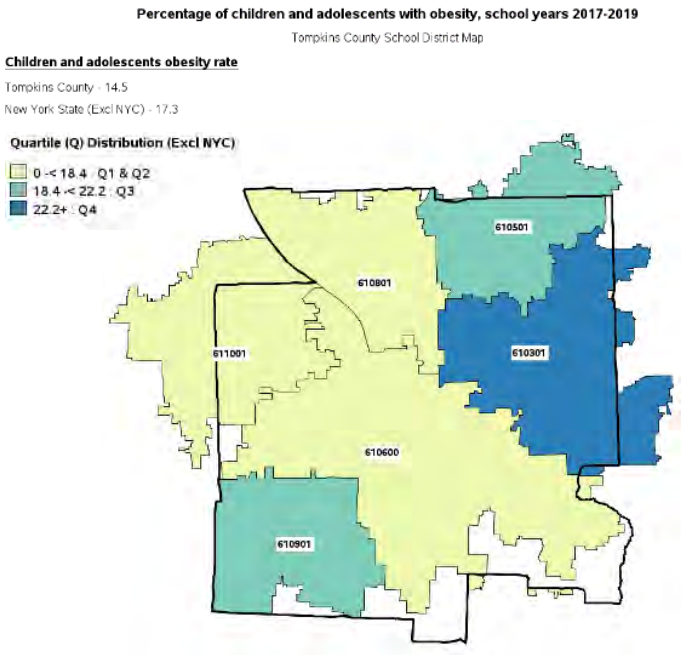

Figure 15

Everyday access to sufficient food of any sort, or food security, is reported in a variety of ways. Among these is population proximity to supermarkets that carry a full range of fresh foods. The Robert Wood Johnson/ University of Wisconsin county rankings report the percent of the low-income residents who do not live close to a grocery store. In Tompkins County, 5.4% of the population qualifies as having limited access to healthy foods. By comparison, the NYS rate is 2.4%.

The NYS CHIRS includes an indicator for the percent of the population who "did not have access to a reliable source of food last year." By this measure, Tompkins County is about at parity with the rate for NYS excluding NYC; 11.6% and 11.0% respectively based on 2019 data. (Figure 16)

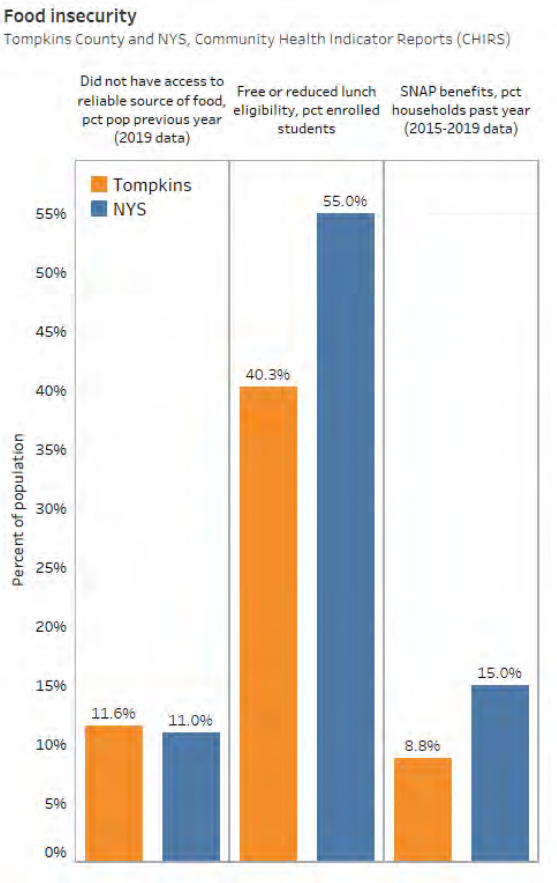

Figure 16

The RWJF County Rankings include three food security indicators, calculated from the USDA Food Environment Atlas and "Map the Meal Gap" from Feeding America. Their Food Environment Index gives a rating from 0-least secure, to 10-most secure. Using 2019 data, Tompkins gets an 8.0 on the index. By comparison, the index for the U.S. overall is 7.8.

A food insecurity rate is also reported by Feeding America's Map the Meal Gap, and the trend in Tompkins County is a decreasing rate from 2017 to 2020 for both the overall population and for children under age 18 years old. The trend is particularly striking for children, for whom the 2017 food insecurity rate was 17%, and in 2020 it was 11%. Unlike the children, the trend for the overall population was not straight down, but instead bounced from 13% in 2017 to 10% in 2018, then back up to 12% and back down to 11% in 2020. (Figure 17)

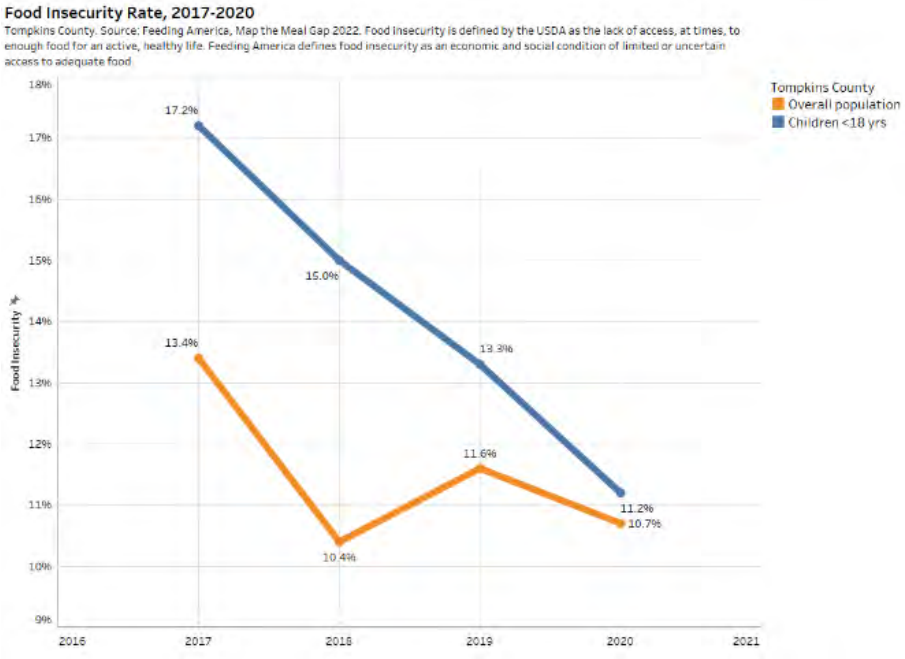

Figure 17

When school is in session, school lunches and breakfast programs provide an important meal for children in households with inadequate food availability or nutritional value. In Tompkins County, 40% of K-12 children are eligible to receive free or reduced-price lunch.

Community Survey

When Community Health Survey respondents were asked to identify the barriers to eating healthy food as often as they would like, over a quarter (27%) cited "Time," and 40 percent cited "Cost." One-in-eight (12%) checked "It's too much trouble or I'm not interested." Respondents could check up to 3 of the options listed. (Figure 18)

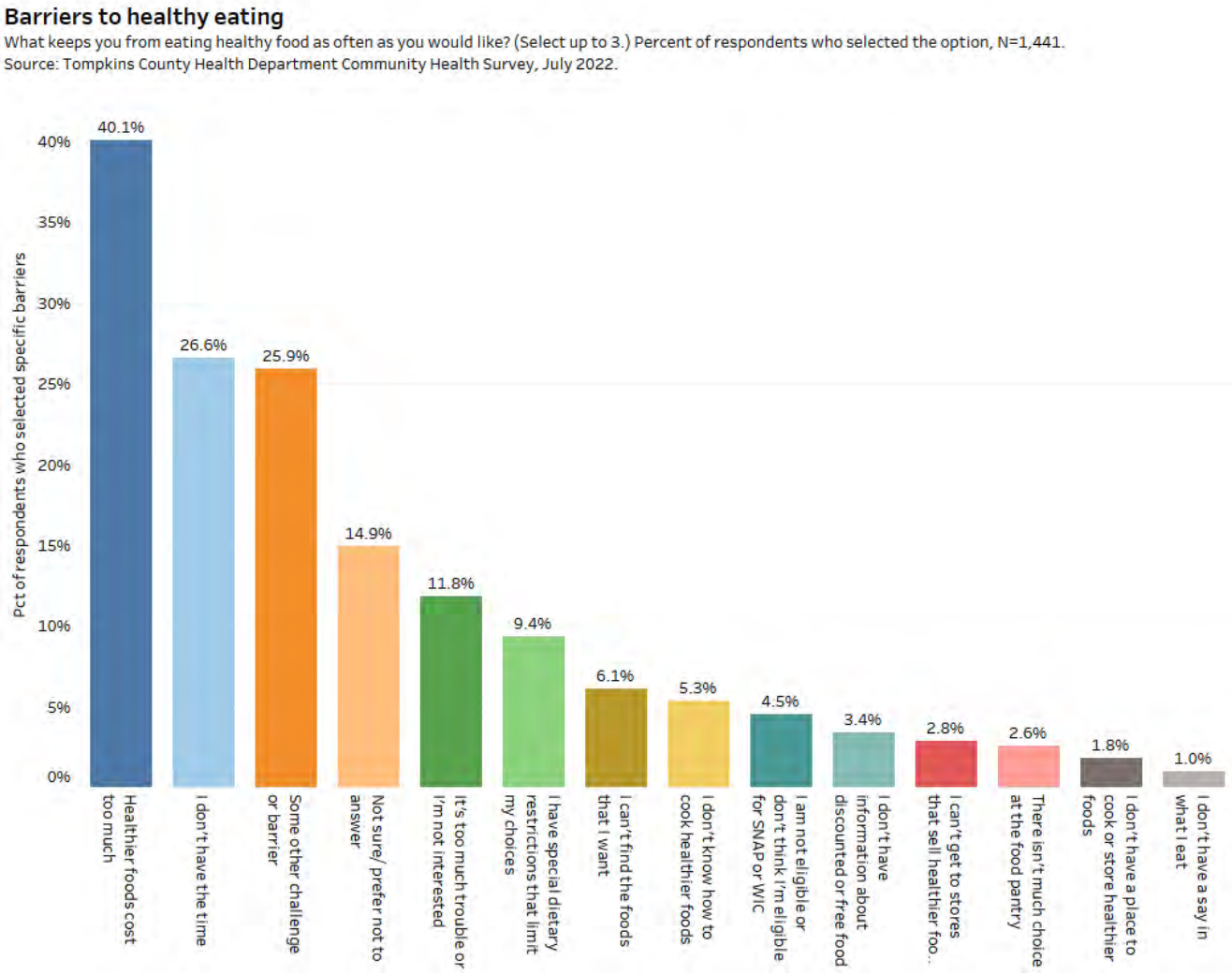

Figure 18

In a similar question asked about barriers to physical activity, 39% cited "Time" and nearly one-third (32%) included "The local weather" as one of the reasons they are not getting as much physical activity as they would like. There is more about physical activity later in this section.

Focus Area 4: Preventive Care Management

Goal 4.1: Increase cancer screening rates for breast, cervical, and colorectal cancer
Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity

Over the ten-year span from 2010 to 2019, cancer and heart disease have evenly shared the #1 cause of death in Tompkins County with five years each. However, while cancer was the leading cause for 2016, 2017, and 2019, the rate of cancer deaths per 100,000 has decreased from 155/100K in 2016 to 127/100K in 2019. Heart disease, CLRD, unintentional injury, cerebrovascular disease, diabetes, and suicide rounded out the top seven for 2019, which is the most recent data available. (Figure 19)

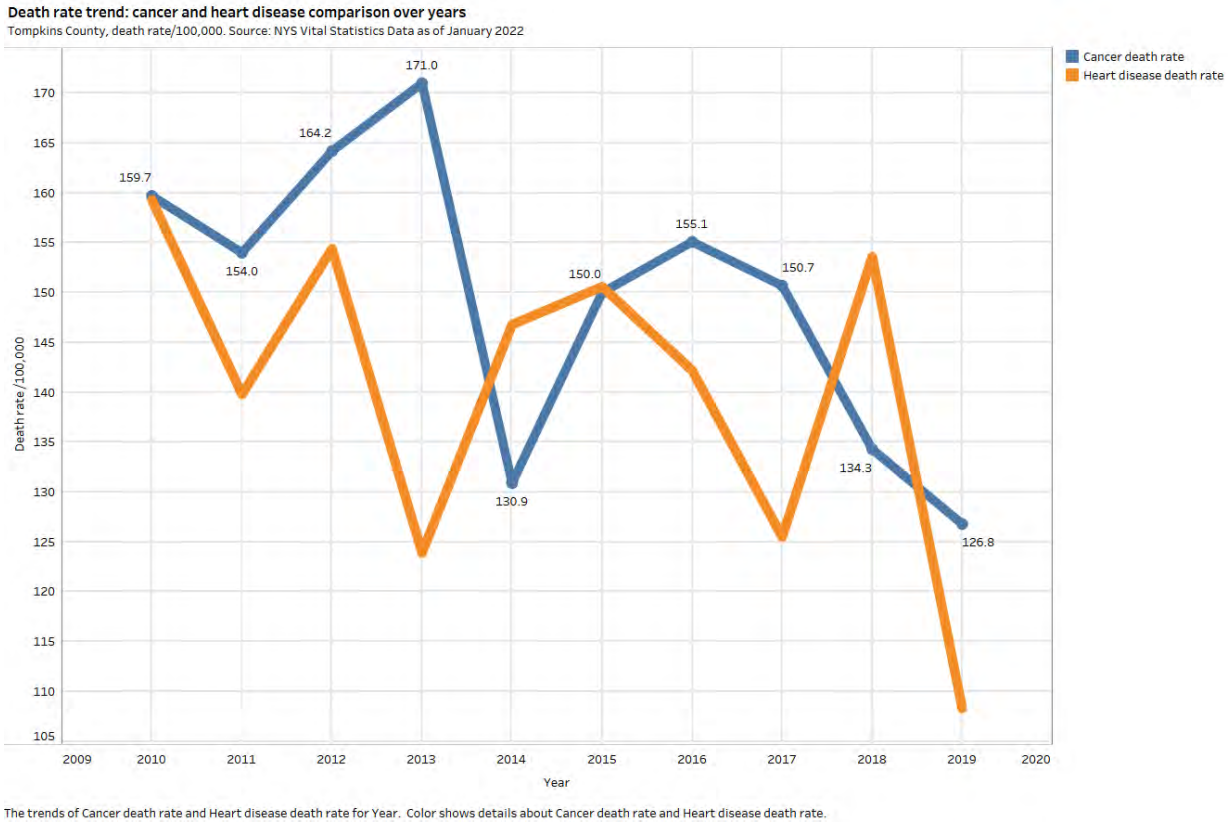

Figure 19

Increasing screening rates is well recognized as a preventive measure for reducing cancer mortality, and is a Prevention Agenda (PA) goal. The PA goal targets breast, cervical, and colorectal cancers.

Among Tompkins adults aged 50-75, 78% were screened for colorectal cancer based on 2018 BRFSS data. In our CHA published in 2019, that rate was 84% based on 2016 data, six points higher. Still, the current Tompkins County rate for colorectal screening is 11 percentage points higher than the current rate for NYS excluding NYC. (Figure 20)

The comparison is flipped for cervical cancer screening where only 68% of Tompkins women aged 21-65 are screened, compared to 86% across the rest of the state. This is seven percentage points lower than the 75%, 2016 data reported in our 2019 CHA.

The most recent rates for breast cancer screening of Tompkins women aged 50-74 is 80%, essentially equal to the ROS rate of 81%. New York State also reports the rate of mammograms among women aged 50-74 who are enrolled in the Medicaid program, up from just 56% previously (2016 data reported in the 2019 CHA). (Figure 21)

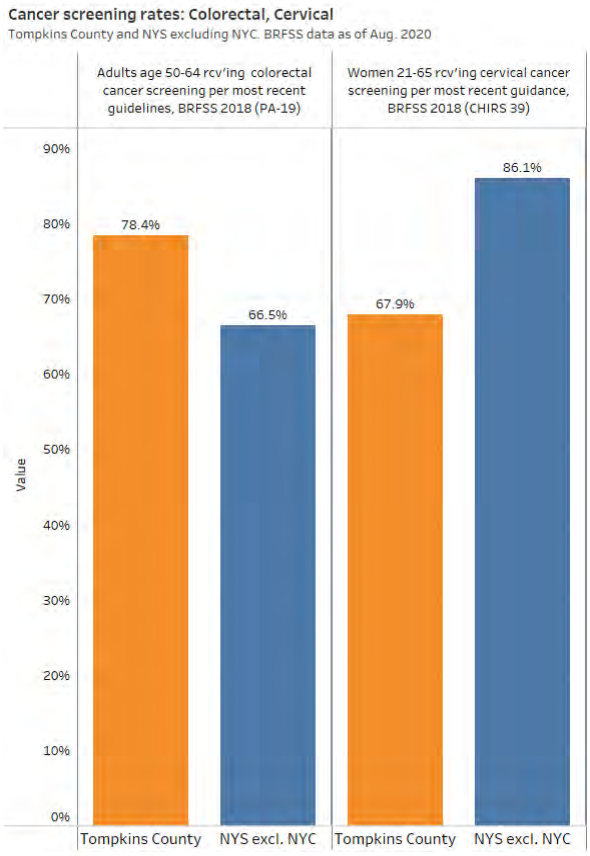

Figure 20

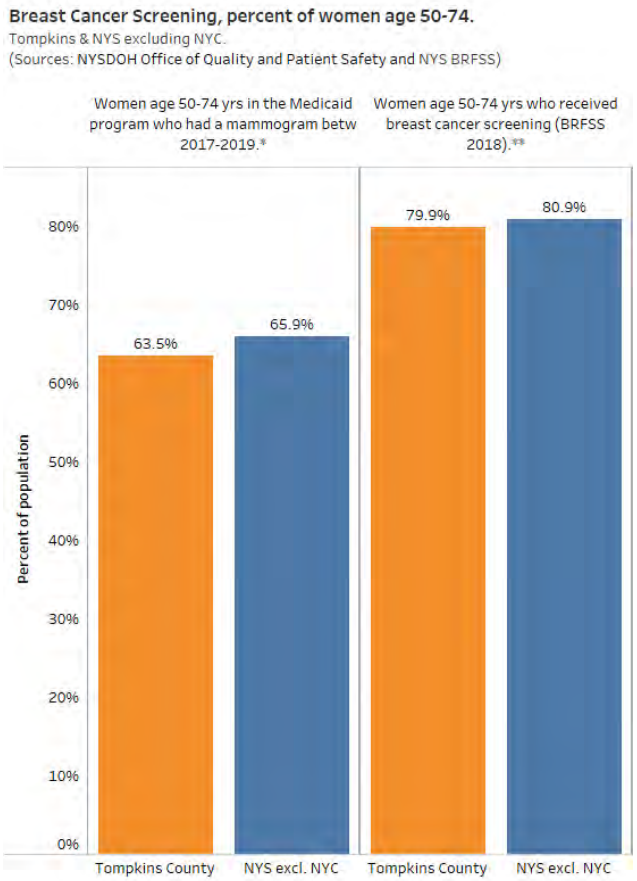

Figure 21

Cardiovascular Disease and Diabetes

The burden of cardiovascular disease, cancer, and diabetes is not distributed evenly. The risks of developing or dying from heart disease, cancer or diabetes are linked to a variety of social determinants of health, such as race, ethnicity, gender, sexual orientation, age, disability, socioeconomic status, and geographic location.

Mortality per 100,000 population, age-adj

	Non-Hispanic				
	White	**Black**	**Asian/ Pacific Is.**	**Hispanic**	**Total**
Total mortality	678.7	837.2	248.3	172.4	661.8
Diseases of the heart	132.6	114.5	23.7*	16.3*	129.2
Cerebrovascular disease (stroke)	30.5	43.6*	23.7*	0.0*	29.6
Coronary heart disease	68.3	59.8*	0.0*	16.3*	66
Congestive heart failure	15.7	18.9*	0.0*	0.0*	14.9
Diabetes	16.4	73.7*	19.7*	0.0*	17.5

* The rate is unstable | Source: CHIRS by Race/Ethnicity, 2017-2019

Table 3

Heart disease is consistently among the leading causes of death in the United States, and diabetes consistently impacts the Black population to a greater degree than the White population. In Tompkins County, heart disease has been first or second cause of death for at least the last decade, and a look at the associated racial disparity is warranted. And as seen elsewhere, the racial gap with diabetes is clearly visible in Tompkins County. A comparison of Tompkins County across race and ethnicity is in Table 3 and Figure 22.

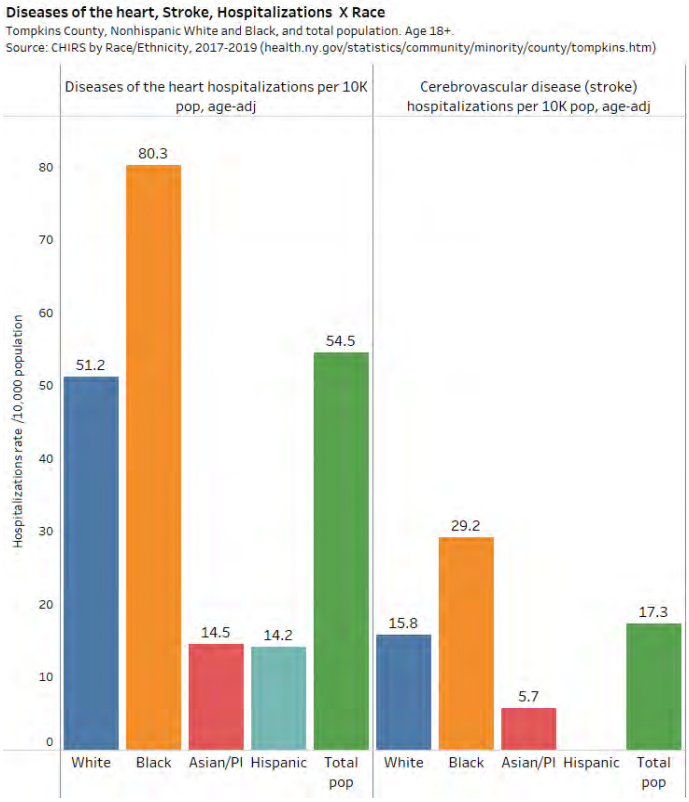

Figure 23

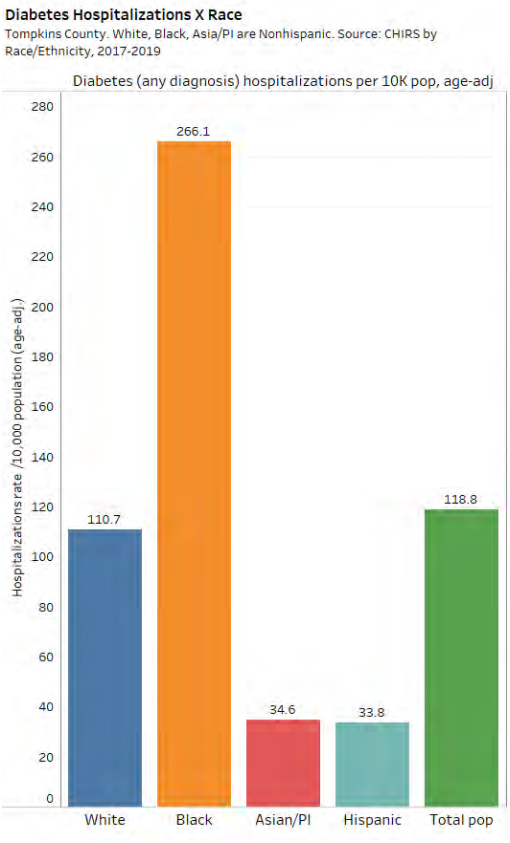

Figure 22

Diabetes

While the rate of hospitalizations for diabetes in Tompkins County is far below that of the rest of the state outside NYC (ROS), the racial gap is equally as striking with more than double the incidence for the Black population as for the White (Figure 23 and Figure 24).

Tompkins County, NYS CHIRS Table, 2017-2019 data

Indicator	Tompkins	ROS
Cardiovascular disease, hospitalization rate/10K (age adj, 2017-2019)	80	122.9
Heart attack hospitalization, rate/10K (age adj, 2017-2019)	8.2	14.6
Diseases of the heart hospitalization rate/10K, (age adj, 2017-2019)	54.5	84
High blood pressure, physician diagnosed, pct. adults BRFSS survey (2016)	26.9 (21.8-32.0)	29.4
Blood cholesterol screening, pct adults (age adj) BRFSS survey (2013-2014)	75.2 (67.3-83.1)	83.2
Diabetes hosipitalization, rate/10K (age adj, 2017-2019)	118.8	195.6
Diabetes, physician diagnosed, pct adults (age adj) BRFSS survey (2018)	7.2 (4.5-9.9)	9.2
Diabetes, Potentially preventable short-term complications hospitalization rate per 10,000, age 18+ years (2017-2019)	3.3	6

Table 4

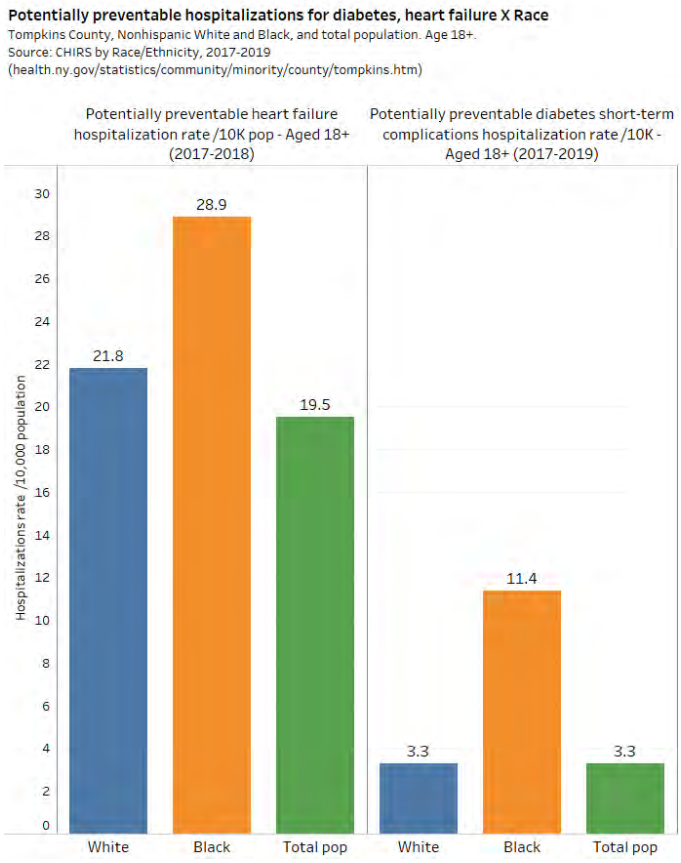

Figure 24

Additional Chronic Disease Prevention Agenda Indicators

While the Prevention Agenda (PA) tracks a total of 70 chronic disease indicators, the previous sections only include those most related to the PA goals selected by the CHA-CHIP Steering Committee.

Following is a selection of chronic disease indicators that are of interest to the community, even though they do not directly relate to the selected goals. Data is primarily pulled from the Prevention Agenda (PA) and Community Health Indicator Reports (CHIRS) datasets from the period 2017-2019 and published by NYS in early 2022. The PA covers 56 indicators and the CHIRS 356 indicators. Both were most recently revised in February 2022. ROS refers to "Rest of State," another way of referring to data for NYS excluding NYC.

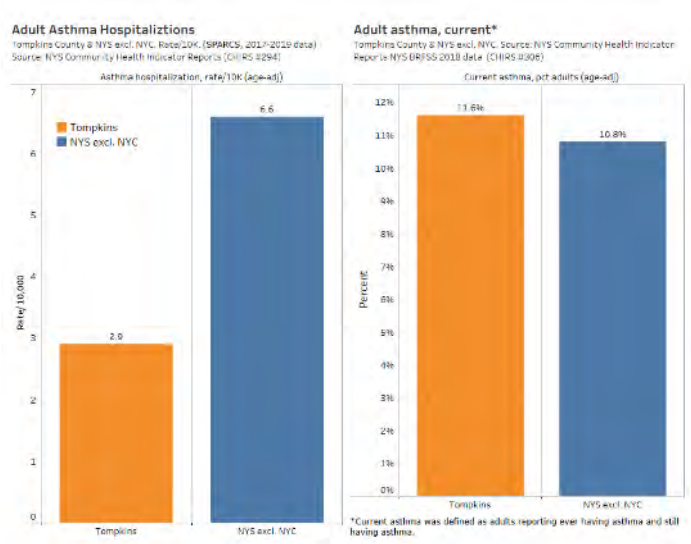

Figure 25

Asthma

The CHIRS includes adult asthma hospitalizations and self-reported current diagnosis, and asthma emergency department visits by children ages 0-17 years by Zip code. Tompkins' rate for adult asthma hospitalizations is less than half that of the ROS, while the two rates for self-reported current asthma are about the same when accounting for margin of error associated with BRFSS data. (Figure 25)

Reviewing child ED visits, the highest prevalence is Newfield residents, and the lowest is Freeville. All are considerably below the NYS rate and PA objective.(Figure 26)

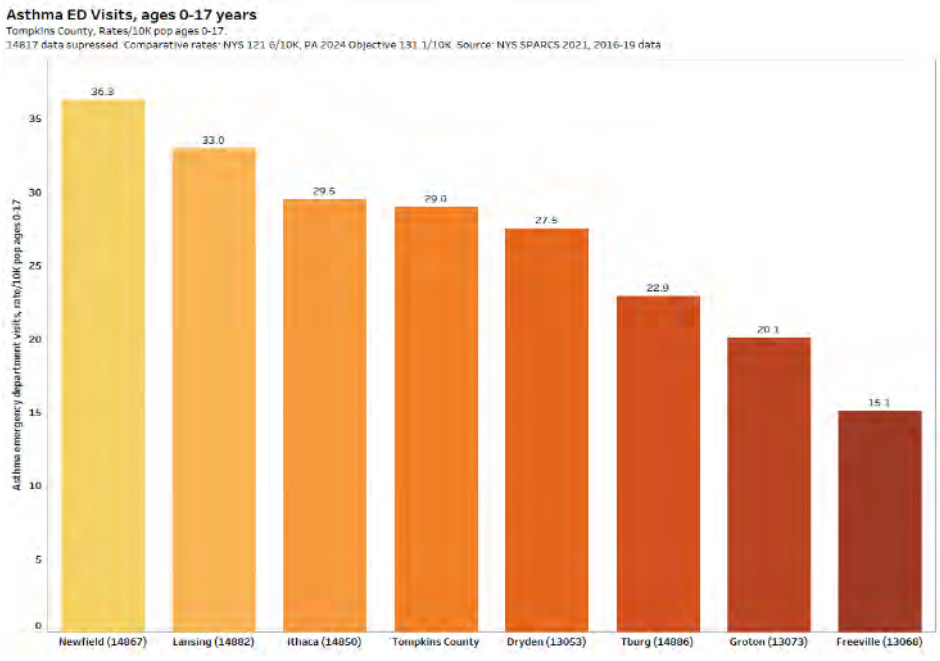

Figure 26

Physical Activity

Leisure time physical activity is generally recognized as an important part of a healthy lifestyle, yet the PA does not include an indicator to track it. The CHIRS includes just one indicator that relates to physical activity: the percentage of adults who participated in leisure time physical activity in the past 30 days. In Tompkins County the rate is 87% of adults, significantly higher than the ROS (78%). These are age-adjusted data from 2018 and are slightly up from the 2016 numbers published in the 2019 CHA (83% and 75% respectively).

The Community Health Survey conducted in July 2022 included the question, "What are the barriers to getting as much physical activity as you would like?" "Time" was the most commonly selected barrier to getting physical activity, with 39% of respondents selecting it from a list of options. Next on the list was "Local weather," which was checked by 32% of respondents. "Physical limitations" was cited by 27%, and 11% picked "It's too much trouble or I'm not interested."

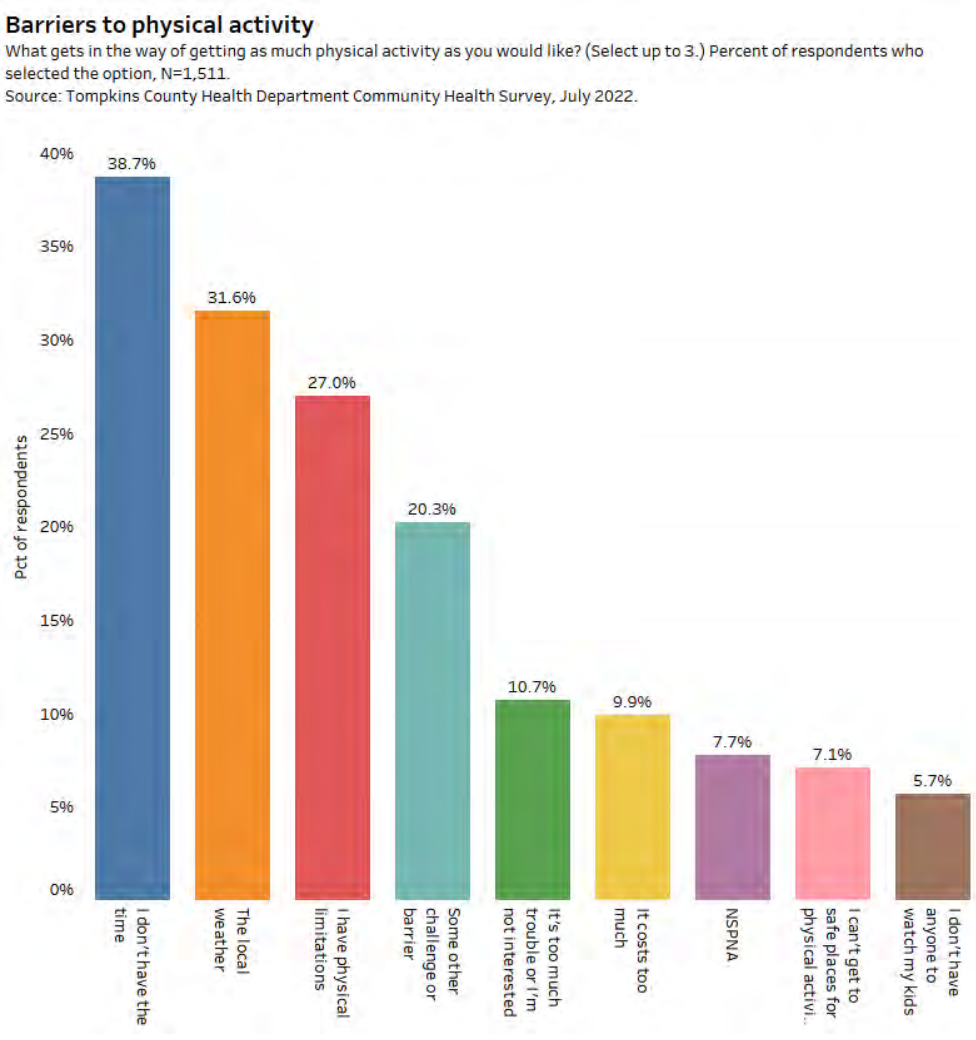

Figure 27

When the Community Health Survey asked respondents to pick "the three most important factors that create a 'healthy community,'" 16% included "Parks and green space" and 11% checked "Easy to walk and bike." These were not dissimilar from the 2019 survey where the percents were 18% and 13%, respectively. (Figure 28)

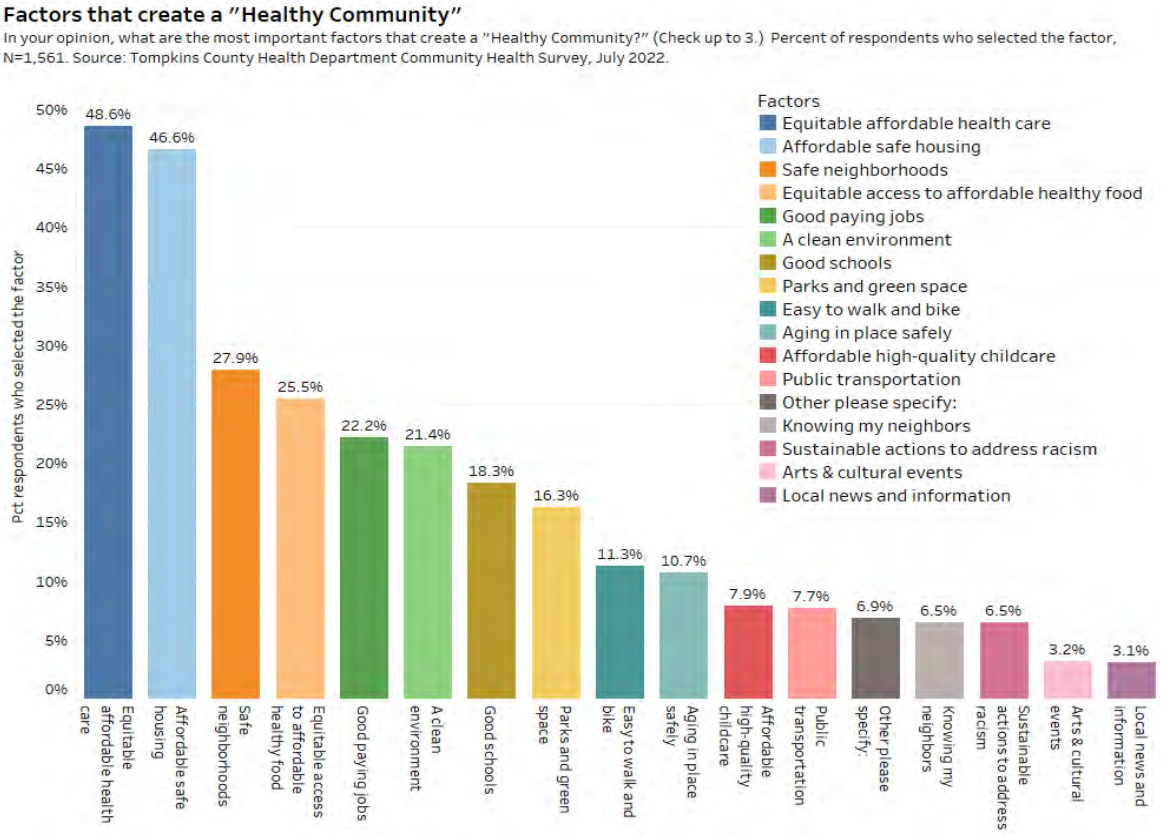

Figure 29

In that same "important factors" question, 28% selected "Safe neighborhoods," the same as in 2019. A separate question in the survey asked respondents to rate their home neighborhood in terms of safety for outdoor activity such as walking, biking, and children playing. Nearly three-quarters checked "Excellent" or "Good" (31% and 42%, respectively). Nineteen percent rated their neighborhood "Fair" for outdoor activity, and 7% rated "Poor." (Figure 29)

Among those with annual household income less than $15,000, 47% gave a Fair rating and 12% Poor. Respondents with an income over $150K were the most likely to rate their neighborhood Excellent (42%). (Figure 30)

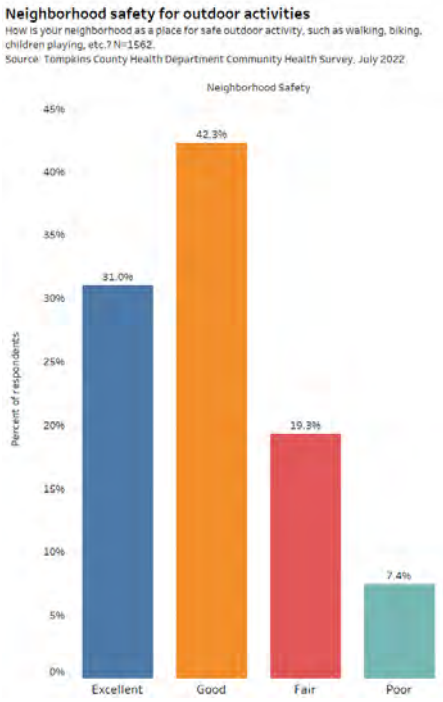

Figure 28

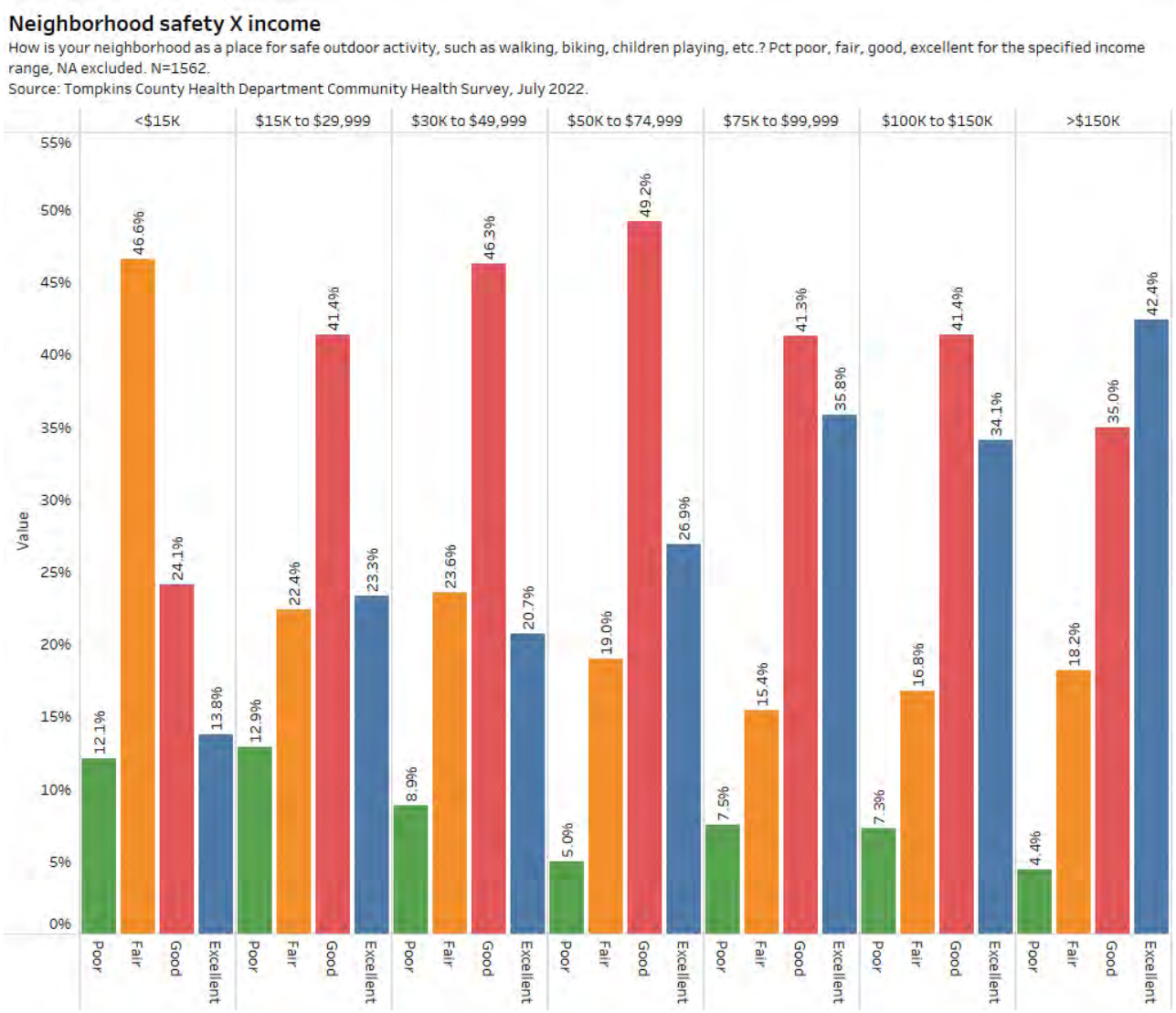

Figure 30

Tobacco Use

At 13%, cigarette smoking among Tompkins County adults is just slightly below the ROS rate of 14%, though still above the Prevention Agenda objective of 11% (these rates are not age-adjusted). Smoking rates among adults with mental illness, those with a lower income or education level, and those with a disability is typically higher than their counterparts, and numbers for Tompkins County follows that pattern; all three are more than or just below double the rate for the general adult population. (Figure 31 and Figure 32)

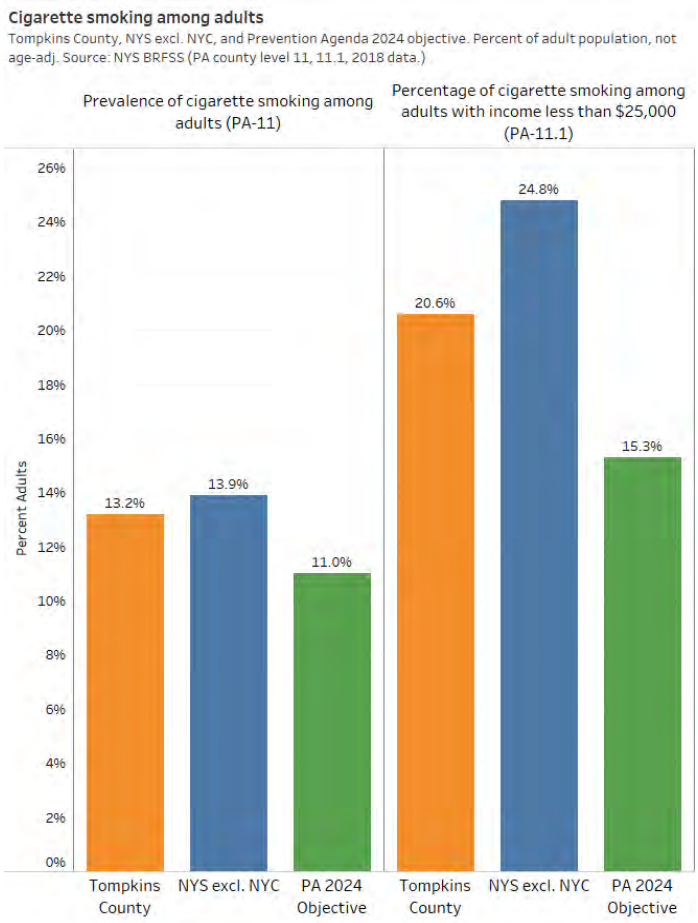

Figure 32

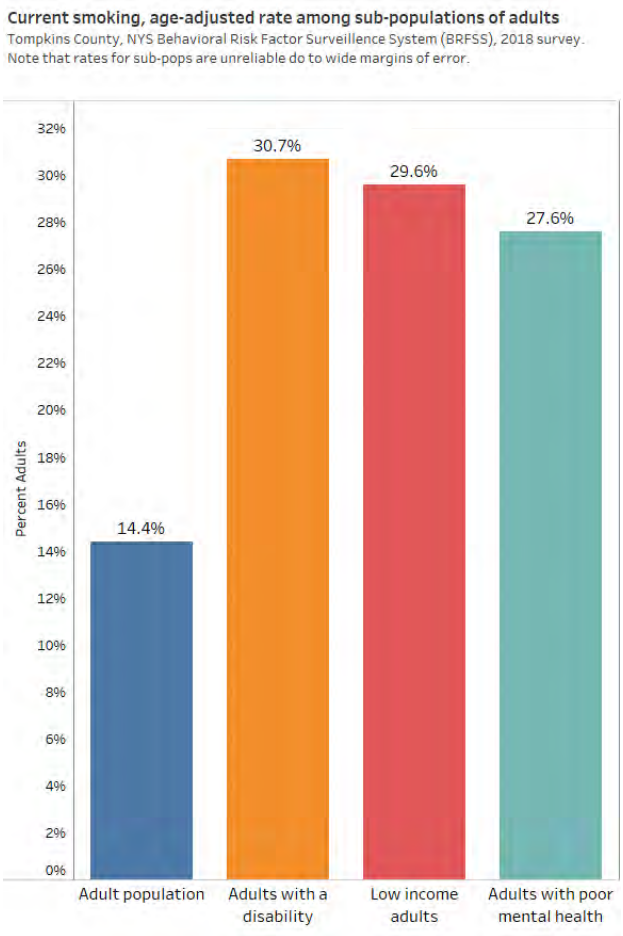

Figure 31

The Community Coalition for Healthy Youth, in partnership with TST-BOCES conducts a bi-annual survey to assess risk and protective factors among students grades 7-12 in all Tompkins County school districts. The most recent survey was conducted in October 2021 using the The Community-Level Youth Development Evaluation (CLYDE) Survey platform. The survey includes questions related to smoking cigarettes and vaping nicotine.

Cigarette use among high school students statewide has been on a steady decline since 2000, until 2018 when it ticked up slightly. In Tompkins County (all districts), average 30-day use of cigarettes (considered, "currently using") across grades 7-12, was 3.3%. However, a review of each grade shows 30-day use among 12th graders at 7.9%, a steep increase from 2.7% for 10th graders, and 4.4% for students in grade 11. (Figure 33)

Lifetime use of cigarettes ("even just one puff") across all grades and Tompkins County districts is 8.7%. Looking at lifetime use by grade the graph shows a stepwise increase from 2.1% of seventh graders to 17.3% of high school seniors.

Youth use of electronic cigarettes (e-cigs) and other vaping devices has skyrocketed over the past 5 years, nationally and statewide. In Tompkins County, 2018 was the first year that a question about vaping was asked on the biennial student survey, administered to all students in grades 7 to 12 in all school districts. In that survey, administered in October 2018, one-in eight students were currently using e-cigs (16% across all grades and all districts). In each of 10th and 11th grades current use was 20%, and among 12th graders, 26%.

The new numbers are much improved. According to the October 2021 survey the 30-day (current) vape use across all grades is 9.1%, a 44% decline from 2018. Current use among students in grade 10 is 11%, 11th grade 15%, and seniors 19%. Lifetime use is 15% for all grades, and 16%, 24%, and 30% for grades 10, 11, and 12. (Figure 34)

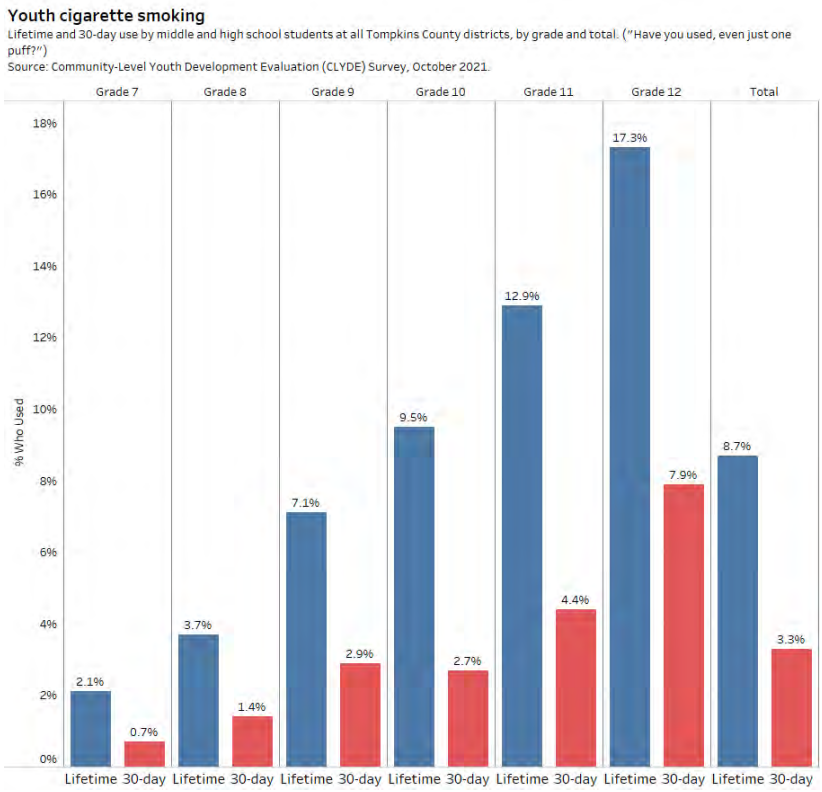

Figure 33

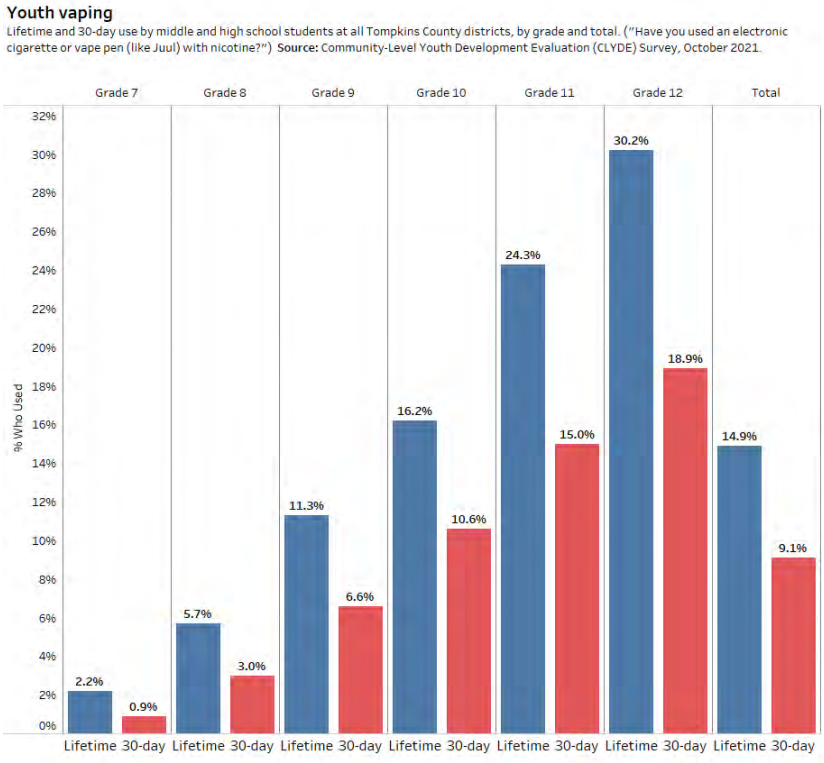

Figure 34

PREVENTION AGENDA PRIORITY: PROMOTE HEALTHY WOMEN, INFANTS, AND CHILDREN

Focus Area 2: Perinatal and Infant Health

Goal 2.1: Reduce infant mortality & morbidity

Perinatal refers to the period immediately before and after birth. These early weeks are an important period for addressing the health of both mothers and infants. Key perinatal and infant outcomes such as preterm birth (<37 weeks gestation), low birth weight (< 2.5 kg), and infant mortality (the death of an infant before age 1) are inseparably linked to maternal health outcomes. Babies born too early (especially before 32 weeks) have higher rates of death and disability, including breathing problems, feeding difficulties, cerebral palsy, developmental delay, vision problems and hearing problems. The short and long-term challenges associated with preterm births may also take an emotional toll and be a financial burden for families.

In NYS's report: *Chronic Disease, Contributing Causes of Health Challenges*, a life course approach is referenced to recognize that early experiences and exposures during critical periods of development may "program" a person's future health and development, including reproductive health. These experiences may include the accumulation of ACES and toxic stress over one's life course. The report notes that persistent disparities in maternal and infant heath are in part due to chronic, toxic stress related to "pervasive and systemic racism in the US."

While Tompkins County's overall preterm birth rate in 2018 (7.6%) met NYS' Maternal & Child Health objective (8.3%), differences in preterm birth rates by race are alarming. Between 2017-2019, the rate of preterm birth among Black women (18.1%) was about 250 percent higher than the rate of preterm birth among white women (7.0%).

Focus Area 4: Cross Cutting Healthy Women, Infants, & Children

Goal 4.1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health.

While Tompkins County is consistently in the top ten of healthiest counties, racial, economic, and geographic disparities are evident, and efforts to build health equity among all county residents must be in the foundation of health assessment and improvement.

A prenatal data profile by ZIP code — premature birth, low birth weight (LBW), late or no prenatal care, out of wedlock births, Medicaid or self-pay, and teen pregnancy rate —

shows differences across Zip Codes, primarily for the difference between premature births and low birth-weight births (LBW).

For example, the rate for premature births and the rate for LBWs are relatively close for Ithaca-Danby-Enfield, and Lansing when compared with the spread between the two in the other Zip Codes. For example, the rates are the same in Lansing, and less than 1.0 percentage point apart for the others cited. By comparison, in Trumansburg the difference is 4.5 percentage points, 3.5 in Newfield, 2.2 in Dryden, and 5.1 in Brooktondale. For the County as a whole, there is a 1.5 percentage point difference between premature births and LBWs. In all cases the premature births rate is the higher of the two, except Lansing where they are the same. (Figure 35)

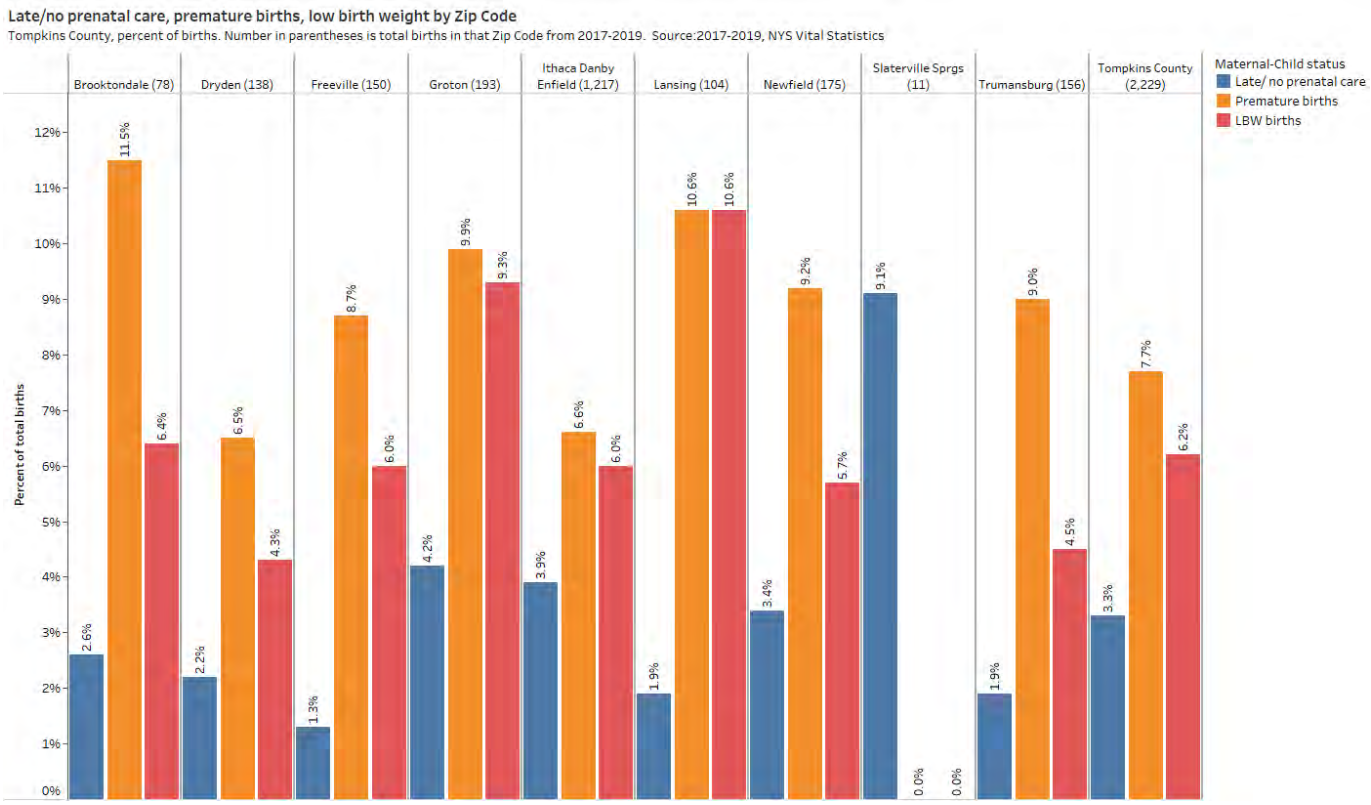

Figure 35

That said, Lansing has the highest rate for both indicators at 10.6% of births, with the exception of Brooktondale where 11.5% of births are premature and 6.4% of LBWs. (Note that Brooktondale and Lansing have the second and third lowest number of births of all Zip Codes with 78 and 104 total births respectively. Dryden has the fourth lowest with 138 total births for the 3-year period from 2017-2019.) Variation across Zip codes is also evident for Medicaid or self-pay, unmarried parent, and teen pregnancy, with the latter perhaps being the most dramatic. (Figure 36)

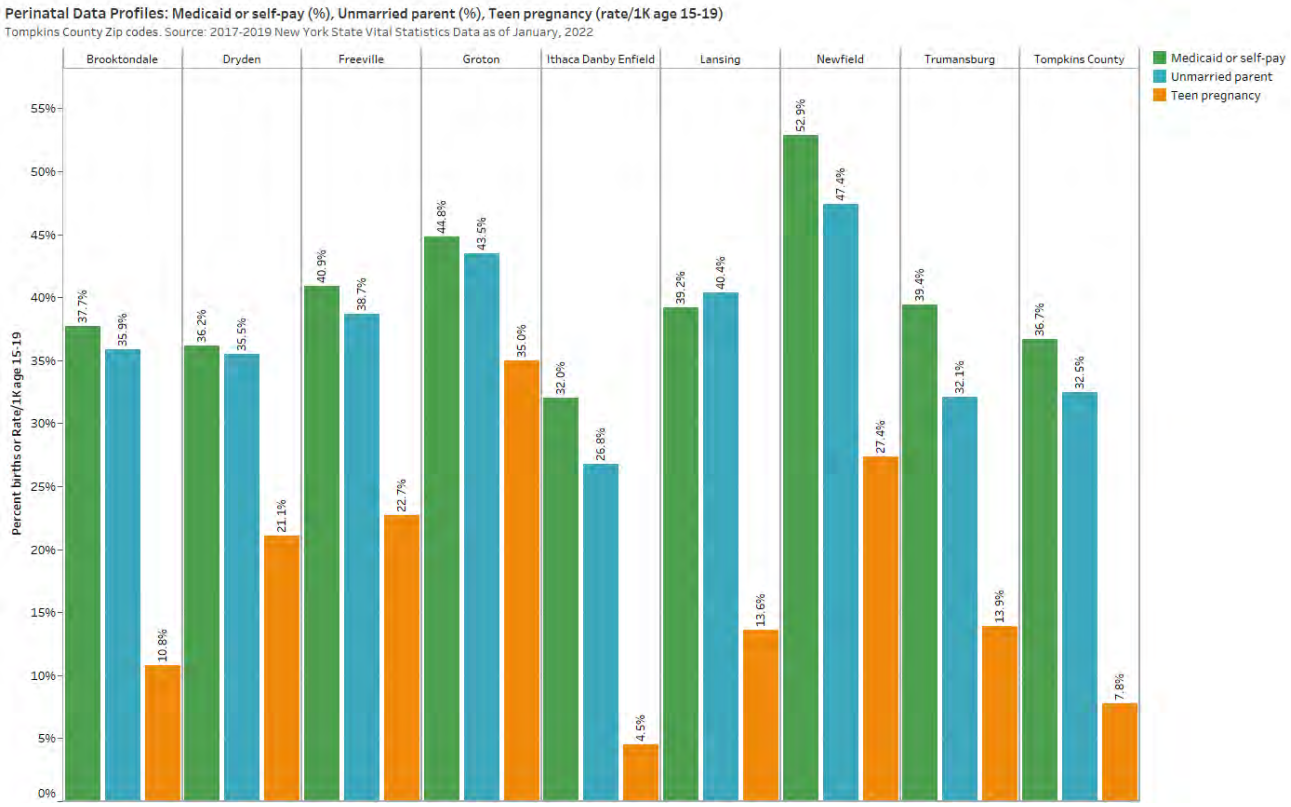

Figure 36

Inequity in prenatal care is also present by race in Tompkins County, and it appears to be widening. NYS Vital Statistics Tompkins County birth data for the rate of births with early prenatal care in 2017 was 81% for White mothers, compared to 69% for Black mothers. Moving up to 2019, the gap increased to where early prenatal care among Blacks was 28% lower than for Whites, 85% of White births and 61% of Black births.

The rate of births with late or no prenatal care was more than five times higher for Blacks in 2019 that for whites (11% and 2%) a striking increase from rates in 2017 (6% and 3%) and 2018 (3% and 2%). The rate for mothers who identify as ethnically Hispanic show a similar jump over the 3-year period of 2017, 2018, and 2019 (5%, 5%, and 10%). (Figure 37)

The average number of births per year from 2017-2019 was White 543, Black 31, Asia/PI 76, and Hispanic 52.

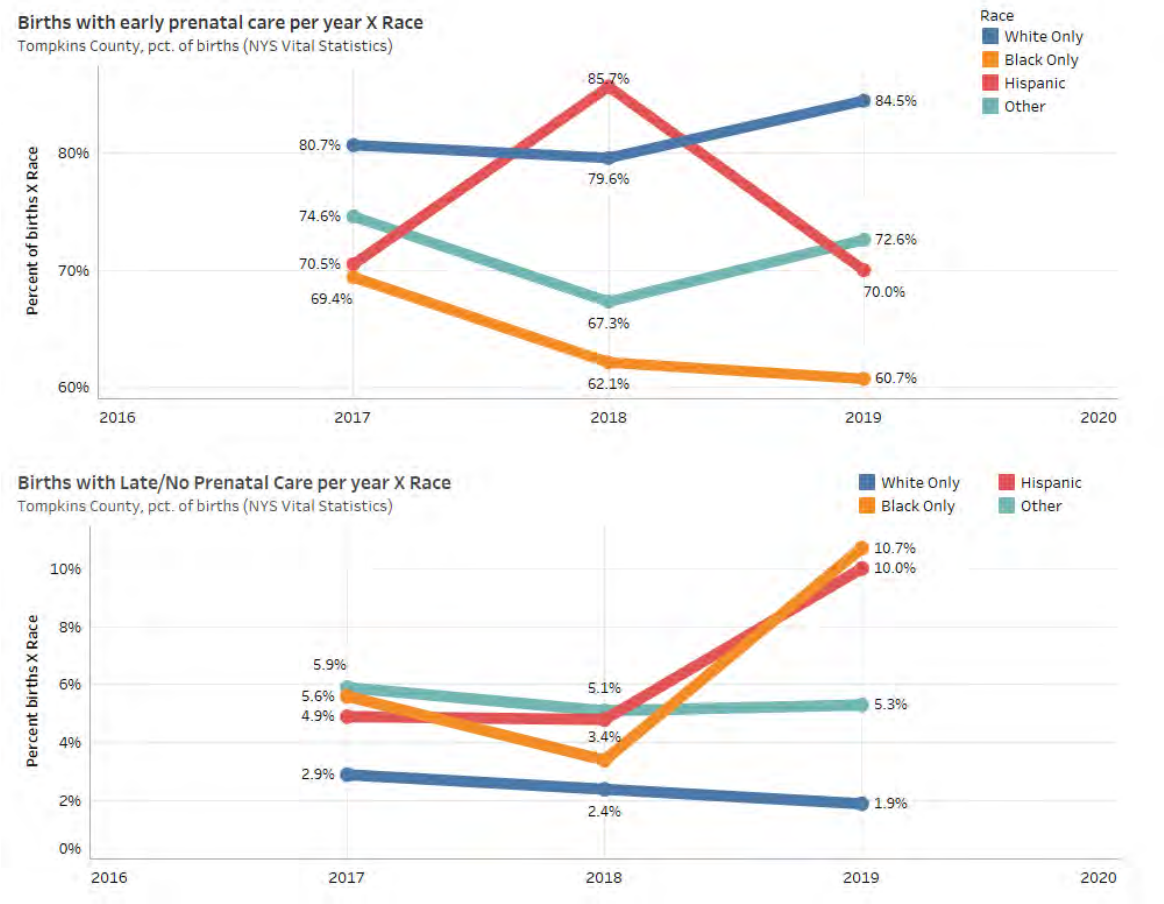

Figure 37

Additional Women, Infants, and Children Prevention Agenda Indicators

Child and Adolescent Health

Assigning a qualitative indicator to assess social and emotional development is a difficult task. This is especially true for children and adolescents, where real time social and emotional inputs are a constantly moving target influencing future outcomes.

The New York State Council on Children and Families publishes the Kids' Well-being Indicators Clearinghouse (KWIC), "to advance the use of children's health, education, and well-being indicators as a tool for policy development, planning, and accountability." KWIC indicators are organized by seven "Life Areas," including economic security, family, community, and behavioral health.

The Tompkins County Youth Services Department's Community Action Plan and Achieving Youth Results (AYR), references KWIC indicators in all Life Areas. Their reporting should also be consulted at tompkinscountyny.gov/youth.

Much of the KWIC data used in this report is from 2020, accessed at nyskwic.org in July 2022. KWIC data is presented for a "Baseline" rate and a "Current" rate. The baseline for 2020 (current) data is from 2015, unless otherwise noted.

In Tompkins County, 12.4% of children age birth to 17 live below the poverty level, down from 16.8% reported for the 2015 baseline. Statewide that number is 16.7% of children. Among Tompkins children aged 0-17, 2.4% receive public assistance, down from a 3.9% baseline. NYS is 5.3%.

KWIC education indicators look at academic performance; percent of students scoring at or above proficiency in third and fourth grade English Language Arts (ELA), and eighth grade math. While less than half (47.2%, 2018-19 data) of Tompkins third graders meet the mark for ELA, it is an improvement from the 2015-16 baseline of 43.7%. The current statewide rate is 52.3%. For math, 20.4% of eighth graders meet the learning standard, essentially unchanged from the baseline of 19.6%. The current NYS rate is 33.2%.

The 2019/20 high school graduation rate for Tompkins County students is 83.5%, down slightly from the baseline, 85.2%. High school dropout rates are 5.8% current, 5.5% baseline.

Child abuse/maltreatment and foster care admission indicators are reported in the "Family" life area as a rate per 1,000 (/1K) children age birth to 17 years. In Tompkins County, the 2020 rate for Children/Youth in Indicated Reports of Abuse/Maltreatment was 12.5 /1K, down from the rate of 15.3 /1K youth in 2015. The Tompkins rate for children aged 0-21 in foster care has dropped from 3.8/1K in 2014 to 2.1/1K in 2020. Foster care admissions in the population age birth to 21 were 0.8/1K per 2020 data, down from 1.8 in 2015.

Early Postpartum Care

Breastfeeding is an important part of early postpartum care, and Tompkins County has a track record for a high rate of infants being breastfed. While there are a number of indicators for the prevalence of breastfeeding, the Prevention Agenda (PA) refers to just one, percentage of infants exclusively breastfed in the hospital. In Tompkins County the current number (2019 data) is 77%, a marked increase from 72% in 2017. Elsewhere in the state, the 2019 rate for the Southern Tier Region is 71%, for NYS ex. NYC 50%. Tompkins County's rate is well above the Prevention Agenda 2024 objective of 52%.

Data by race and ethnicity for the 2019 data are suppressed for Tompkins County to protect confidentiality.

Number of well child visits in govt sponsored insurance pgms	Tompkins County	NYS excl. NYC
Children with recommended # , pct, 2019 data (CHIRS 103)	75.4%	73.9%
Children (aged 0-15 months) with recommended #, pct, 2019 data (CHIRS 104)	91.7%	84.5%
Children (aged 3-6 years) with recommended #, pct, 2019 data (CHIRS 105)	85.9%	84.6%
Children (aged 12-21 years) with recommended #, pct, 2019 data (CHIRS 106)	68.1%	67.5%

Table 5

Well child visits can be a valuable indicator of preventive care, and the PA includes the "percentage of children who have had the recommended number of well child visits in government sponsored insurance programs." Tompkins County and NYS excluding NYC (ROS) show roughly the same level of participation, with 75.4% and 73.9% of children, respectively. Looking at specific age cohorts, the similarity of Tompkins County and ROS rates continues for ages 3-6 years and 12-21 years. The exception is with children ages 0-15 months where the Tompkins County rate is 7 percentage points higher than the ROS rate, 91.7% and 84.5%, respectively. (Table 5)

In Tompkins County, 94.8% of adults age 18-64, and 97.3% of children under age 19 had health insurance. These numbers are close to the numbers for NYS as a whole. (Table 6)

Health Insurance, 2019 data	Tompkins County	NYS
Adults aged 18-64 with health insurance, pct., 2019 (CHIRS 322)	94.8%	92.5%
Children aged <19 years with health insurance, pct., 2019 (CHIRS 321)	97.3%	97.7%

Table 6

PREVENTION AGENDA PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Focus Area 1: Promote Well-Being

Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan.
Goal 1.2: Facilitate supportive environments that promote respect and dignity for people of all ages.

Focus Area 1 of the Prevention Agenda's mental health priority is "Promote Well-Being." The term "Well-Being." is defined by the NYSDOH this way:

> "Well-being is a relative and dynamic state where one maximizes his or her physical, mental, and social functioning in the context of supportive environments to live a full, satisfying, and productive life. Well-being is based on the relationship between social determinants of health and person's experiences with quality of life." [Prevention Agenda 2019-2024, ver. 1.6, 9/2/2021, p.210]

As with indicators that track eating and activity behaviors, most of the few widely used mental health indicators are self-reported. The most widely used tool is the Behavioral Risk Factor Surveillance System (BRFSS), a 104-question RDD telephone survey that is regularly conducted at the statewide, NYC, and ROS levels. The Expanded BRFSS provides data at the county level, but due to smaller sample size it lacks the demographic detail of the wider surveys. In Tompkins County's 2018 survey the highest number of respondents among all the questions was 516. As such, the margins of error can be high and small differences when comparing one survey to another (e.g., 2016 and 2018) are likely not statistically significant.

Well-being is, by the definition above, directly related to social determinants of health. Interventions suggested in the PA for building well-being include supporting housing improvement, creating and sustaining healthy public spaces, and establishing caring and trusted social relationships. In its Local Services Plan (LSP) for 2023, Tompkins County has put forward Housing and Non-Clinical Supports as two of five 2023 Goals. The latter states, "Recognize the importance of social determinants of health, health equity and peer supports." The objectives of the LSP include:

- Become familiar with the barriers to healthcare access including dental and optical care for Medicaid recipients receiving developmental disabilities services.
- Identify gaps in community supports for mental hygiene recipients.
- Collect benchmark data on health equity to improve access to quality services for minoritized communities.
- Identify strategies to improve health equity across Tompkins County.

- Support greater awareness and utilization of peer support services in the community
- Improve data integrity/collection related to opioid overdose deaths to guide prevention efforts
- Support implementation efforts of the Action Plan approved by the Collaborative Solutions Network, the System of Care (SOC) for children's services in Tompkins County, to improve access to care through program expansion and improved communication/coordination of service offerings.
- Establish next steps to promote greater understanding of the impact Adverse Childhood Experiences (ACES) and the importance of early intervention strategies to build resiliency in youth and families.

COVID-19

During and after the COVID-19 pandemic, its impact on individual's mental and emotional health was and continues to be widely discussed. In our Community Health Survey conducted in July 2022, we asked two multiple response questions related to the pandemic: Rate what your life is like now compared to before the pandemic for 15 items, and what are you most concerned about moving forward?

The former included two items more directly related to well-being: What is your life now compared to your life before the COVID-19 pandemic *for feelings of isolation (feeling alone)*? The rating options were Got worse, Stayed the same, Got better, Does not apply. Broken out by age, the younger cohorts were more likely to rate the change as worse.

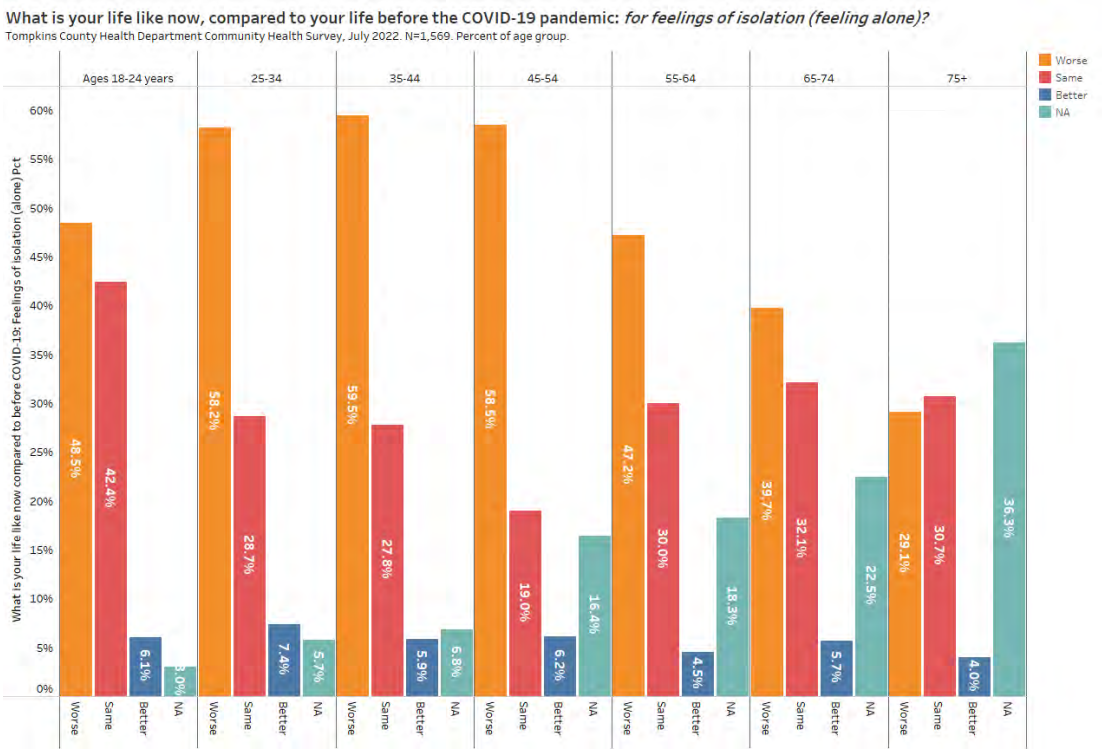

Figure 38

Only a fraction of respondents rated their feeling of isolation after the pandemic as better than before. (Figure 38)

For “What is your life like now… *for your mental health*” the pattern of younger cohorts giving a lower rating carried over, though not quite as dramatically, with ages 55 up more likely to say their mental health stayed the same. (Figure 39)

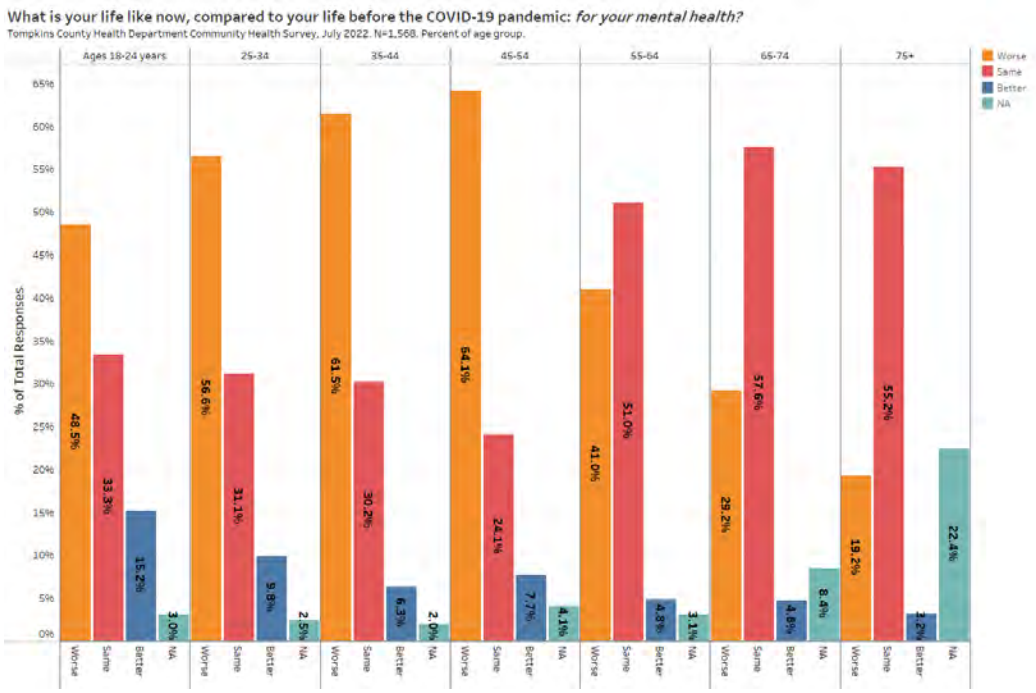

Figure 39

Focus Area 2: Prevent Mental and Substance Use Disorders

Goal 2.2: Prevent opioid overdose deaths.
Goal 2.3: Prevent and address adverse childhood experiences.
Goal 2.4: Reduce the prevalence of major depressive disorders
Goal 2.5: Prevent suicides.

Opioids

New York State carefully tracks opoid use through a number of indicators, which are all compiled in an Opoid Data Dashboard. Tompkins County data for a set of nine "overview" indicators shows that adverse events associated with opioid use held steady --- no significant change in the numbers --- over the last few years for overdose deaths, emergency department visits and hospital discharges. However, two indicators have registered significant changes: admissions to OASAS-certified treatment programs have significantly decreased, and the rate of unique Naloxone EMS administrations per 1,000 911 EMS dispatches has significantly increased. (Table 7)

Unique naloxone administrations by EMS agencies, crude rate per 1,000 unique 911 EMS dispatches

Data Year(s)	Tompkins County	NYS exc. NYC	NYS
2016	6.2	5.7	5.1
2017	7	5.6	5.3
2018	5.4	4.5	4.4
2019	4.8	4	3.9
2020	7.7	5.4	5.6

Data Source: NYS EMS Data as of November 2021

Table 7

Subcounty data mapped by Zip Code for the Naloxone indicator shows a stretch of the population in the fourth quartile in a pool of all counties outside of NYC. This statistic means that the administration rate in these Zip Codes is in the highest 25% of the entire ROS population (14886, 14850, 14853, and 14817). (Figure 40)

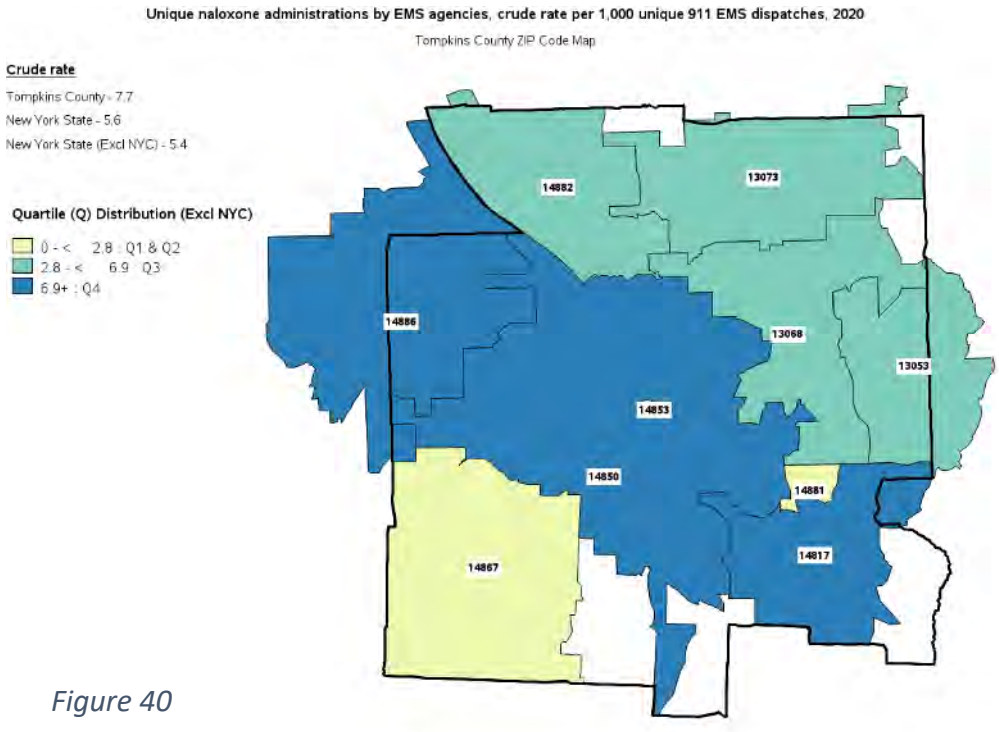

Figure 40

All calls that come into Tompkins County's 9-1-1 center at the Tompkins County Department of Emergency Management are coded based on the type of the emergency. The code (called a Nature Code) informs the dispatcher on whether to assign the emergency to police, fire, or EMS.

When the 9-1-1 dispatcher receives a call for medical assistance, they will ask the caller certain key questions to ascertain if the cause might be drug induced based on protocols established by the department's emergency medical dispatch program. Sometimes the cause is known by the caller, and other times the dispatcher makes the coding decision based on answers to their questions and other circumstances, and years of experience.

Whole Health is monitoring the montly numbers for calls coded as "Overdose/ Poisoning" and posting them on its website. Of note in the graph below is the sudden drop in April 2020 from 24 to 12, the persistent number from May to November 2021 of 39 to 41, and the peak number in September 2022 of 57. (Figure 41)

Patients who received at least one buprenorphine prescription for opioid use disorder, rate per 100,000 pop. (age-adj)

Data Year(s)	Tompkins County	NYS exc. NYC
2015	266.1	442.1
2016	289	477.6
2017	426.1	520.6
2018	639	569.6
2019	749.7	620.1
2020	736.3	638.7

Data Source: NYS PMP Data as of June 2021

Table 8

Benzodiazepine prescription, rate per 1,000 population (age-adj)

Data Year(s)	Tompkins County	NYS exc. NYC
2015	277.6	296.3
2016	273.1	302.4
2017	268.6	294.6
2018	272.6	285.3
2019	274.3	278.9
2020	268.7	282

Source: NYS PMP Data as of June 2021

Table 9

Opioid analgesics prescription, rate per 1,000 population (age-adj)

Data Year(s)	Tompkins County	NYS exc. NYC
2015	595.7	541.6
2016	550.1	510.5
2017	507.3	466.4
2018	444.5	412.3
2019	418.1	377.3
2020	378.6	342.6

Source: NYS PMP Data as of June 2021

Table 10

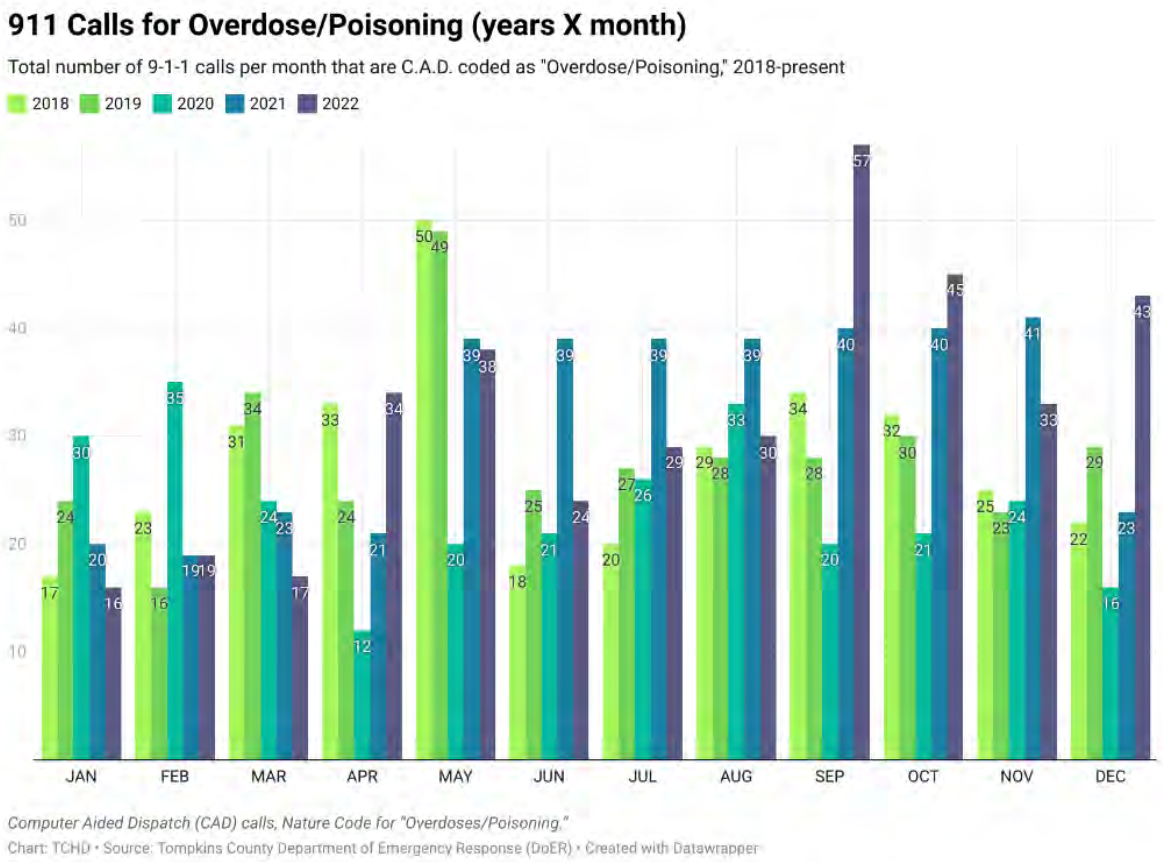

Figure 41

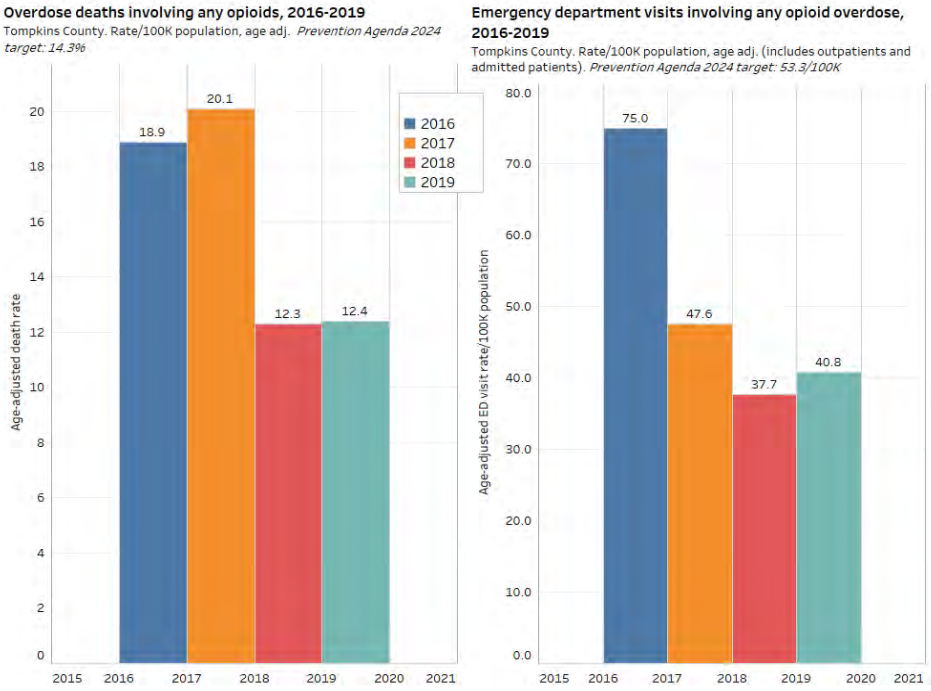

Figure 42

Adverse Childhood Experiences (ACES)

Ever increasing research demonstrates that Adverse Childhood Experiences (ACEs) are widely common and impact lifelong health and opportunities. As the CDC describes, ACEs are potentially traumatic events that occur in childhood. ACEs can include violence, abuse, and growing up in a family with mental health or substance use problems. Toxic stress from ACEs can change brain development and affect how the body responds to stress. ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood. However, ACEs can be prevented. National estimates indicate that at least 61% of adults had at least one ACE and 16% had 4 or more types of ACEs. Preventing ACEs can help children and adults thrive and potentially lower the risk of chronic physical and mental health conditions, improve education and employment outcomes, and prevent the intergenerational transmission of ACEs. Strategies can increase awareness, change how people think about ACEs, and help us understand how we can prevent ACEs and better support people with ACEs. By shifting the focus from individual responsibility to community solutions, we can reduce stigma and promote safe, stable, nurturing relationships and environments where children live, learn, and play.

Major Depressive Disorders

There are two mental health questions in the BRFSS; one about depressive disorder and the other about poor mental health days. Looking at the data across the two most recent surveys, 2016 and 2018, there has been a jump in the rate of adults who report having ever been told by a health care professional they have a depressive disorder from 15% to 21%, while the rate for adults reporting poor mental health for 14 or more days in the last month was steady with 12% in 2016 and 13% in 2018. (Figure 43)

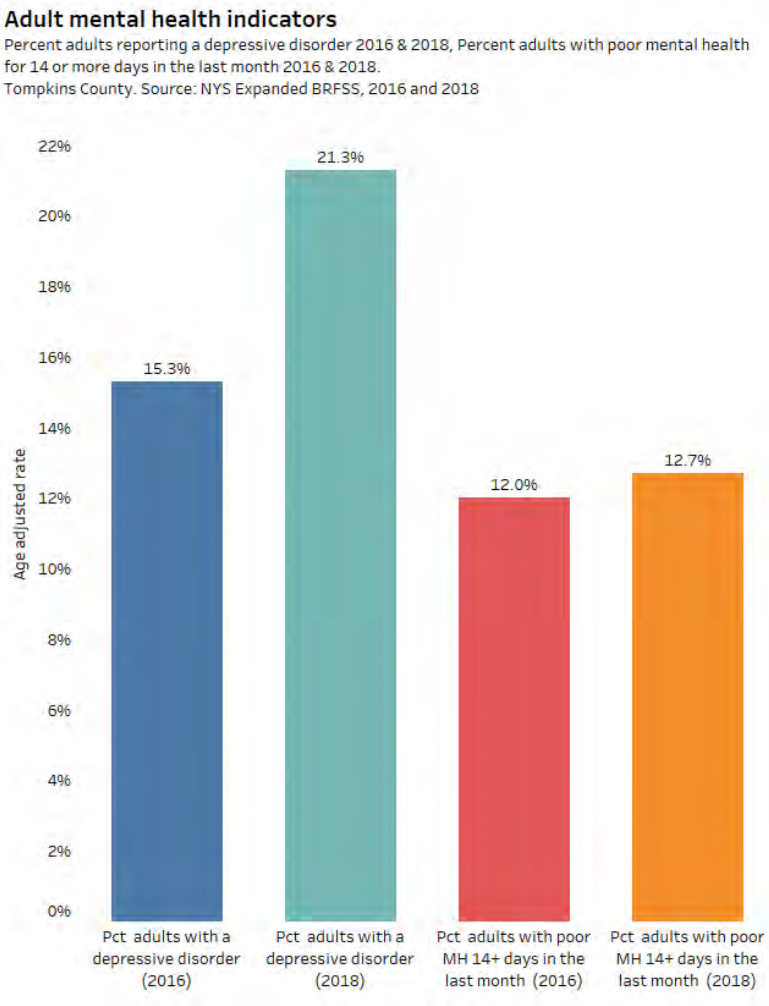

Figure 43

Suicide

The most widely used hard data indicator for a population's mental health status is suicide mortality rate per 100,000 residents. Looking at age-adjusted rates for the total population, in Tompkins County the average annual suicide mortality rate for the 3-year period 2017-2019 is 12.4 per 100,000, up from 8.9/100K in the 2014-2016 period. Across the rest of the state excluding NYC (ROS) the 2017-19 average rate is 9.9/100K, up just slightly from 9.6/100K, ROS average for 2014-16. (Figure 44)

Hospitalizations for self-inflicted injuries are also shown in the graph. For this indicator, rates for Tompkins County and the ROS are equal with 4.6 hospitalizations per 10,000 each (2017-2019 average, age-adjusted).

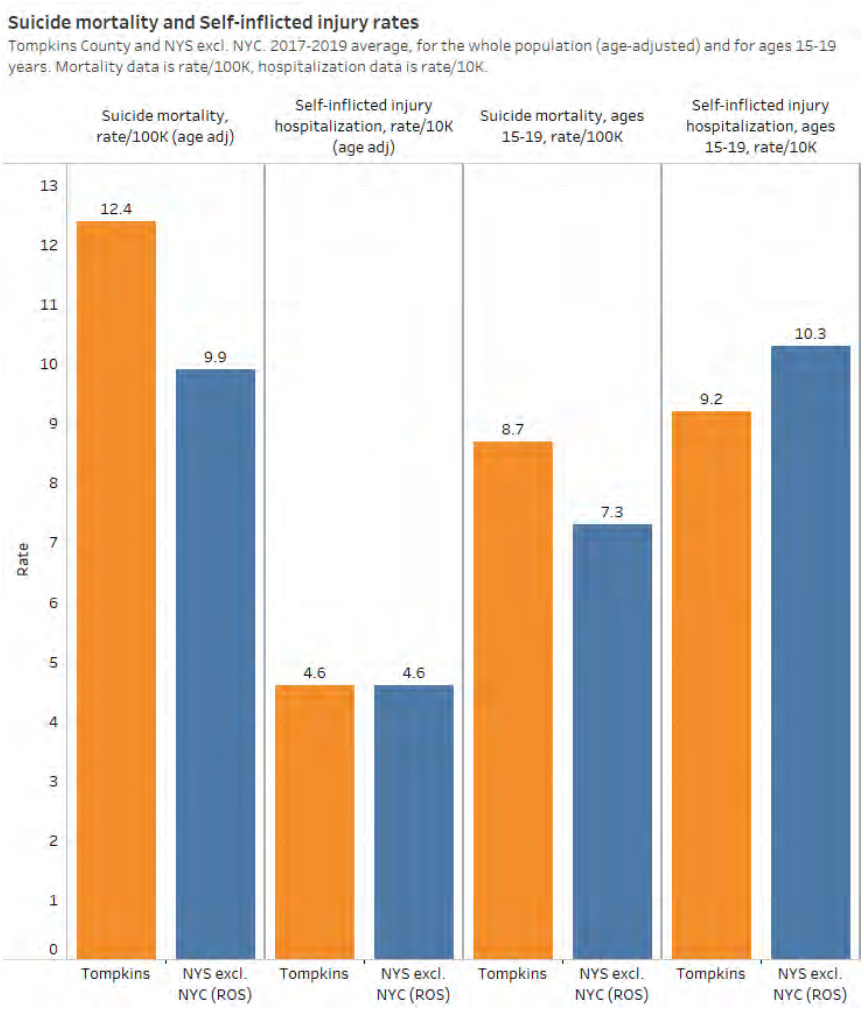

Figure 44

Ages 15-19 years

Similar to the whole population, suicide mortality rates among ages 15-19 years are higher for Tompkins County than for the rest of the state excluding NYC, though the gap is not as wide: 8.7 suicide deaths per 100,000 for Tompkins County teens, and 7.3/100K for the ROS (2017-2019 average). On the other hand, in this age group hospitalization rates for self-inflicted injuries are lower in Tompkins County than for the ROS, 9.2/10K compared to 10.3/10K. (Figure 43)

Finally, an indicator not in the Prevention Agenda, but still noteworthy, is a measure of youth grades 7 to 12 who report feeling depressed. The Community Coalition for Healthy Youth, in partnership with TST-BOCES conducts a bi-annual survey to assess risk and protective factors among students grades 7-12 in all Tompkins County school districts. The survey scheduled for the Fall 2020 was postponed due to COVID-19 and conducted in October 2021. Relevant to risk factors and the well-being and mental disorders priority here, the survey includes the following question: "In the past year have you felt depressed

or sad MOST days, even if you feel OK sometimes." Response options are, "NO, no, yes, or YES." In the 2021 survey, 41.4% of all students surveyed answered "yes or YES, I have felt depressed or sad…" This rate was 36% in the 2018 survey. (Table 11)

The 2021 Community-Level Youth Development Evaluation (CLYDE) Survey dashboard for Tompkins County can be accessed here: clyde.catalyst-insight.com/public/dashboard/tompkins_ny

In the past year, have you felt depressed or sad MOST days, even if you felt okay sometimes? Percent of respondents, all Tompkins County School Districts, Oct. 2021

	Grade 7	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12	Total
NO!	33.7	29.7	31.9	24.9	19.5	20.2	26.8
no	30.2	33.5	32.2	28.7	34.8	31.8	31.8
yes	25.7	21.9	19.8	28.9	23.8	30.1	24.9
YES!	10.4	14.9	16.1	17.6	21.9	17.9	16.5

Source: 2021 Community-Level Youth Development Evaluation (CLYDE) Survey

Table 11

PREVENTION AGENDA PRIORITY: PREVENT COMMUNICABLE DISEASE

Focus Area 3: Sexually Transmitted Infections

Total annual cases of sexually transmitted infections (STI) reported in Tompkins County have continued to rise in recent years. The Gonorrhea case rate per 100,000 (/100K) males age 15-44 increased 34% from 213.8 in 2017 to 285.9 in 2019. The rate in 2019 (285.9/100K) is comparable to the case rate for NYS exclusive of NYC of 287.4/100K. Among Tompkins County females in 2019, the Gonorrhea rate is a more modest 131.7/100K, significantly less than the NYS excl. NYC rate, 226.5/100K. (Figure 45)

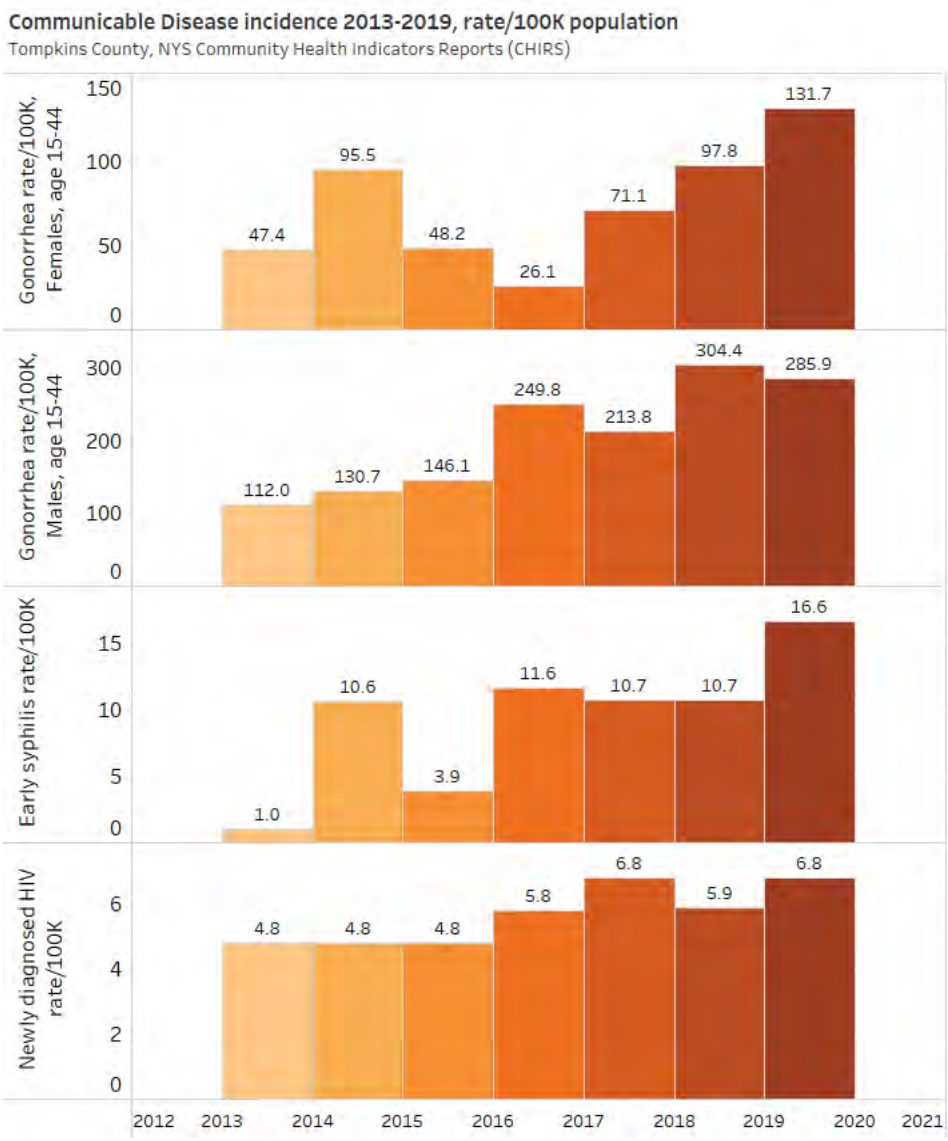

Figure 45

Chlamydia cases continue to rise in Tompkins County. Although Chlamydia cases are higher in females than males, the case rate in 2019 for males age15-44 rose 49% from 2017. Chlamydia cases in Tompkins County female residents age 15-44 rose from 980.2/100K cases in 2017 to 1019.6/100K cases 2019. The ratio of cases in females to cases in males in 2019 was 1.2:1 in Tompkins and 1.9:1 in NYS excl. NYC.

The NYS Bureau of Sexual Health and Epidemiology reports Syphilis cases at three stages: Primary & Secondary, Early Latent, and Late & Late Latent. The indicator reported in the CHIRS is for early syphilis cases as a rate per 100,000. Early Syphilis case rates continue to rise in Tompkins County, from 10.7/100K in 2017 to 16.6/100K in 2019. For comparison, Tompkins County has slightly higher rates that the rest of the state: 2017-2019 data shows the rate in Tompkins is 12.7/100K, and NYS excl. NYC is 11.7/100K. (Figure 46)

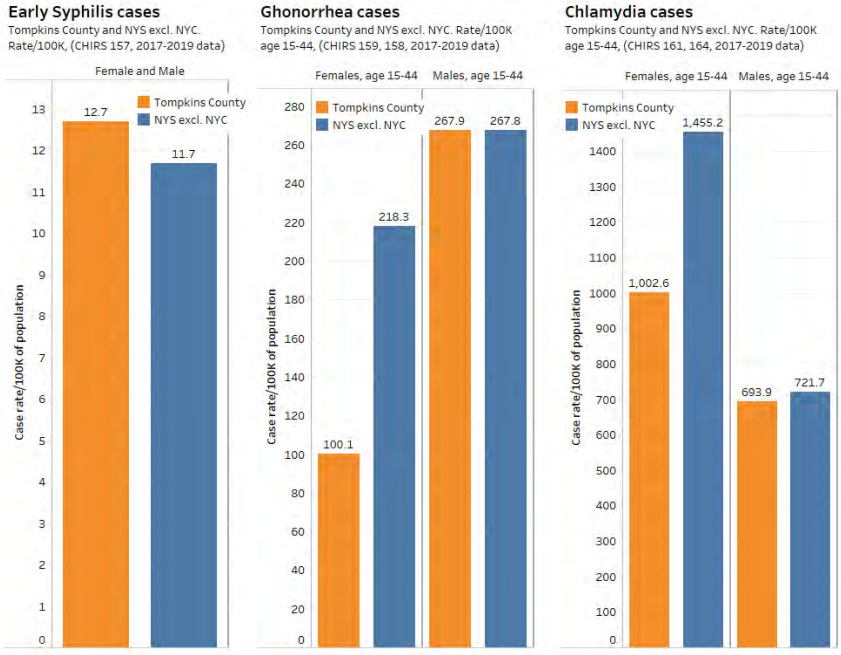

Figure 46

Additional Communicable Disease Prevention Agenda Indicators

While vaccination rates are an important part of the Prevention Agenda priority addressing communicable disease, the indicators lean heavily to incidence of sexually transmitted infections, of which only HIV was not included with the Goal, above. Historically, HIV rates have been among the most tightly held personal health information. Even now, as its protected status is more on par with other STIs, rates in relatively small populations such as Tompkins County are often labeled "unstable" due to the low number of incidents. That said, the "Newly diagnosed HIV case rate" for Tompkins is 6.8/100K in 2019. For comparison, NYS excl. NYC is 5.5/100K.

The PA reports two immunization/vaccine indicators, one for children 24-35 months and one for adolescents. During 2020, in Tompkins, 81.4% of children age 24-35 months have received the 4:3:1:3:3:1:4 immunization series, notably higher than NYS 66.1%, and above the Prevention Agenda 2024 objective of 70.5%. (Table 12)

Children and adolescent vaccinations

	Tompkins County	ROS	PA 2024 Objective
Children age 24-35mo with 4:3:1:3:3:1:4 immunization series	81.4%	66.3%	70.5%
Adolescents with a complete HPV vaccine series, age 13+, pct	39.7%	32.80%	37.4%

Source: NYS Prevention Agenda #51-52, 2020 data as of Feb 2022

Table 12

Adolescents age 13 are followed by whether they receive a complete series of HPV vaccine, and here the comparison rates in are more closely aligned. During 2020, in Tompkins, 39.7% of adolescents age 13 with a complete HPV vaccine series and the NYS 39.8%. The state PA 2024 objective is 37.4%. (Table 12)

COVID-19 Pandemic

COVID-19, the disease caused by SARS-CoV-2, has impacted Tompkins County, though often not as deeply on a per capita basis as in other NYS counties. The first positive test in a resident of Tompkins County came on March 13, 2020. This number has continued to rise since then at varying rates. As of December 1, 2022, there have been a total of 25,394 positive cases in Tompkins County residents. Tompkins County reported 71 county resident deaths caused by COVID-19 of as of 12/1/2022, based on death certificates filed with Vital Records. With access to death certificates statewide, the NYSDOH reported 97 deaths of Tompkins County residents. Counties only file death certificates for county residents whose death occurs in county, or if they are informed by an out-of-county entity. (Figure 47)

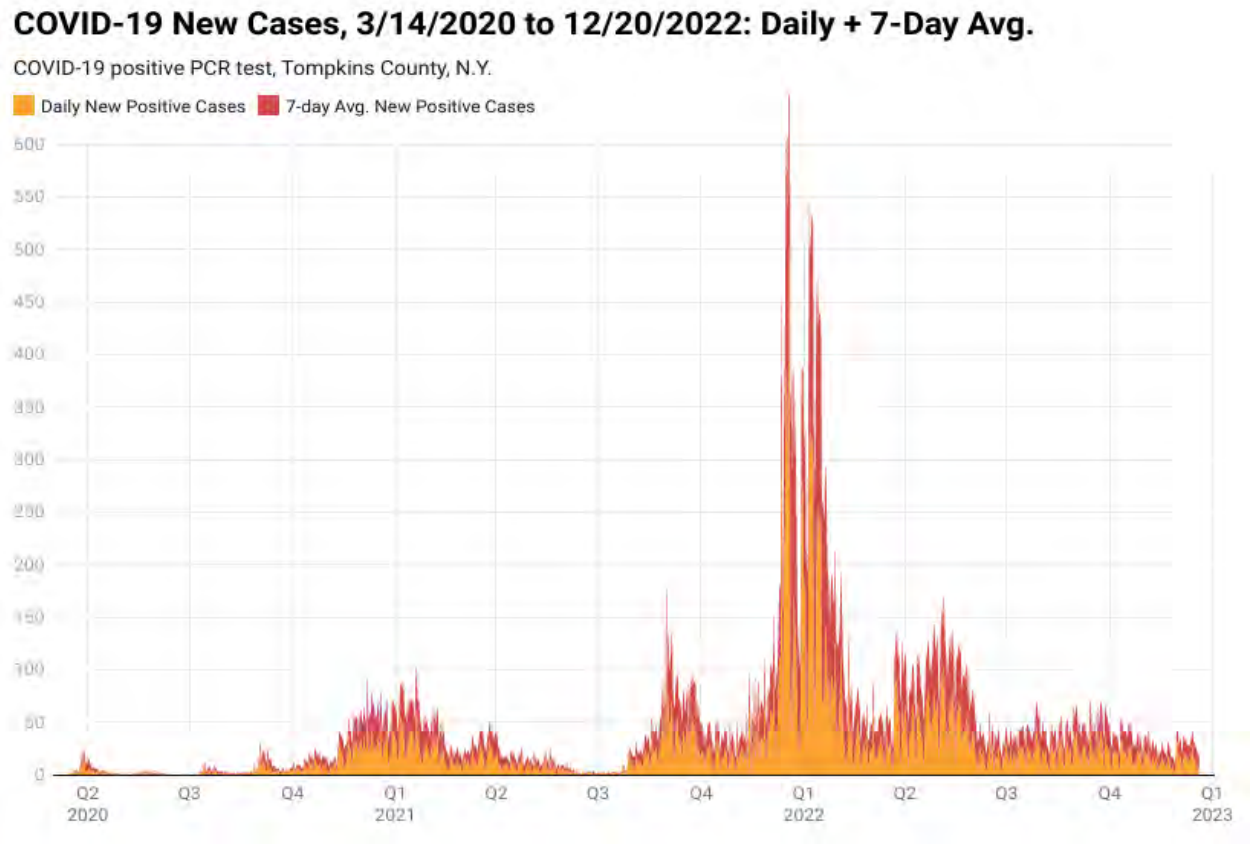

Figure 47

PREVENTION AGENDA PRIORITY: PROMOTE A HEALTHY AND SAFE ENVIRONMENT

Focus Area 1: Injuries, Violence and Occupational Health

Falls are the number one reason for ambulance calls in Tompkins County. The Prevention Agenda (PA) indicator for these occurrences is the rate of hospitalizations for injury due to falls per 10,000 (/10K) adults age 65 and over. In Tompkins County, the 2019 rate was 221.6/10K individuals age 65+. This is an increase from the 2017 of 164.7/10K. The 2019 rate is higher than the NYS rate of 193.9/10K and the PA 2024 goal of 173.7/10K. (Figure 48)

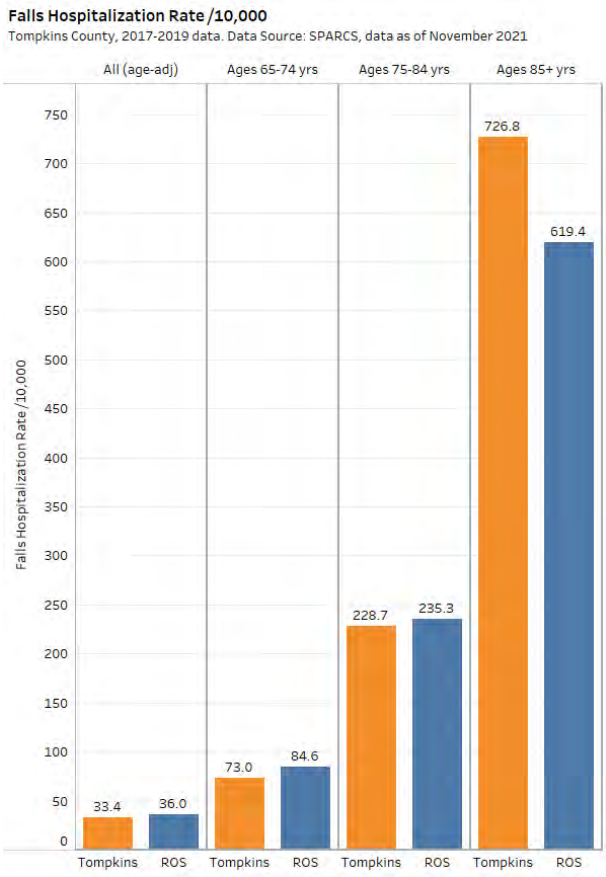

Figure 48

Reducing the number of assault-related hospitalizations is a factor contributing to a healthy and safe environment and is provided in the PA as a rate per 10,000 residents. The 2019 rate for Tompkins County, 0.6/10K -- the numerator for the calculation is 6 -- is marked "unstable because there are fewer than 10 events in the numerator. The PA also lists the ratio of rates between Black non-Hispanics and White non-Hispanics, between Hispanics and White non-Hispanics, and between low-income ZIP Codes and non-low-income ZIP Codes. The values for all of these indicators is marked "Supressed" because the data do not meet reporting criteria.

The Healthy Neighborhoods Program (HNP) is a grant-funded service offered by local health departments across New York State. In it, household residents may request a free assessment of the indoor environment in order to identify situations that trigger asthma (such as air pollutants or harsh cleaning chemicals), hazards that may cause falls, and the presence of working smoke alarms, carbon monoxide detectors, and fire extinguishers.

HEALTHY NEIGHBORHOODS PROGRAM
Tompkins County Health Department · (607) 274-6688

Figure 49

Focus Area 4: Water Quality

Currently, the Prevention Agenda includes just one indicator for water quality: the percent of residents served by community water systems with optimally fluoridated water, which

in Tompkins County is zero. However, one of 12 Principles in the Tompkins County Comprehensive Plan (2015) is that "Tompkins County should be a place where water resources are clean, safe, and protected." Furthermore, the five-year review of the 2015 Plan includes new action items to be initiated by 2023, including to "Establish a detailed countywide Harmful Algal Blooms (HABs) strategy." In April 2021, Tompkins County released a draft Harmful Algal Bloom Strategy. [Tompkins County Comprehensive Plan 2015: Five-Year Review, 11/7/2019 and Tompkins County Harmful Algal Bloom Strategy, draft 4/19/2021.]

Additional Environmental Prevention Agenda Indicators

Traffic crashes involving pedestrians and bicycles is an ongoing concern in Tompkins County and across the state. The Ithaca-Tompkins County Transportation Council (ITCTC) publishes a Vehicular Crash Summary Report, which includes comprehensive data on pedestrian and bicycle crashes, and is available on the Tompkins County website (link at the end of this section). (Figure 50)

In 2018, there were 50 crashes involving pedestrians. This is a 63% increase from the average of the prior 3 years (2015-2017 average is 30.7). Of the 50 crashes in 2018, 10 resulted in a serious injury and 1 resulted in a fatality. 84% of the 50 pedestrian crashes occurred in the City of Ithaca. In 2020, the City of Ithaca received a grant of $590,000 through Pedestrian Safety Action Plan (PSAP) project to provide safety improvements at local intersections. These improvements include installing new, accessible push button pedestrian signals, new pedestrian crossings, enhanced crosswalk striping, installation of a refuge island, and installing/replacing curb ramps. [PSAP Project]

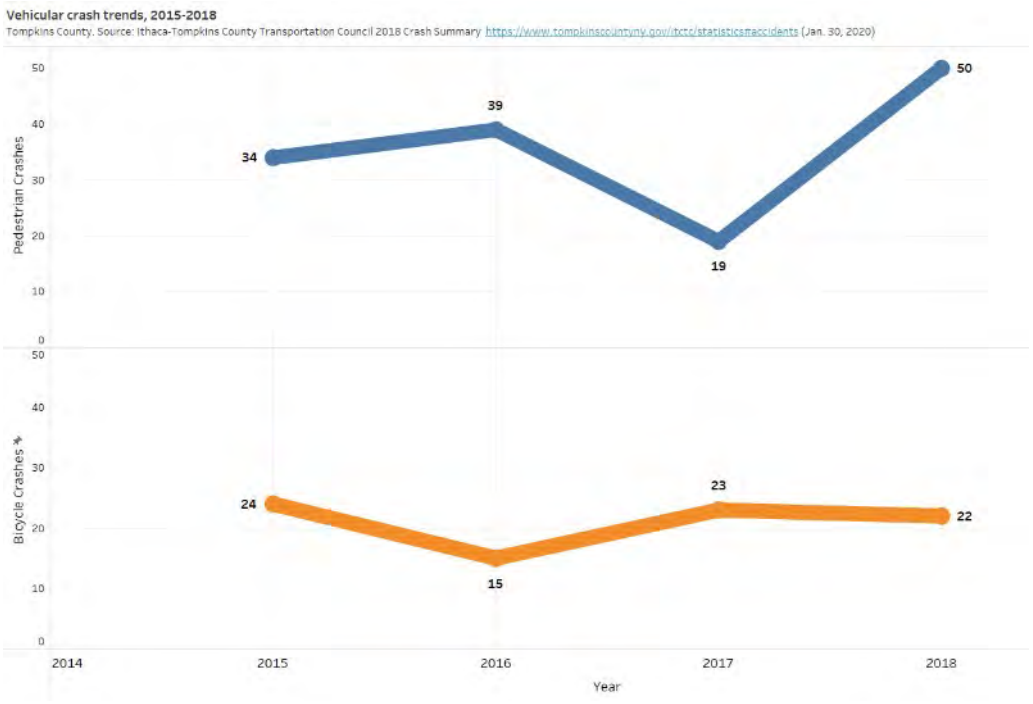

Figure 50

During the same year, 2018, there were 22 traffic crashes involving bicyclists in Tompkins County, a 6.5% increase over the 2015-2017 average of 20.7. Three of the 2018 bicycle incidents resulted in a serious injury or fatality. Just over one-quarter (27%) of 2018 crashes involving bicyclists occurred when the vehicle was making a left turn, one of which resulted in a bicyclist fatality. Pedestrian and bicycle data are from the ITCTC Crash Summary Report released in January 2020.

EQUITY AND DISPARITIES

Achieving greater levels of health equity and reducing health disparities is a cornerstone of community health improvement. One of the ways NYSDOH tracks racial disparities is by comparing indicator rates for the Black non-Hispanic population with those for the White non-Hispanic population, and of Hispanic to White non-Hispanic populations. The Prevention Agenda (PA) reports these disparities for premature deaths and for preventable hospitalizations, among others cited elsewhere in this report.

In Tompkins County, premature death (death before age 75, 2017-2019) within the Black non-Hispanic population is 51% higher than it is within the White non-Hispanic population, and for Hispanics nearly twice as prevalent (94%) compared to White non-Hispanics. (Figure 50)

Looking at premature death across all NYS (excl. NYC) sorted by quartile, four Tompkins County towns are in the fourth quartile, meaning their premature death rate is in the highest 25% compared with the ROS (in this presentation defined as <65 years, 2016-2019). These are Enfield, Newfield, Caroline, and Dryden. Ulysses, Ithaca, Danby, and Groton are in the combined first and second quartiles, meaning the lower half (below the median) of all across the ROS. (Figure 52)

The difference in the rate of potentially preventable hospitalizations between Black non-Hispanic adults and White non-Hispanic adults has been on an upward trajectory in Tompkins County, from a low of 10 per 10,000 in 2016 to 104/10K in 2019 (age-adjusted rates). The 2019 ROS rate difference was 128.4/10K, and the Southern Tier Region was 174.5/10K. The PA 2024 objective is 94/10K. (Figure 53)

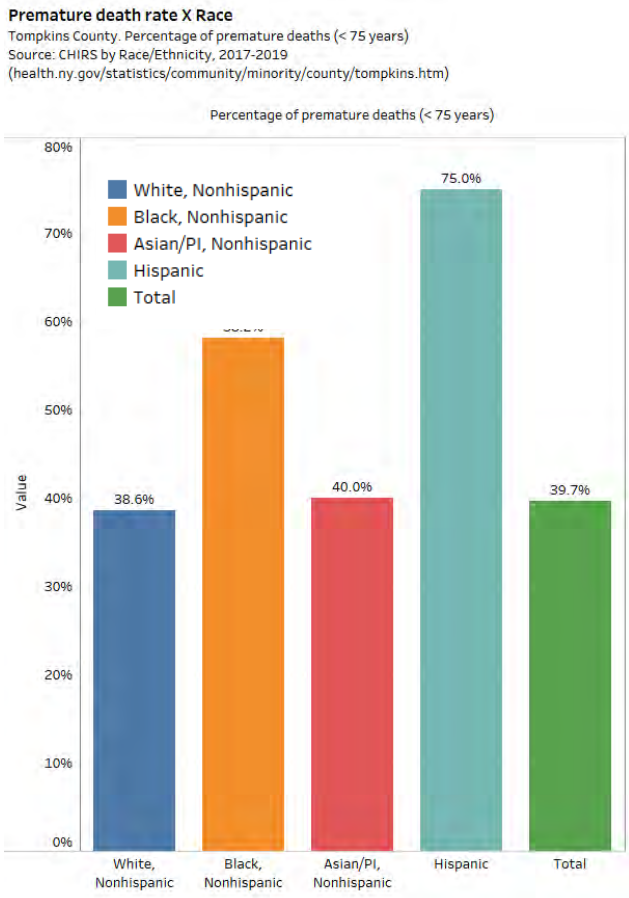

Figure 51

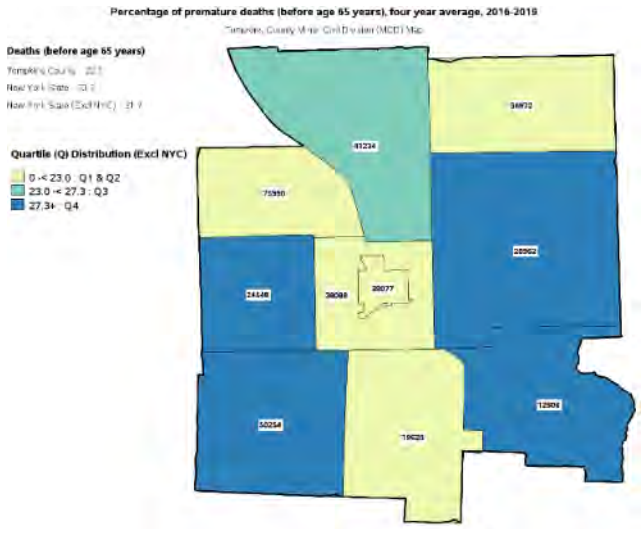

Figure 52

For all Tompkins County adults, the 2019 rate for potentially preventable hospitalizations was 80.6/10K (age-adjusted); the 2019 ROS rate was 120.4/10K (all adults age-adjusted). All Tompkins County towns are in the combined first and second quartile.

Among the indicators used to track basic access to care are adults and children with health insurance, and adults with a regular health care provider. Data for both of these indicators are self-reported through the Behavioral Risk Factor Surveillance System (BRFSS), a telephone survey conducted by the state.

The percentage of adults age 18-64 with health insurance is 95% in Tompkins County (2019), compared to 93% for all of NYS. Among the population of children under age 19, in Tompkins 97.3% have insurance, not significantly different from the state rate as a whole (97.7% for all NYS). (Figure 54)

Regarding a health care provider, 77% of Tompkins adults reported having a regular provider in 2018, down from 83% in 2016 and 87% reported in 2014 (BRFSS, 2014, 2016, 2018). The Prevention Agenda 2024 objective is 87%. (Figure 55)

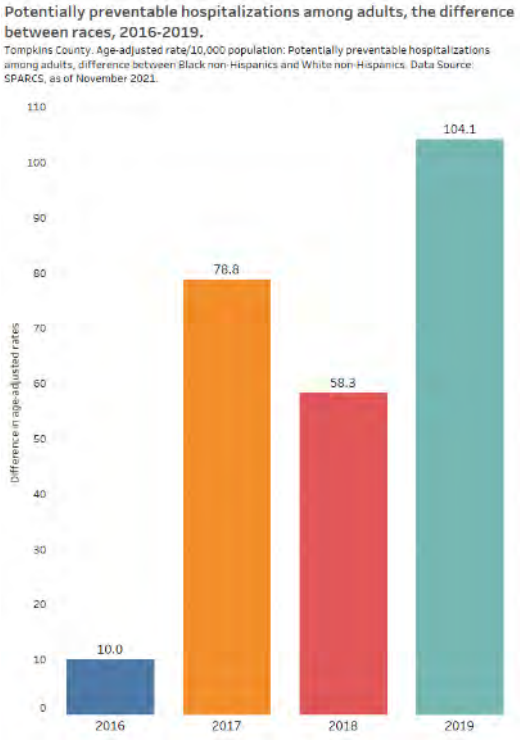

Figure 53

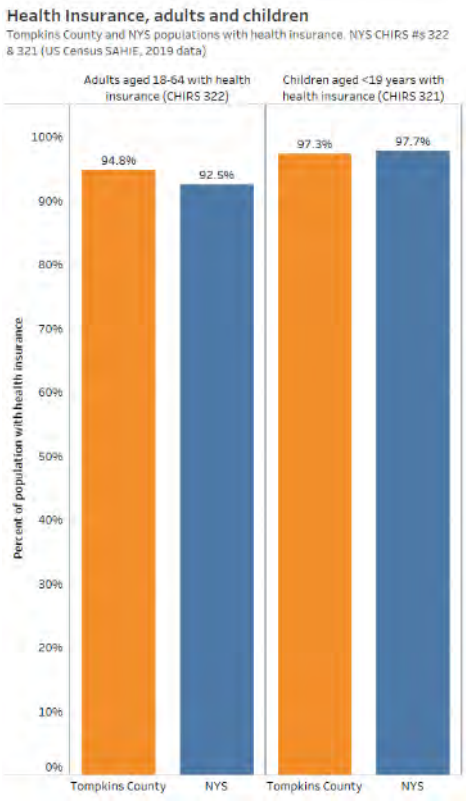

Figure 54

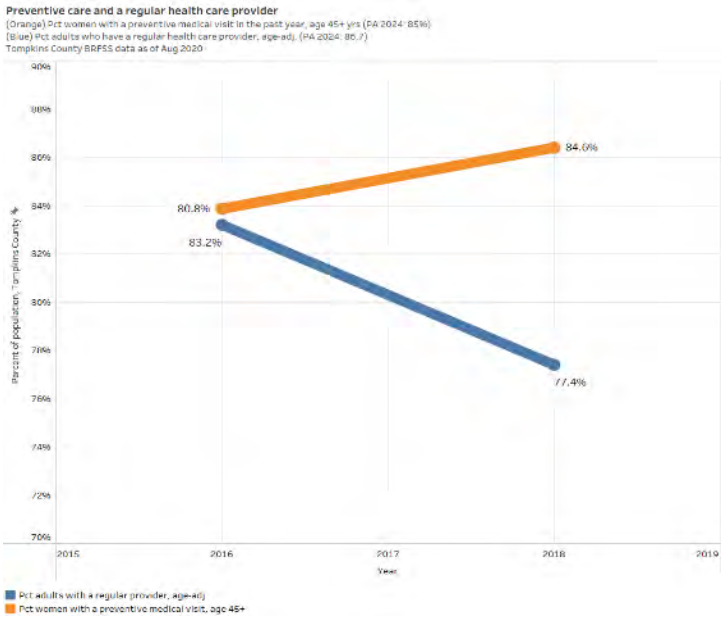

Figure 55

Incarceration

Research demonstrates that incarceration causes negative health risks and outcomes for individuals. Incarceration was declared a public health crisis during the COVID-19 pandemic. Incarceration is associated with chronic disease, including HIV, mental health diagnoses, hypertension, heart-related problems, diabetes, asthma, stroke, and overall lower life expectancy, both due to the experience of incarceration itself, as well as pre-incarceration exposure to structural determinants of health such as poverty, houselessness, and racism. [https://info.primarycare.hms.harvard.edu/review/incarceration-covid-19]

The total in-house population of the Tompkins County Jail has declined from 2019 to 2020. The high point was 73 in April 2019, while a year after that in May 2020 the population was just 28. More recently, the in-house population was 29 in June 2022, and 46 in November 2022. (Figure 56)

Tompkins County Jail Population

Jan 2019 to Dec 2022, In-House only. Source: Tompkins County Sheriff's Office, Corrections Division.

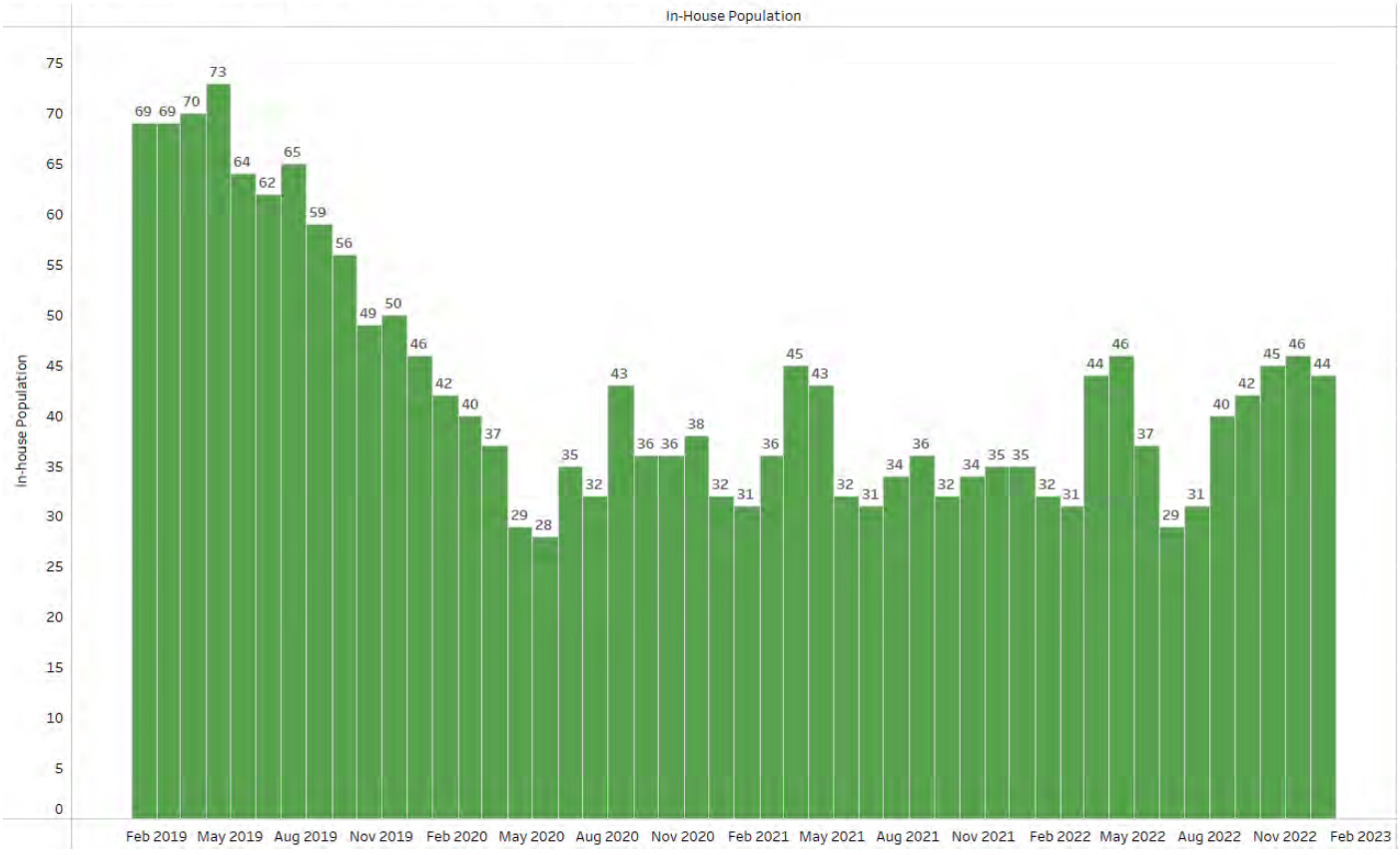

Figure 56

An assessment of the Tompkins County Jail, commissioned by the Legislature, was presented in July 2017 by CRG, Inc., of Rochester, N.Y. According to the report, the racial breakdown of the jail population from 2012-2016 was 73% white and 22% Black. By contrast, only about 4% of the county population identify as Black only. The report states the following (p. 37): "For both arrests and jail admissions, the rate for blacks is overwhelmingly disproportionate to the black proportion in the overall county adult population. Blacks comprise only 4 percent of the total county population age 16-plus, but about 14.5 percent of female jail admissions and 24 percent of all male admissions [are Black].

A report commissioned in 2018 by the Ultimate Reentry Opportunity initiative, examines systemic barriers to effective reentry in Tompkins County. This qualitative research study illustrates the impact incarceration has on individual health. One obstacle incarcerated individuals face is the suspension of their health insurance while incarcerated. Specifically, upon release, there may be a delay in reactivation of an individual's Medicaid leading to difficulty obtaining prescriptions in a timely manner upon release. (https://docs.google.com/document/d/1948V7c0lH4SyGVJQSsTsKSgMvy5wrSpv-AuwGHIcTAU/edit)

Community Survey

Results from the Community Health Survey's Health Status section demonstrated how disparities and inequity may have some impact on an individual's perception of health.

Perception of personal health was accessed by how participants responded to the question, "How do you rate your health in the following categories?" Categories were Physical and Mental. Ratings were 1 (poor) to 5 (excellent). N=1,569. Demographic questions allowed perceptions of personal health to be compared by race, health insurance status, employment status, gender, disability status, and location of current residence. Graphs for these cross-tabs are below, and show a lower self-perception rating for the population identifying as Black or African American, for both physical and mental health. Among age groups, the mental health rating is lowest for age 25-34, and highest for age 75 and over. And those earning less than $15,000 annually have the lowest ratings for both physical and mental health.

Mental health is rated lower by those without or not sure if they have a primary care provider, by those who are or not sure about living with a chronic condition, and by those who do not own their housing (renters and those not living in a private home or apartment), by those with less than a high school education, and by those who rate the safety of their neighborhood for outdoor activity either poor or fair.

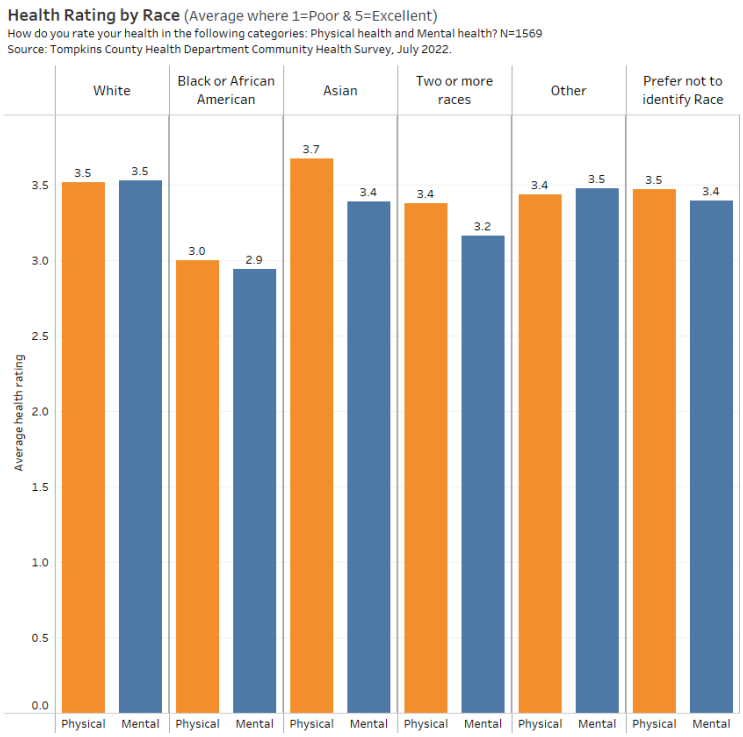

Figure 57

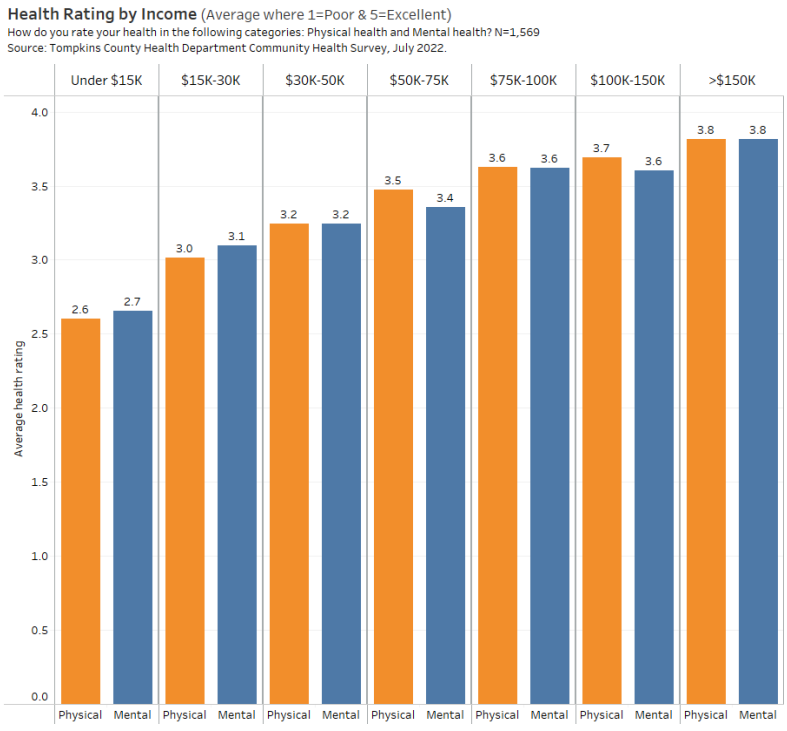

Figure 58

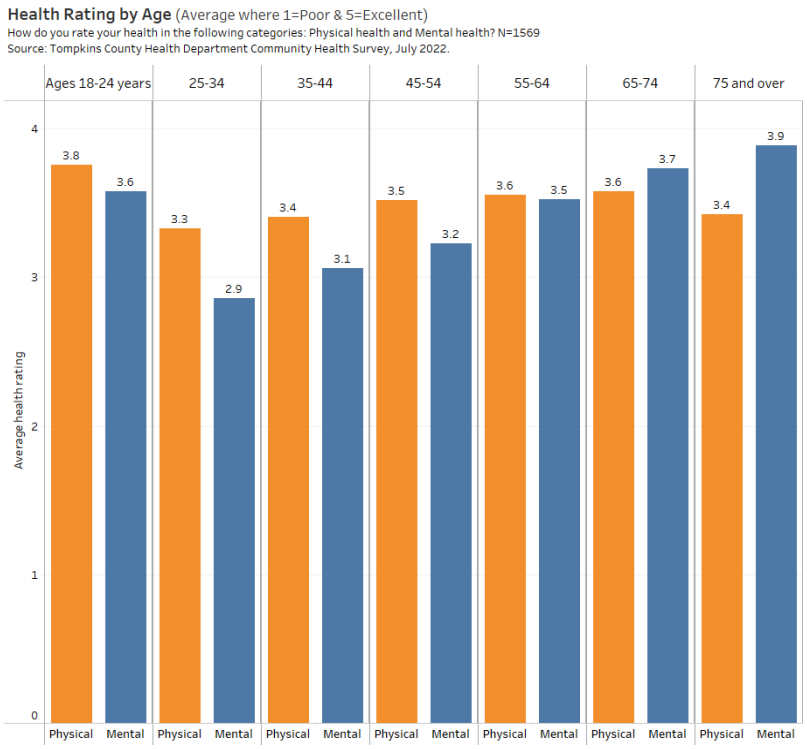

Figure 59

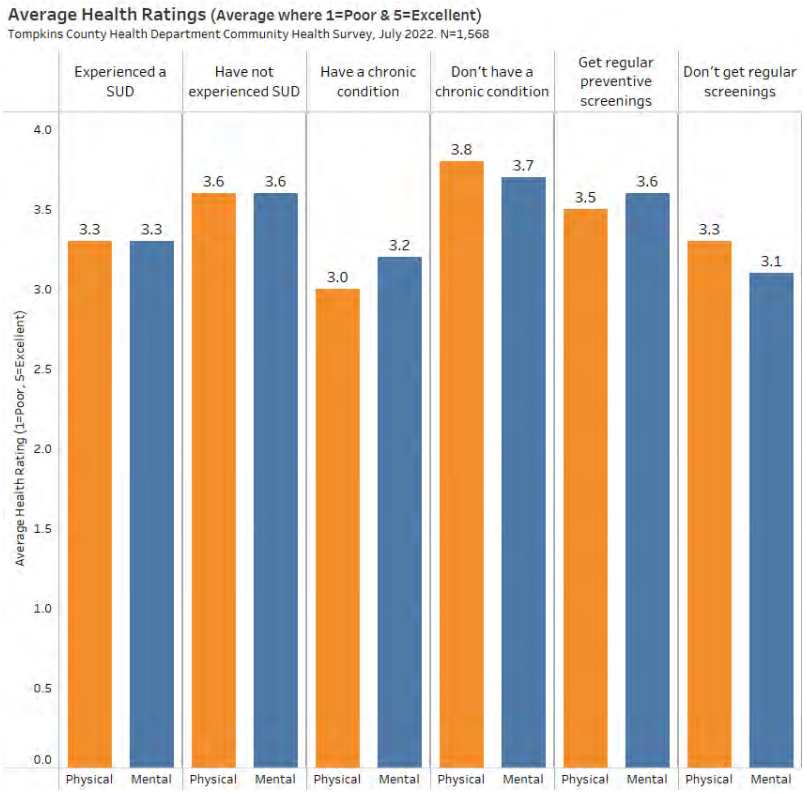

Figure 60

MAIN HEALTH CHALLENGES

Social Determinants of Health

Everyone is born into and leads their lives within both social and physical environments. These Social Determinants of Health (SDoH) are the conditions in which we live, work, and play. They include community, government, and culture, and the institutions, systems, norms, and behaviors that shape our environment.

Social determinants explain in part why, in a given community, some people are healthier than others, and many are not as healthy as they could be. They are barriers to greater well-being, often not revealed by traditional health assessments, and not understood by those who are affected. The institutions and systems that create a condition may neither recognize nor take ownership of their impact on health. Yet all too often they are the root cause of poor health.

The Healthy People 2030 website states the following

> *One of Healthy People 2030's 5 overarching goals is specifically related to SDOH: "Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all."* (health.gov/healthypeople, accessed 12/1/22.)

The HP2030 framework includes five key areas of social determinants of health (health.gov/healthypeople/priority-areas/social-determinants-health, accessed 12/1/22)

- Economic Stability (employment, food insecurity, housing instability, and poverty
- Education Access and Quality (Early Childhood Development and Education, Enrollment in Higher Education, High School Graduation, Language and Literacy)
- Health Care Access and Quality (Access to health services, Access to primary care, Health literacy)
- Neighborhood and built environment (Access to foods that support healthy dietary patterns, Crime and violence, Environmental conditions, Quality of housing)
- Social and Community Context (Civic participation, Discrimination, Incarceration, Social cohesion)

Within each of these areas social determinants influence health-related disparities. This framework establishes a common language that will be referred to throughout this report.

Community Survey

The most important health challenge facing the community is the connection between a favorable perception of personal health and broad social determinants of health. Often in matters of health, self-perception is reality. In July 2022, the Health Department in partnership with Cayuga Health conducted a community survey, which included asking respondents how they rate their own health, both physical and mental.

As described elsewhere in this report, rating levels are apparent across social determinants of health for the following

- Age
- Race
- Income
- Education level
- Homeownership status.
- Assessment of neighborhood safety and opportunities for children to play outdoors.
- Whether or not respondents had a primary care provider.
- Whether or not the respondent had a chronic disease.
- Whether or not the respondent gets preventive screenings.

Other County Departments

While the concept of social determinants has been well documented for years, it was fully integrated into 2019-2024 Prevention Agenda for the first time. And, as was the case with the TCWH's March 2019 community survey, the July 2022 survey clearly shows that social determinants are a reality in Tompkins County.

For the most part, these results are not new or surprising to the County. The County Office for the Aging, and Departments of Planning & Sustainability and of Whole Health Mental Health Services periodically develop service and comprehensive plans that address gaps they find in resource equity, and to utilize assets for the betterment and aspirations of the community and its residents.

Planning & Sustainability

In mid-2019, the Tompkins County Department of Planning and Sustainability conducted a five-year review of their 2015 Comprehensive Plan. Among the principles and policies that the

Department determined to be still appropriate were housing options for an aging population and for people requiring supportive services, transportation systems that consider the needs of populations that are challenged by transportation, and neighborhoods that encourage opportunities for daily activity, recreation, and social interactions.[10] [Source]

The Department further proposed action items to be added to the 2015 Plan in order to further the policies of the Plan. These include:

- Healthy Community Plans: Provide professional planning support to assist County departments working on healthy community plans.
- Housing Funding: Identify and pursue funding sources to support low income and workforce housing opportunities, including expansion of the Community Housing Development Fund Program.
- Track Housing Development: Track housing development (including supportive, senior, and student housing) and maintain a list of housing projects within the Development Focus Areas that have a strong potential to meet housing needs.

Office for the Aging

The AARP Network of Age-Friendly Communities (Network) is an affiliate of the World Health Organization's Age-Friendly Cities and Communities Program, an international effort launched in 2006 to help cities prepare for rapid population aging. In 2014, the Tompkins County Office for the Aging (COFA) led efforts to apply to participate in the AARP Network.

Tompkins County and the City of Ithaca were accepted into AARP's Network in May 2015. The Network helps participating communities become well-designed, livable communities that promote health and sustain economic growth, and make for happier, healthier residents—of all ages. In essence, the initiative is aimed at transforming the social and physical environment to support health and well-being for community members across the lifespan.

The Age Friendly Ithaca and Tompkins County Action Plan, published by COFA in December 2016, maps out Goals and Tasks across seven designated domains: outdoor spaces and buildings, transportation, housing, respect and social inclusion, civic participation and employment, community and health services, and communication and information. The document's timeline runs through 2019.[11]

In 2019, COFA conducted a needs assessment to understand the current needs of Tompkins County residents 60 years and over. Health specific concerns indicated by survey respondents included: having a way to get to medical appointments (both in county and out of county), being lonely or socially isolated, understanding Medicare, preventing falls in and out of the home, and being able to safely cross the street. Nearly 40% of respondents indicated that they are familiar with Age Friendly and Livable Communities while 61.6% said they are aware of

programs and services provided by COFA.(COFA 2019 Needs Assessment Report Final.pdf (tompkinscountyny.gov))

TC Whole Health - Mental Health Services

At the County level, local mandates and programs from the NYS Offices of Mental Health (OMH), Alcoholism and Substance Abuse Services (OASAS), and for People with Developmental Disabilities (OPWDD) are all managed under one roof by the legislatively defined Local Government Unit (LGU). In Tompkins County, the LGU is the mental health services of TC Whole Health.

All LGUs are required to submit to the State an annual Local Services Plan (Plan) for Mental Hygiene Services. These plans include an Overall Needs Assessment by Population, and Goals Based on Local Needs. In addition, the 2020 Plan for the first time includes a section defined as a "survey ... intended to promote alignment with the NYS Prevention Agenda (PA) for 2019-2024 as part of the local services plan development." The survey only covers LGU plan alignment with the PA priority, "Promote Well-Being and Prevent Mental Health and Substance Use Disorders," (WB-MHSUD) and its two Focus Areas, which are identified within the title of that priority.

In the overall needs assessment section of its Plan, TCWH identifies "safe and affordable housing of all levels," and "reliable, accessible, and affordable transportation" as both unmet needs and to some degree, services that have worsened. Unmet needs cited by TCMH also include workforce recruitment and retention, and treatment and service opportunities.

In the Goals section of the TCWH Plan, both housing and transportation are checked as a priority goal. The goal statement for housing keys in on the need to increase the supply of new housing options that are licensed or supported by each of the three NYS Offices. Among this Goal's Objectives is, "Address housing as a key determinant of health."

The goal statement for transportation seeks to improve access to transportation to community social support services and treatment for the populations in need of these services. Objectives focus on access for rural and high need populations, and on collaboration with county and regional committees and networks to meet the demand. Other TCWH plan goals are for workforce recruitment and retention and SUD residential treatment services.

In the Plan's Prevention Agenda alignment survey, interventions for goals within both Focus Areas for the WB-MHSUD priority are listed, and the LGU is asked to check-off those interventions that have begun or will begin. TCWH identifies two or more interventions under each of the eight goals. Many of these build on social determinants of health such as housing improvement, integrating social and emotional factors into support programs, using policy and environmental approaches in prevention, and thoughtful messaging.

A survey was conducted as part of the planning for 2023 in which county mental health providers were asked about racial equity. Local providers demonstrated a commitment to addressing racial equity with 21% currently implementing a plan to address racial equity and 16% having begun the process of implementing a plan for racial equity. When asked what resources are needed to assist in planning efforts to address racial equity, respondents highlighted a need for local data with more accessible demographics, training and toolkits, Tompkins County specific data from the State, and support for analysis of data. The survey also asked what racial equity issues are of most concern regarding their impact on children and adults. For children, respondents were most concerned with access to mental hygiene service and physical health and safety. For adults, respondents were most concerned with housing and access to and quality of mental hygiene services. Overall, the survey responses indicate a desire to address racial equity as it related to mental health hygiene, but additional support is needed to accomplish this objective.

Tompkins County's mental hygiene subcommittee identified non-clinical supports as an area of need. By doing so, mental health providers recognize the importance of social determinants of health, health equity and the importance of peer supports. The subcommittee will work to identify strategies to improve health equity across Tompkins County.

SUMMARY OF ASSETS AND RESOURCES

Tompkins County is a resourceful community, characterized by its commitment to seeking solutions to social needs and inequities. Residents also work to enhance and build on existing resources in the environment and community infrastructure to address health issues. Local government and agencies are committed to diversity and inclusion in the work force and in program implementation. While individuals might say that certain of these efforts are insufficient, misdirected, or disingenuous, historically the community continues to look for the best path to equity.

The cultural and artistic landscape offers a wide range of opportunities for participation and enjoyment in music, theater, art, dance, and intellectual programming. Seasonal community markets, festivals, and celebrations promote the diversity of cultures, local agencies, local artists and music, and local food and agriculture. The Ithaca Farmers Market is a centerpiece for local food and fresh produce; other municipalities have their own farmers markets or are affiliated with the Ithaca market.

The County is rich in geographical diversity, known for its gorges and numerous hiking trails that provide a range of opportunities for physical activity. The website IthacaTrails.org lists over 70 different trails, which can be searched by activity, difficulty, and ecology. Some are connected with one of the three State Parks within the county, and the others are stewarded by any one of well-over a dozen different municipalities and nonprofits.

One showcase is the Cayuga Waterfront Trail, a multi-phase collaboration between the City of Ithaca and the Tompkins County Chamber of Commerce. The five and a half mile trail connects the Allan H. Treman State Marine Park on the west side of Cayuga Inlet, to Stewart Park on the east side. The ten-foot wide asphalt trail was designed to be used by walkers, joggers, bicyclists, inline skaters, mobility-impaired users, and parents with strollers.

Tompkins County has an integrated system of healthcare resources along with activities and programming in the towns, villages, schools, and community centers that focus on promoting healthy lifestyles across the age spectrum and healthy communities. For the community organizations that want to refer clients to local resources, the perennial challenge is to be aware of and up-to-date on program availability. The challenge broadens with the need to ensure that the diverse population in our county, especially those most vulnerable, are able to access both the healthcare system and available cultural and recreational opportunities.

Finally, the assets that individuals offer to the well-being of our community must be recognized. Everyone has aspirations, interests, knowledge and talents to offer that we want to celebrate and acknowledge in the community's effort to improve health outcomes and achieve a more equitable future.

Access to Healthcare Services in Tompkins County

Many of the agency names below are linked to the organization's website.

Tompkins County Whole Health (TCWH)

Tompkins County Whole Health, formerly Tompkins County Health Department and Mental Health Department, merged as one department in December 2019 and completed the process of integration in 2022. This new department is under shared leadership to better serve the community through enhanced service delivery. The mission of TCWH is to build a healthy, equitable community in Tompkins County by addressing the root causes of health disparities and integrating mental, physical and environmental health.

The core public health services of TCWH are comprised of the Divisions of Administration (including Health Promotion, Public Information, and Emergency Preparedness) Environmental Health, Community Health, and Children with Special Health Care Needs.

TCWH provides pre- and post-natal care through the MOMS Plus+ program and through pre- and postnatal home visits for at risk families through registered nurses and Community Health Workers. The Supplemental Nutrition Program for Women Infants and Children (WIC) is a federally funded program provided by TCWH. WIC improves the health status of eligible women, infants and children (up to five years) through the purchase of nutritious foods, nutrition and health education, breastfeeding promotion and support and referrals to local health and human service agencies. TC WIC uses eWIC and operated fully remote during the COVID pandemic.

The Children with Special Health Care Needs Division serves children who have or are at risk for chronic, physical, and developmental, behavioral or emotional conditions and who require a broader scope of health and related services to reach their fullest potential.

The Department provides childhood immunizations to children, flu immunizations to targeted populations and the public. Rabies post-exposure immunizations are also provided to the community, in collaboration with Cayuga Medical Center. Communicable disease surveillance and case management, tuberculosis, contact investigation and treatment, and anonymous HIV counseling and testing are essential programs.

The Environmental Health Division (EH) provides educational and regulatory programs including, Onsite Wastewater Treatment Systems, Rabies Control, Lead Poisoning Prevention, Food Program, and Water Systems, including harmful algal blooms (HABs) and Hydrilla. EH manages the Adolescent Tobacco Use Prevention Act (ATUPA) program, which enforces compliance with the county's minimum legal age for retail tobacco sales.

The Health Promotion Program (HPP) focuses on evidence-based programs to reduce the risk of chronic disease among Tompkins County residents. The Tobacco Control Program (Tobacco Free Tompkins, T-Free Zone), a partner in NYS Advancing Tobacco Free Communities, works to eliminate all exposure to secondhand smoke and vape aerosol, de-normalize tobacco use, and reduce youth initiation through outreach, policy, and environmental change. The Healthy Neighborhoods Program (HNP). HNP is a free, in-home assessment program to prevent indoor air pollution, residential fire deaths, lead poisoning, and asthma hospitalizations.

The Public Health Preparedness program plans, coordinates, and facilitates training, table-top and point of dispensing exercises to prepare for public health emergencies, as mandated by the Cooperative Agreement with the CDC and the NYSDOH. The program offers a variety of opportunities for organizations, agencies, municipalities, and businesses to support countywide preparedness efforts.

TCWH convenes community coalitions, including the Lead Poisoning Prevention Network, and the Tompkins County Immunization Coalition.

Cayuga Medical Center (CMC) -

Cayuga Medical Center, a member of Cayuga Health, is a 212-bed federally designated Sole Community Hospital. Annually, CMC serves over 150,000 patients with approximately 7,500 inpatient discharges, 8,000 inpatient and outpatient surgeries, 30,000 emergency visits, 45,000 urgent care visits, and 15,500 hematology/oncology visits. Over 60% of CMC's inpatient discharges are for patients with Medicare or Medicaid, and about 2% for patients without insurance. CMC is dedicated to providing excellent care to all patients, regardless of their ability to pay and offers a Financial Assistance Program, which helps to cover the cost of services for patients with a household income at or below 300% of the Federal Poverty Level. Tompkins County represents the majority of CMC's primary service area, and the majority of CMC patients are Tompkins County residents.

CMC has a staff of over 1,500 healthcare professionals and over 200 affiliated physicians to serve Tompkins County. CMC works closely with the outpatient arm of Cayuga Health, Cayuga Medical Associates (CMA), which includes primary and specialty care practices throughout Tompkins County. In an effort to continue to expand access to care and meet community need by increasing the number of medical providers in the area, CMC launched an Internal Medicine Residency Program in 2019 and partners with several regional academic institutions to provide learning opportunities and career pathways for new healthcare professionals and providers.

Cayuga Health Partners (CHP) -

A partnership between Cayuga Area Physicians' Alliance and Cayuga Medical Center that includes more than 40 primary and specialty care practices spanning Tompkins, Cortland and

Schuyler counties. As a clinically integrated network, CHP unifies more than 450 providers and 2 community hospitals to drive improvements in population health and control the total cost of healthcare in our community. CHP does this by leveraging innovative data capabilities while promoting evidence-based best practices across our practices working to achieve optimal health outcomes for our community.

Guthrie -

Primary care physicians and providers include specialists in family medicine and internal medicine who provide comprehensive services, including women's health care, newborn and well-child care, pediatrics and adult/geriatric care. Guthrie providers are affiliated with Robert Packer Hospital in Sayre, PA.

Hospicare and Palliative Care Services -

Provides hospice care for people of any age with any terminal diagnosis. Palliative care service for relief of pain, symptoms, and stress at any point in an illness. Bereavement support services provide grief counseling and support groups.

Ithaca Free Clinic (IFC) -

A program of the Ithaca Health Alliance, is a nonprofit organization which facilitates access to health care for all, with a focus on the needs of the un- and underinsured. A completely free, integrative medical center, IFC is staffed by volunteer physicians, herbalists, acupuncturists, nurses, and other professionals. The Ithaca Health Alliance also operates the Ithaca Health Fund, a medical assistance program.

Ithaca Health Center (PPSFL) -

Abortion services, birth control, HIV testing, LGBTQ services, men's health care, morning-after pill (emergency contraception), pregnancy testing & services, STD testing, treatment & vaccines, women's health care. Operated by Planned Parenthood of the Southern Finger Lakes.

REACH Project, Inc.

Is a nonprofit organization with the belief that all individuals deserve respectful, equitable, access to compassionate healthcare in a setting where they will not be stigmatized or judged based on drug use, homelessness, or any other issue that may cause less than adequate care in the healthcare environment. The REACH Project owns and operates the first low threshold, harm reduction medical practice in Ithaca, NY: Reach Medical.

Reach Medical offers a wide range of services including: opioid replacement therapy, medical cannabis certification, Hep C treatment, primary care and behavioral services.

Visiting Nurses Association (VNS) -

VNS is a private, nonprofit home health agency, and the County's only Certified Home Health Agency. VNS services include home health care, rehabilitation, tele-health, private duty care, and long-term home health care.

Mental Health and Substance Abuse

Tompkins County Whole Health – Mental Health Services

The county's Local Government Unit (LGU) as defined by NYS. Their mission is to meet the needs of the residents of Tompkins County in the areas of mental health, developmental disabilities, and chemical dependency by providing prevention and early detection, comprehensively planned care, treatment, and rehabilitation services. Services are provided through contracts with private sector agencies except where individuals, not-for-profit agencies, or other levels of government cannot or will not provide such services. Oversight by the Community Services Board. TC Mental Health Services is now part of TC Whole Health.

Cayuga Medical Center Behavioral Services -

Two Behavioral Services units for inpatient care—one for adults over the age of 18 years, and one for adolescents between 13 and 17—for people with identifiable, diagnosable, and treatable psychiatric illnesses who are at imminent risk.

Alcohol and Drug Council of Tompkins County

A private, non-profit agency which provides information, education, counseling, and referral services for area residents and organizations. The Council views addiction as a progressive, treatable disease with recognizable symptoms, and provides prevention, education and counseling services to individuals and families.

Cayuga Addiction Recovery Services (CARS) -

Offers comprehensive longer-term residential treatment at the 60-bed Residential Addiction Recovery Center in Trumansburg. Outpatient chemical dependency services include individual and group counseling, and will be providing Opioid Treatment Program (OTP) and Ancillary

Withdrawal Services (AWS), including dispensing daily medications for clients meeting the criteria.

Collaborative Solutions Network (CSN) -

Initiates and supports collaboration within and between individuals, schools, human service agencies, communities and other working groups, to increase the effectiveness, interdependence and efficient use of existing resources that support children and youth with mental health challenges and their families. Guided by the System of Care approach.

Family & Children's Services -

Provides mental health care and related social services across all ages, including trauma-informed counseling for children and families, counseling services for teens and students, and for adults and caregivers. FCS provides EAP services for employers.

Franziska Racker Centers -

Serves children, adults, and families with a broad range of special health and mental health needs across 30 sites in 3 counties. Racker's service areas encompass preschool special education, clinical therapies, mental health treatment programs, residential opportunities, and community support services for all ages.

Lakeview Health Services -

Provides safe, affordable housing and support to persons recovering from mental illness, and health care coordination services to individuals with chronic mental and physical health challenges using person-centered, recovery-oriented, and trauma-informed practices.

Mental Health Association in Tompkins County -

Supports active, public involvement—including providers, family members and recipients—in all aspects of mental health, including the definition of needs, the promotion of community, and the provision of services, and works toward empowering individuals, families, and groups through advocacy and services which promote mental health. MHA provides peer-peer training, including Mental Health First Aid.

Housing

211 and 211 online -

An information service that provides referrals to health and human services agencies and organizations within the community. Telephone, online chat line, and online database of community information. Referrals to services and providers according to caller's situation. Dial 211 for free, 24/7 phone service. Live chat service Mon.-Fri. 8:30 a.m.-5:00 p.m. Text service Mon-Fri 9:00 a.m.-4:00 p.m., text your zip code to TXT211 or 898211.

Continuum of Care (CoC) -

The Ithaca /Tompkins County Continuum of Care System (CoC NY-510) is a local network of public, private, and non-profit agencies working collaboratively to end homelessness in Tompkins County. Issues include supportive housing development, barriers to entry into housing and homeless services, and at-risk youth. Led by the Human Services Coalition, ongoing initiatives include Point-in-Time Count, Coordinated Assessment System, Homeless and Housing Task Force, Independent Living Survey, CoC Program Competition.

Ithaca Neighborhood Housing Services (INHS) -

Works with individuals of moderate income to find and remain in high-quality, affordable housing, INHS provides low-interest loans to first-time home buyers, manages well-maintained rental units, rehabs old homes, provides home-repair assistance to seniors, builds new LEED-certified green houses. Service area is Tompkins and contiguous counties.

Tompkins Community Action (TCA) -

Collaborates with individuals and organizations to sustain and improve economic opportunity and social justice for families and individuals impacted directly or indirectly by poverty. Working through three Departments: Family Services, Energy Services and Housing Services, TCA operates Head Start, supportive housing programs, and weatherization services. TCA's service philosophy is based on the Family Development Model.

Unity House -

Provides transitional and permanent housing, respite care, and rehabilitative and employment services for individuals with mental illnesses, developmental disabilities, and/or chemical dependencies from which they are recovering. Partners with these individuals to develop their personal skills and potential, enabling them to live more full and independent lives. Tompkins County services include 9 Independent Residential Alternative (IRA) sites, Supportive Apartment Program, and Day and Community Habilitation Services.

Food and Nutrition

Childhood Nutrition Collaborative (CNC)

CNC is a cross-sector coalition including community organizations, agencies, school districts, and the Cornell MPH Program that comes together to use principles of collective impact to address food systems, food access, education and food insecurity. The goal is to coordinate resources and efforts in the community. The Health Department has served on this collaborative for the past three years and will continue in this role. Initiatives have included providing advisory support for Farm to School collective purchasing, expanding universal breakfast in school settings, and expanding access to underutilized nutrition programs.

Cornell Cooperative Extension of Tompkins County (CCETC) -

Offers free or low-cost educational workshops, applied research projects, and information on food-related topics including food safety, cooking and nutrition classes, healthy eating on a limited budget, food preservation. Programs include Finger Lakes Eat Smart NY, Food Entrepreneurship, Farm to School, Healthy Food for All, Fruit and Vegetable Prescription (FVRx Tompkins), Cooking Matters, the Nutrition, Health & Safety Program Committee, plus multiple programs for small farms and agriculture.

Food Bank of the Southern Tier -

Distributes food to people coping with hunger through a network of food pantries, meal programs, shelters, the BackPack Program, Mobile Food Pantry Program, and other hunger relief agencies in six counties including Tompkins. Through advocacy, education and community partnerships, the Food Bank's vision is to create a future without hunger for everyone in the Southern Tier. Named the 2017 Food Bank of the Year, the Food Bank of the Southern Tier is a member of Feeding America and a regional agency of Catholic Charities of the Diocese of Rochester.

Foodnet Meals on Wheels -

The only local agency that delivers hot meals directly to clients, staff includes Registered Dietitian that provides meal planning, nutrition assessment, counseling and education. Their mission is to provide meals and other nutrition services that promote dignity, well-being and independence for older adults and other persons in need in Tompkins County. Meals are delivered directly to their clients' door or to one of 4 congregate meal sites.

Greenstar Community Projects -

- Esty Street Youth Garden is an urban garden program that teaches youth how to grow their own food, and provide fresh produce to the community
- Children Nutrition Collaborative empowers individuals to create a food system and help end hunger (see above).

Loaves and Fishes of Tompkins County -

A Christian ministry providing a place for free meals, hospitality, companionship, and advocacy for those in need, regardless of their faith, beliefs, or circumstances. Founded in 1983, Located in St. John's Episcopal Church in Downtown Ithaca, L&F is Tompkins County's only community kitchen serving free meals Monday through Friday, and serves nearly 2,700 meals each month.

Community Agencies, Resources, Initiatives

Cancer Resource Center of the Finger Lakes (CRC) -

Outreach and services for individuals with a cancer diagnosis, their families, and caregivers; navigation, networking, support, and referrals to other local programs and services for additional information and needs.

Cancer Services Program

TCHD will continue working with the Cancer Services Program of Cayuga, Cortland, and Tompkins to promote free breast, cervical, and colorectal screening for eligible, uninsured, or underinsured women ages 40-64 and men ages 50-64.

County Office for the Aging (COFA) -

Provides a point of entry into aging services in Tompkins County with unbiased information regarding the array of services available for older adults and their caregivers. The COFA mission is to assist older adults and persons with long term care needs to live independently in their homes and communities with quality of life and dignity. See also page *47* in the *Main Health Challenges* section, above.

Catholic Charities -

Resources and support to help vulnerable populations in need, advocate for social justice, and address the needs of the community and issues pertaining to poverty.

Cayuga Center for Healthy Living (CCHL) -

An individualized, medically-based program focused on disease prevention and wellness promotion through lifestyle change including diet, lack of exercise, excess weight and tobacco use. A program of the Cayuga Medical Center.

Cornell Cooperative Extension of Tompkins County (CCETC) -

Offers a wide range of programming that includes agricultural programming, consumer issues, nutrition, healthy families, environmental issues, and programs that address nutrition and obesity prevention.

Health Planning Council (HPC) -

A program of the HSC, is committed to improving the health and wellbeing of Tompkins County residents. By convening stakeholders across multiple sectors and providing a neutral forum to exchange ideas, HPC promotes collaboration, alignment of resources, and shared leadership to achieve the common goals.

HPC manages the *Tompkins Health Network,* a rural health network program focused on improving access to health care, enhancing coordination of services, and ensuring equitable health outcomes for all people. Through its Health Insurance Assistance and Community Health Advocates Programs, HPC staff meet with individuals and families looking for guidance in enrolling into a health plan or finding a doctor or other medical services. The Long-Term Subcommittee has launched Ripple Effect, a program for persons aged 50-65. Partners include Cornell, TCHD, and COFA.

Human Services Coalition (HSC) -

The mission of the Human Services Coalition is to identify information and service needs, to provide planning and coordination, and to enhance the delivery of health and human services in the Tompkins County area.

Lourdes Mobile Mammography Van

TCWH will host the Lourdes Mammography Van to provide breast cancer screening to women 40 and older. The van currently serves Newfield and Freeville communities, and the Free Clinic in downtown Ithaca.

Women's Opportunity Center (WOC) -

Part of the NYS statewide Displaced Homemakers Program, WOC helps displaced homemakers enter the workforce after divorce, separation, or widowhood. Job search and preparation workshops emphasize job retention and the development of essential computer skills, career development, and the success of families in reaching their goals.

Youth Services

Tompkins County Youth Services -

Works with not-for-profit agencies that run programs for children, youth, and families, and support the volunteer members of Municipal Youth Boards and bureaus that are responsible for planning and providing youth programs in every community within Tompkins County.

Ithaca Children's Garden -

A 3-acre public children's garden designed for kids to provide authentic opportunities for open-ended, youth-directed discovery, nature connection, play, and empowerment, and a mission to inspire the next generation of environmental stewards.

Ithaca Youth Bureau -

A public multi-service agency that provides a broad variety of recreation and youth development programs to promote the health, happiness, and well-being of all youth and families in the greater Ithaca area.

Learning Web -

Community-based organization that provides hands-on experiential education to Tompkins County youth through the mentor-apprentice model, teaching job and life skills to empower them with self-awareness and self-esteem and make a successful transition into adult roles and responsibilities.

Village at Ithaca -

Advocates for excellence and equity in Ithaca and area schools by developing strategic community relationships, programs, and services to ensure that all students, particularly Black, Latino/a, low income, and other underserved students consistently meet or exceed local and New York State standards of achievement. Includes tutoring and Achievement Coaches through the Student Success Center and Family Advocacy Program.

Additional youth development and recreational resources

Greater Ithaca Activities Center, Southside Community Center, CCE Urban Outreach and 4-H, and the YMCA.

Academia

Colleges

Cornell University (Cornell Health) and Ithaca College (Hammond Health Center) provide primary care and counseling services for their student populations; Nurse Practitioners provide services to Tompkins-Cortland Community College students.

The Cornell Center for Health Equity (CCHEq)

The CCHEq responds directly to community priorities by focusing on practical, relevant research topics. It brings together research experts at Weill Cornell Medicine and at Cornell University's Ithaca campus to collaborate on how to achieve health equity. The Center engages members of the public in every step of the research process, from conceptualization through dissemination and implementation. If you are interested in multiple vulnerabilities to health disparities or stigmatized conditions, consider becoming a member. The CCHEq seeks to facilitate your research, training and community service initiatives. We look forward to working with you to transform science into better health for all.

Cornell University MPH Program

College of Veterinary Medicine, focused on the One Health/Planetary Health model. The two concentration areas are: Infectious Disease Epidemiology and Food Systems and Health. The program provides faculty expertise and engaged student learning and community partnerships through student Applied Practice Experience and research initiatives.

Ithaca College -

School of Health Sciences and Human Performance, Department of Health Promotion and Physical Education offers B.S. majors in six majors. Faculty expertise and engaged student learning through internships and presentations in the classroom by Health Department staff.

Tompkins County Community College (TC3) -

TC3 has a broad range of courses and opportunities in degree programs and continuing education. Associate degree programs include nursing, human services, chemical dependency counseling, and sustainable farming and food systems.

Transportation

Bike Walk Tompkins -

Facilitates bike share, bike education, and community planning projects. Produces semi-annual *Streets Alive!* event.

Friends in Service Helping (FISH) -

Volunteers provide smoke-free, private, confidential rides to Tompkins County residents in need of medical and health related services that are within the County. FISH primarily serves elderly citizens who may be frail or who no longer drive, and Tompkins County residents who have limited transportation options and resources.

Gadabout -

Safe, reliable, affordable transportation services for older and disabled residents of Tompkins County.

Ithaca CarShare -

A local nonprofit, membership-based, transit-oriented carsharing service providing 24/7 access to vehicles on an hourly basis. Members can book a car online, by smartphone, or by calling. Members pay an hourly and mileage rate to use the cars. 25 vehicles, 1,416 active members (2017 Annual Report).

Supports for Health -

A pilot project designed to improve access for Medicaid individuals to critical, non-medical, health related needs for which Medicaid does not cover transportation costs, such as access to pharmacies or grocery stores, by providing short term financial assistance in the form of vouchers for transportation, or the delivery of certain items. Supported by Care Compass Network Innovation Funds

Tompkins Consolidated Area Transit (TCAT) -

Public transit system of 34 bus routes operates daily, 360 days a year with an annual ridership of over 4 million (2018) traveling 1.6 million miles on 54 40-foot buses.

WayToGo -

Transportation information and learning hub that connects riders with transportation options and facilitates new community solutions; expands access to transportation by connecting people to existing options, and helping develop new community solutions.

Economic

Alternatives (AFCU) -

A Community Development Credit Union (CDCU), member-owned, locally controlled and self-supporting, providing access to safe financial services and education for underserved people. Community Programs include Free Tax Preparation, Student Credit Union, Financial Wellness, and Business CENTS.

Workers' Center -

Workers' Rights Hotline, local community union organizing the Living Wage Campaign, and community outreach through Occupational Safety and Health programs.

Workforce NY -

Workforce New York Career Center provides a one-stop shopping approach for accessing employment-related services for businesses, workers, and job seekers in Tompkins County. Priority of Service to veterans and their eligible spouses.

Additional economic development resources -
Youth Employment Services (YES), Hospitality Employment Program

PROCESS AND METHODS

To complete the CHA, data was compiled and collected through various means. Community input was sought in the data collection process. Preliminary findings of the assessment were presented to the Health Planning Council of Tompkins County and the CHIP Steering Committee. The document was produced by the Health Promotion Program of the Tompkins County Health Department and the Health Equity Team of Cayuga Health, with support from the CHIP Steering Committee.

Data Collection

Most secondary data for the Community Health Assessment came from federal (U.S.) and state (NYS) sources.

- U.S. Census Bureau American Community Survey 2016-2020 5-year estimates.
- New York State Department of Health (NYSDOH)
    - Community Health Indicator Reports (CHIRS) is close to 350 data points organized into 15 categories, including cancer, cardiovascular disease, child and adolescent health, injury, occupational health, health status, and tobacco, alcohol, and other substance abuse. Most of the CHIRS data available for this CHA is from years 2017 through 2019.
    - Prevention Agenda (PA) dashboard. The PA dashboard tracks 44 indicators, categorized by the five PA priority areas.
    - Data for both the PA and the CHIRS are pulled from a variety of NYS databases, including Vital Records, the Behavioral Risk Factor Surveillance Survey (BRFSS), the Youth Risk Behavioral Survey (YRBS), and the Statewide Planning and Research Cooperative Systems (SPARCS). Additional information on methodology may be found at health.ny.gov/statistics/chac/indicators/methods.htm.
- The Robert Wood Johnson Foundation (RWJF) works with the University of Wisconsin to publish annual County Health Rankings, a comparison of proprietary indicators across every U.S. County. The top six counties in the 2022 Health Factors rankings for New York State are Putnam (1), Tompkins (2), Saratoga (3), Nassau (4), New York, NY (5), and Westchester (6).
- Cornell University MPH students, as part of summer coursework, assisted with visualization of secondary data.

Senior Leadership

The Senior Leadership Teams from both Whole Health (TCWH) and Cayuga Health (CHS) have recognized the importance of the CHA and CHIP process and provided input across various stages of the project as Priorities and Focus Areas were considered. The Senior Leadership Teams provided high-level recommendations about what should be investigated further during

the CHA process and review of data. These discussions and recommendations informed the structure of the CHA and the data collected from secondary sources.

Steering Committee

The CHIP Steering Committee includes partner agencies: TCWH Mental Health Services and Health Promotion Program, County Office for the Aging, Human Services Coalition and Health Planning Council, Cayuga Health Partners/Health, Cornell University MPH Program, County Youth Services, Cornell Cooperative Extension of Tompkins County

The steering committee provided guidance and feedback on the qualitative data collection process and population-level data (secondary sources) for the CHA. They drew on their professional expertise and personal experience as residents of Tompkins County to inform the decision-making process for the CHIP focus areas.

Community Survey

A Community Health Survey of Tompkins County residents was conducted via Qualtrics during July of 2022. Those who identified as age 18 or over and living in Tompkins County were eligible; there were 1,569 eligible respondents.

The survey instrument was distributed widely through an electronic link on the TCWH website, social media (Facebook and Twitter), and the Human Services Coalition email Listserv. Paper fliers with the URL and a QR code were distributed to at least 20 community-based organizations, some of which sent the information out further to their staff and listservs. Paper copies of the survey were also available at community outreach events through Community Health Workers. CHWs and Public Health Graduate Fellows assisted with online entry.

The survey instrument and additional data will be available as an Appendix.

Tompkins County Board of Health

The local health department's Board of Health was updated at the December 6, 2022, meeting. The Board membership includes a representation from the County Legislature, Ithaca College, Cornell University, Cayuga Health, local school districts, and REACH Medical.

Tompkins County Health Planning Council and Tompkins Health Network

The Health Planning Council was updated at their November 14, 2022 meeting. A summary of the CHA and initial priorities for the CHIP were presented at this meeting. A Community Health and Access subcommittee of the Health Planning Council will be convened to monitor and evaluate progress on the CHIP.

Tompkins County Community Health Improvement Plan, 2022-2024

THE PREVENTION AGENDA (PA) is New York State's blueprint to be "the healthiest state." It is categorized by the five PA priorities: Prevent Chronic Disease, Promote a Healthy and Safe Environment, Promote Healthy Women, Infants, and Children, Promote Well-Being and Prevent Mental and Substance Use Disorders, and Prevent Communicable Disease. Within each Prevention Agenda priority, the structure is: Priority > Focus Areas > Goals > Objectives > Interventions. County status and progress on PA priorities are tracked through 44 indicators in the PA dashboard.

IDENTIFICATION OF PREVENTION AGENDA PRIORITIES

The CHIP priorities and Focus Areas selected for the period 2022-2024 addressed are:

1. Prevent Chronic Disease, Focus Area 1: Healthy Eating and Food Security, Focus Area 4: Preventive Care and Management
2. Promote Healthy Women, Infants, and Children, Focus Area 2: Perinatal and Infant Health, 4: Cross Cutting Healthy Women, Infants, and Children
3. Promote Well-Being and Prevent Mental and Substance Use Disorders, Focus Area 1: Promote Well-Being, Focus Area 2: Prevent Mental and Substance Use Disorders

Disparities and Health Equity

Health equity occurs when every person has fair and just opportunities for optimal health and well-being. While Tompkins County is recognized as one of the healthiest counties in New York State per County Health Rankings, local and state-level data sources show significant disparities, or differences across different populations in health indicators, health outcomes, and healthcare access. Health and healthcare disparities are strongly related to the social determinants of health, stemming from socioeconomic inequities and systemic barriers that disproportionately impact people by race, ethnicity, gender, sexual orientation, disability status, geographic location, and more.

It is clear from Prevention Agenda Dashboard data and additional data presented in the Community Health Assessment (CHA), racial health disparities exist Tompkins County, with Black and Hispanic community members experiencing some of the greatest inequities. It is important to note that racial disparities are the result of persistent structural inequities and systems of oppression. Black and Hispanic residents of Tompkins County are significantly more likely to be affected by poverty than White residents, but even when controlling for income,

racial health disparities still exist and deserve targeted interventions across individual, institutional, and structural levels.

In Tompkins County, poverty and financial barriers consistently underly unmet needs across all Focus Areas. In a community with a relatively high cost of living and a lack of available, affordable housing, financial insecurity translates quickly to housing insecurity, food insecurity, and difficulty accessing needed healthcare services. Community members recognize affordable healthcare, housing, and healthy food as central to a healthy community. In fact, equitable, affordable healthcare and affordable, safe housing were identified by survey respondents as the top two most important factors that create a healthy community.

Access to healthcare and social services and additional resources can be limited for a number of reasons. Geographically, services and resources tend to be clustered in a few areas of the county, and transportation options are limited across rural areas and the City of Ithaca. Just getting to a medical appointment can be a challenge, especially for people using public transportation who might need to take up to whole day off work, find and pay for childcare, and would have limited ability to stop by a pharmacy to pick up any medications they need. Limited transportation and other barriers can prevent individuals from getting the healthcare and resources they need to live their healthiest lives.

We commit to the following goals, objectives, and strategies to improve health outcomes, enable well-being, and promote equity across the lifespan for all members of our community, as outlined in the Prevention Agenda. The interventions described here will be implemented with an intent focus on identifying, addressing, and eliminating disparities in order to achieve community health equity.

Process and Criteria

Tompkins County Whole Health (TCWH) convened a Steering Committee to advance the objectives of the 2019 CHIP, and this committee has continued to guide the planning and development process for this CHIP. The committee includes representatives from TCWH, Cayuga Health (Cayuga Health and Cayuga Health Partners), Health Planning Council (Human Services Coalition), County Office for the Aging, County Mental Health Services, Tompkins County Youth Services, Cornell Master of Public Health program, Cornell Cooperative Extension of Tompkins County, and NYS Public Health Fellows. This committee met in person monthly and communicated via email, phone, and Google Drive/Microsoft OneDrive throughout the process.

To inform the decision-making process for selecting the CHIP focus areas, the Steering Committee drew on their professional expertise and organizational experience, their extensive review of secondary and primary data, and their personal experience as residents of Tompkins County. On November 3, 2022, the Steering Committee met to conduct a virtual “data walk” to

review the results of the Community Health Survey and multiple additional sources of county data. We conducted a Menti poll of the committee to determine the focus areas of most interest based on the review of data and discussion.

On November 14, 2022, the Steering Committee presented at the Health Planning Council and conducted a Menti poll about the different focus areas to solicit existing interventions or ideas for activities related to the goals. The Health Planning Council represents over 20 community organizations in Tompkins County. The Menti results and a follow up survey were reviewed, and priority interventions were included in the CHIP matrix. Additional suggestions are included in this narrative.

Progress on 2019-2021 Community Health Improvement Plan (CHIP)

In February 2020, just a few weeks before the World Health Organization declared COVID-19 a pandemic, Samantha Hillson, Director of Health Promotion and Public Information Officer, and Ted Schiele, Planner, presented the 2019 CHA and CHIP to a crowded room of health and human service professionals, and other members of the Tompkins County community. In addition to describing three community health priority areas that had been identified by a participatory CHA process, their presentation was a call to action, welcoming and encouraging the community to engage with the plan, a plan that is intended to be a dynamic document.

The evidence-based interventions that were recommended in the CHIP would not be effective without collaboration across organizations and sectors nor without meaningful input from the communities the interventions are intended to benefit. The CHIP steering committee proposed the formation of working groups to foster transparency, participation, accountability, and inclusion in the implementation and evaluation of our CHIP. The committee did not anticipate that this work would need to be put on hold for close to a year in order to effectively manage pandemic response.

Two very important things happened during this year: 1) effective collaboration for emergency response across public health, healthcare, human services, and higher education was accelerated in ways we never could have imagined; 2) COVID-19 shined a spotlight on the health inequities throughout the nation and called upon all public health professionals to view our work through this lens. With this imperative, in December 2020, the Tompkins County Whole Health and Cayuga Health turned the course of our county's CHIP to make health equity the first value in all of our community health interventions, beginning with racial equity.

We formed a Steering Committee for the CHIP with the following functions:

- **Engagement:** Developing outreach strategies to facilitate ongoing partnership with the community, including being present and listening to gather qualitative data (stories, observations, shared input), and establishing opportunities for ongoing and future

community involvement, such as community advisory boards, outreach workers, volunteers, and ambassadors.

- **Data Collection:** Developing a process for collecting and analyzing quantitative data to define our racial equity deficit and evaluate the efficacy of interventions.
- **Leadership:** Creating working groups for each CHIP intervention to facilitate planning and procedure for collecting both quantitative and qualitative data, intervention planning, and cultural competency. Working groups will be supported by the Steering Committee both individually and collectively through consultation, feedback, and community networking.

Four CHIP interventions, 1) screening for food insecurity, 2) removing barriers to cancer screening, 3) increasing access to prenatal care, and 4) increasing access to primary care via school-based healthcare, were identified by the CHIP Steering Committee to be the focus of the working groups. Each working group consisted of professional and non-professional members with content or context expertise.

The working group chairs kicked off their first meeting with the following discussion questions:

- If this is an existing intervention, what is its status during the pandemic?
- How has this intervention changed or how does it need to change in light of COVID and structural racism?
- How does this intervention/work address health? Racial equity?
- What data (qualitative or quantitative) do we have or need to better understand the structural barriers that exist?
- Who else needs to be involved in this conversation?
- What are next steps/action items?

CHIP Intervention Working Groups

Food Insecurity Screening / Social Determinants of Health Working Group

Food insecurity can adversely impact individual and population health outcomes. The New York State Prevention Agenda highlights national recommendations to screen for food insecurity in clinical settings and create effective systems for referral to help individuals and families access services and benefits for which they eligible. Screening can ensure timely referral to public health nutrition programs such as WIC, SNAP, and, if necessary, local emergency food services. Screening and referral alone, however, may not be sufficient. Successful case studies of screening and referral programs for food insecurity use online referral systems or staff resources to facilitate connection, application, and enrollment in the appropriate public health nutrition or community program.

This working group was formed to support and monitor a new social needs screening and referral program being piloted by Cayuga Health's Internal Medicine Residency Program in

collaboration with Cayuga Health Partners, the Human Services Coalition of Tompkins County, Cornell's Master of Public Health Program and Cornell's Center for Health Equity. This program was selected because it was the first of its kind in the county, and it included food insecurity screening and facilitated and actively supported referrals to address food insecurity.

Beginning January 2021, patients who saw a physician at Cayuga Primary Care Internal Medicine of Trumansburg Road for their annual well-visit received an 8-question, Yes/No screening form. The first question asked about food insecurity:

> "In the last year, did you ever eat less than you wanted to because there was not enough money for food?"

If a patient answered Yes to this question (or any of the other questions on this form), they received a community resource brochure that included 2-4 programs or services per social determinant of health domain.

Beginning April 2021, in addition to being offered a community resource brochure, patients were asked if they would like to receive assistance from a Community Health Worker to address their unmet social needs. Three additional CMA primary care offices soon added the screening to their patient workflow. Of these four practices, only one had an embedded community health worker to directly assist patients with identifying the most appropriate community resources to address their needs.

In 2022, two social needs referral programs were piloted – one in partnership with the Human Services Coalition's Community Health Advocates Program and the other with Cornell Cooperative Extension's Student Resource Navigator Program. These pilot programs are using Cayuga Health Partners' online referral management system, PtRefs, to send referrals from the primary care practices directly to the Community Health Advocates and Resource Navigators. The data collected from the pilot programs will inform the development of a social needs screening and referral program for Cayuga Health in response to Joint Commission requirements effective January 1, 2023.

The next step for this working group is to enhance the training on social determinants of health and social needs screening and referral programs provided to the healthcare providers. The training will be designed to increase provider confidence in talking with their patients about unmet social needs, improve provider understanding of how patients' unmet social needs might impact treatment plans, and improve provider ability to explain the value of working with a Community Health Worker, Resource Navigator or Community Health Advocate.

Cancer Screening

The 2019 CHIP identified three key actions to increase cancer screening rates in Tompkins County: 1) Finalize construction of a more accessible medical facility with primary care and

imaging services in downtown Ithaca, 2) Host the Lourdes Mobile Mammography van in at least 4 locations in Tompkins County, and 3) Put systems in place for patient and provider screening reminders.

An interprofessional working group was set up to a) gather more data to better understand barriers to cancer screening from the perspective of physicians, practice managers, and community members from population groups with low screening rates and b) prioritize and tailor population-specific solutions to those barriers. Through a research partnership with Cornell's Master of Public Health Program, the working group has completed an assessment of barriers and facilitators to cancer screening, including policies and practices, at the primary care practice level via interviews with physicians and practice managers. Based on the findings from the interviews and a review of the scientific literature, we have co-created preliminary recommendations for CHIP partners and developed an interview guide to assess population specific concerns about and solutions to improve cancer screening in Tompkins County.

The next step is to refine the recommendations based on community member interviews and support the implementation and evaluation of the recommendations selected in 2023.

Prenatal Care

The Prenatal Care Working Group was established with the overarching goal to reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and to promote health equity for maternal and child health populations in Tompkins County. The group was comprised of staff and patient stakeholders from Cayuga Health, OBGYN & Midwifery Associates, the Doula Collective, Mama's Comfort Camp, Planned Parenthood, Human Services Coalition of Tompkins County, Tompkins County Whole Health, and Cayuga Health Partners. The focus of the group was to 1) enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children and families across the life course, and 2) improve access to comprehensive and person-centered prenatal care for birthing families.

After working together for several months to articulate a vision and shared goals for equitable and compassionate prenatal care in Tompkins County, members were able to support the development of an application for New York State Department of Health funding to launch a 5-year Perinatal Infant Community Health Collaborative in July 2022 with Tompkins County Whole Health as the lead agency, in partnership with Cayuga Health, the Human Services Coalition of Tompkins County, and Cornell Cooperative Extension of Tompkins County.

School-Based Health

The School-Based Health Working Group was organized to address racial, ethnic, economic and geographic disparities in child health outcomes and promote health equity for school-aged

children in Tompkins County. More specifically, the group tasked themselves with assessing the feasibility of a school-based health program, with an emphasis on mental health supports, at school districts in Tompkins County. The group reviewed and assessed successful models and funding opportunities for school-based telehealth and school-based mental health. Ultimately, the group developed a proposal to launch a school-based telehealth program that would support COVID response, primary care services, and mental health services in collaboration with Tompkins-Seneca-Tioga BOCES. The team implemented a free test and vaccination program in the schools and developed guidelines to reduce the spread of COVID while keeping children in school as much as possible. Working together, they formed an infrastructure that was strong and dedicated to improving health equity in our county.

GOALS, OBJECTIVES, AND INTERVENTION STRATEGIES AND ACTIVITIES

The NYS Prevention Agenda provides guidance for addressing the Focus Areas. Goals and objectives that span the needs and opportunities of each Focus Area are defined, and intervention strategies and process measures are identified. The goals for this Community Health Improvement Plan (CHIP) are as follows:

NYS Prevention Agenda Priority	**Focus Area**	**Goal**	**Disparities Addressed**
Prevent Chronic Disease	CD-1: Healthy Eating and Food Security	CD-1.3: Increase food security	Poverty/ low income; Town of residence/ geography
	CD-4: Preventive Care & Management	CD-4.1: Increase cancer screening rates for breast, cervical, and colorectal cancer screening CD-4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	Poverty; Residence/ geography; Race
Promote Healthy Women, Infants, & Children	HWIC-2: Perinatal and Infant Health HWIC-4: Cross Cutting Healthy Women, Infants, & Children	HWIC-2.1: 2.1: Reduce infant mortality & morbidity HWIC-4.1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations	Poverty (Medicaid beneficiary); Race; Residence /geography
Promote Well-Being & Prevent Mental Health and Substance Use Disorders	WB-1: Promote Well-Being	WB-1.1: Strengthen opportunities to build well-being and resilience across the lifespan WB-1.2: Facilitate supportive environments that promote respect and dignity for people of all ages	Poverty; Social isolation; Persistent mental illness

	WB-2: Prevent Mental and Substance Use Disorders	WB-2.2: Prevent opioid overdose deaths WB-2.3: Prevent and address adverse childhood experiences WB-2.5: Prevent suicides	Poverty; Residence/ geography; Race Persistent mental illness

The objectives, interventions, and process measures for each goal are outlined in the CHIP matrix.

Health System, Local Health Department, and Community-based Organization Collaborative Actions and Impacts

During the 2022-2024 timeframe, Cayuga Health (CH) and the Local Health Department (Tompkins County Whole Health – TCWH) will work in collaboration with additional county agencies and community-based organizations to address numerous health needs identified in the CHA through the strategies outlined below. Collectively referred to in this document as the Tompkins County CHIP partners, these collaborators include the CHIP Steering Committee and additional partner organizations. For the implementation of CHIP strategies, TCWH and CHS will facilitate meetings, organize collaborative efforts, and work closely with the CHIP Steering Committee and related organizations to track progress toward shared goals. For a list of key partners, please refer to the CHIP matrix.

Through evidence-based and best practices in health promotion and community health, the Tompkins County CHIP partners will address the following: the promotion of healthy eating and food security; the prevention and management of chronic diseases, specifically screening for breast, cervical, and colorectal cancers; the promotion of healthy women, infants, and children; and the promotion of well-being and prevention of mental and substance use disorders. The interventions and initiatives described below will be implemented by the Tompkins County CHIP partners, and their impact will be monitored and evaluated by the CHIP Steering Committee.

PREVENT CHRONIC DISEASE

Focus Area 1: Healthy Eating and Food Security

Circumstances that lead to a lack of food security involve many factors: poverty, inability to access food distribution resources, falling just outside the lines for eligibility for food incentive programs, sudden expenses or changes in family or household status, or not having access to a store with a variety of nutritious or culturally appropriate foods. Regardless of the underlying cause, inadequate options to maintain a healthy diet will always have a negative impact on overall health for children and adults, including learning and productivity.

Goal 1.3: Increase Food Security

As revealed through data in the Community Health Assessment (CHA), food security is an issue for a significant segment of the Tompkins County population. Many community-based organizations, social service providers, schools, and programs have initiatives underway to address this challenge. In 2022, the Tompkins County Food System Plan was unveiled following an extensive community engagement process. The vision of the plan is to create a food system that is resilient, equitable, healthy, and affordable for all members of our community. The 3 directions of the plan include: Build Resilience, Cultivate Equity and Economic Opportunity, and Promote Human and Ecosystem Health.

Prevention Agenda (PA) interventions:

- 1.0.5: Increase the availability fruit and vegetable incentive programs.
- 1.0.6: Screen for food insecurity, facilitate and actively support referrals.

During this timeframe, Tompkins CHIP partners will do the following:

- Implement a tool for universal screening for health-related social needs (including food security) in healthcare settings. The tool will be implemented in organizations, including Tompkins County Whole Health (TCWH) and the Human Services Coalition of Tompkins County.
- Develop a system for tracking closed-loop referrals for individuals experiencing food insecurity to receive assistance with accessing/enrolling in nutrition assistance programs and fruit and vegetable incentive programs (e.g., Produce Prescription Program via health care referrals, Farmers Market Nutrition Program, Senior Farmers Market Nutrition Program, SNAP, and WIC). Partners include, CCE Tompkins, County Office for the Aging, Catholic Charities, Foodnet Meals on Wheels and TCWH.
- In partnership with the Rural Health Network of South Central NY, increase the availability of produce prescriptions for Tompkins County residents with food insecurity and diet-related chronic disease.
- Performance will be monitored with following measures:
    - # of organizations that adopt policies and practices to screen for food insecurity and actively support referrals.
    - # of referrals enrolled in nutrition assistance programs and fruit and vegetable incentive programs.
    - # of healthcare providers that receive vouchers to enroll patients in the produce prescription program.

The interventions above will address disparity including poverty, geographic location, and race/ethnicity.

Focus Area 4: Chronic Disease Preventive Care and Management

Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both. Chronic diseases such as cardiovascular disease, cancer, and diabetes are the leading causes of death and disability in the United States. They are also leading drivers of the nation's $4.1 trillion in annual health care costs.

The burden of cardiovascular disease, cancer, and diabetes is not distributed evenly. The risks of developing or dying from heart disease, cancer or diabetes are linked to a variety of social determinants of health, such as race, ethnicity, gender, sexual orientation, age, disability, socioeconomic status, and geographic location.

Goal 4.1: Increase cancer screening rates

Barriers to cancer screening are a key driver of cancer health disparities. Not getting screened for cancer as recommended can result in cancer being found at a late stage, when it's harder to treat. Unfortunately, many adults in the US as well as in Tompkins County are not getting the recommended screening tests for colorectal, breast, and cervical cancers. The Community Preventive Services Task Force and New York State Prevention Agenda recommend several interventions to increase screening for breast, cervical, and colorectal cancers. They include actions designed to reach patients and those designed to reach health care providers. Evidence suggests that combining two or more strategies increases community demand for and access to cancer screening.

In 2023, the Tompkins County Cancer Screening Working Group aims to implement culturally tailored and evidence-based strategies to increase cancer screening awareness, access, and uptake among different population groups in Tompkins County for whom screening is recommended. Cancer Screening Working Group members include staff and patient stakeholders from Cayuga Health, Cayuga Health Partners, Cancer Resource Center of the Finger Lakes, the Human Services Coalition of Tompkins County, Tompkins County Whole Health, and Cortland County Health Department.

Informed by interviews with physicians, outpatient practice managers, and community members, they will work with Cornell Master of Public Health students and faculty to develop a programmatic or policy solution that leverages community assets to reduce or eliminate socioeconomic and structural barriers to cancer screening and increase cancer screening rates among a specific population group for either breast, cervical or colorectal cancer.

PA interventions include:

- 4.1.1 Work with health care providers/clinics to put systems in place for patient and provider screening reminders (e.g., letter, postcards, emails, recorded phone messages, electronic health records [EHR] alerts).
- 4.1.4 Work with clinical providers to assess how many of their patients receive screening services and provide them feedback on their performance.
- 4.1.5 Remove structural barriers to cancer screening such as providing flexible clinic hours, offering cancer screening in non-clinical settings (mobile mammography vans, flu clinics), offering on-site translation, transportation, patient navigation and other administrative services.

During this timeframe, Tompkins CHIP partners will do the following:

- Promote or host mobile mammography vans at least 4 times in Tompkins County
- Collaborate with transportation partners to identify options for individuals who need a ride to and from a colonoscopy procedure
- Implement improvements in patient and provider screening reminders at 3 primary care practices
- Offer extended clinic hours for mammograms at one of its imaging centers
- Improve interpretation services and translation of print materials at Cayuga Health's imaging locations adding at least 5 languages to the print materials most utilized by patients
- Distribute performance report cards to 100% of clinical providers to assess the % of patients who are eligible for screening and who have completed their screening.

Performance will be monitored with following measures:

- # mobile mammography van events promoted.
- Agreement in place with transportation partner
- # primary care practices that receive cancer screening reminder quality improvement training
- # imaging locations with extended hours for mammograms.
- # imaging locations with improved interpretation services.
- % primary care physicians who receive report cards for cancer screening performance

Goal 4.2: Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity

A cluster of conditions, commonly referred to as metabolic syndrome, raises the risk of developing diabetes, heart disease, stroke, or all three.

According to the National Heart, Lung and Blood Institute (NHLBI), the cluster of risk factors involved includes:

- Abdominal obesity. This means having a waist circumference of more than 35 inches for women and more than 40 inches for men. An increased waist circumference is the form of obesity most strongly tied to metabolic syndrome.
- High blood pressure of 130/80 mm Hg (millimeters of mercury) or higher. Normal blood pressure is defined as less than 120 mm Hg for systolic pressure (the top number), and less than 80 mm Hg for diastolic pressure (the bottom number). High blood pressure is strongly tied to obesity. It is often found in people with insulin resistance.
- Impaired fasting blood glucose. This means a level equal to or greater than 100 mg/dL
- High triglyceride levels of more than 150 mg/dL. Triglycerides are a type of fat in the blood.
- Low HDL (good) cholesterol. Less than 40 mg/dL for men and less than 50 mg/dL for women is considered low.

About one in three adults has metabolic syndrome. Because its symptoms can be hard to spot, it's important for people to know the risk factors (see list below), get screened, and see a doctor for diagnosis and treatment.

- Have prediabetes. Prediabetes is a serious health condition where blood sugar levels are higher than normal, but not high enough to be diabetes. More than 1 in 3 American adults have prediabetes. Nearly 90% do not know they have it.
- Are overweight. Are 45 years or older.
- Have a parent, brother, or sister with type 2 diabetes.
- Are physically active less than 3 times a week.
- Have ever had gestational diabetes (diabetes during pregnancy) or given birth to a baby who weighed over 9 pounds.
- Are an African American, Hispanic or Latino, American Indian, or Alaska Native person. Some Pacific Islanders and Asian American people are also at higher risk.

To increase early detection of cardiovascular disease, diabetes, prediabetes and obesity, Tompkins County CHIP partners will promote strategies that improve the detection of undiagnosed hypertension and promote testing for prediabetes and risk for future diabetes in asymptomatic people in adults of any age with obesity and overweight and who have one or more additional risk factors for diabetes. CHIP partners will collaborate with an existing Diabetes Population Health Working Group convened by Cayuga Health.

PA interventions include:

- 4.2.1 Promote strategies that improve the detection of undiagnosed hypertension in health systems.
- 4.2.2 Promote testing for prediabetes and risk for future diabetes in asymptomatic people in adults of any age with obesity and overweight and who have one or more additional risk factors for diabetes.

More specifically, Tompkins CHIP partners will do the following:

- Coordinate at least one community-based health screening event per month in different geographic regions of the county in partnership with Food Bank of the Southern Tier, Latino Civic Association, Calvary Baptist Church, Southside Community Center, and other community partners. Staff at each health screening event will include:
    - At least one clinical staff to provide blood pressure screening, point-of-care HbA1c testing, and answer medical questions,
    - At least one community health worker or other community-based organization staff to provide resources that address health-related social needs and support program enrollment, and
    - At least one Cayuga Health Network Access Center staff to schedule appointments with primary care.
- Performance will be monitored with following measures:
    - # health screening events hosted
    - # community members who receive blood pressure screening at an event
    - # community members who receive HbA1c testing at an event
    - # community members who schedule a primary care appointment at an event

The interventions above will address disparity including poverty, geographic location, and race/ethnicity.

PROMOTE WELL-BEING AND PREVENT SUBSTANCE USE DISORDERS

Focus Area 1: Promote Well-Being

"Well-being is a relative and dynamic state where one maximizes his or her physical, mental, and social functioning in the context of supportive environments to live a full, satisfying, and productive life. Well-being is based on the relationship between social determinants of health and person's experiences with quality of life." [Prevention Agenda 2019-2024, ver. 1.3, 4/25/2019, p.207]

Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan

Reducing the stigma that is historically associated with poor mental health and mental illness requires communities to better understand how to recognize when someone is in crisis or having difficulty coping, and how to approach the individual in a manner that does not exacerbate the event or push the individual away.

A core question in the Behavioral Risk Factor Surveillance Survey is, "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many

days during the past 30 days was your mental health not good?" The resulting indicator, "percentage of adults with poor mental health for 14 or more days in the last month," underlies all of the objectives and interventions for Goal 1.1. The "14+ days" rate for 2018 in Tompkins County was 12.7% of adults, up from 12% in 2016.

Based on intervention 1.1.2, support housing improvement, affordability and stability through approaches such as housing improvement, community land trusts and using a "whole person" approach in medical care, the Tompkins County CHIP partners will do the following:

- Tompkins CHIP partners will have documented information about local housing, including residential supports available to advocate for additional emergency and supportive housing solutions, and made this information accessible to all partners through shared docs or on a website. This is in an effort to restore OPWDD residential beds lost during COVID. This is a goal in the Mental Health Services Plan.
- The Community Capacity committee will maintain regular (up to weekly) capacity-building meetings between Cayuga Health and key partners including community skilled nursing and other facilities, Visiting Nurse Service, transportation providers. Meetings focus on upcoming discharge planning needs, barriers to transition between hospital and facilities, and situational awareness of each partner's capabilities and challenges at that point in time. Extended planning to longer-term partnerships including workforce, communications, and system efficiencies and improvements.
- Performance will be monitored with following measures:
    - # of OPWDD beds restored
    - # of successful discharge plans to beds

Associated Activities:

- Coordinate with the Continuum of Care to participate in a working group and support initiatives to increase safe, affordable housing for those unhoused or unstably housed in our community, and have a model for continued support services to meet health-related social needs. Process measure: number of working groups for CoC and number of people housed.
- Complete an activity with the Youth Homeless Demonstration Project, an initiative that involves youth in the decision-making project. Process measure: one collaborative activity completed, number of people housed.
- The social engagement subcommittee of the Long-term care committee will disseminate an informational brochure throughout the County to build awareness about social opportunities in the County.
- Review TC Housing Plan and the CoC Homeless Needs Assessment and Plan to better understand goals and objectives.

Based on intervention 1.1.4, support programs that establish caring and trusting relationships with older people.

County Office for the Aging will lead the following with support from Tompkins CHIP partners:

- The Senior Planet tablet program is focused on individuals who are low-income, rural, socially isolated, and do not understand how to use a computer and other technology. 20 clients will be matched with friendly visitors to engage and teach the participant how to engage with the program.
- Performance will be monitored with following measures:
    - # of participants in the Senior Planet tablet program.

The interventions above will address disparity including poverty, geographic location, race/ethnicity, and age.

Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages

Supportive environments are critical for people to maximize their physical, mental, and social functioning. These environments can take form in different settings from someone's home, to workplace, to social service agency, to walking on the street. In all settings, no matter one's housing status, gender identity, race, ethnicity, age, socioeconomic status, education level, or disability should be given respect and dignity. Interventions to improve the public's mental health should be delivered before a disorder manifests itself and focused on creating supports that prevent the development of disorders. NYS's report: *Chronic Disease: Contributing Causes of Health Challenges*, notes promoting community support and social acceptance increases well-being. People experiencing poor well-being, disability, and mental, emotional, and behavioral disorders (MEB) are often faced with prejudice, bias, discrimination, lack of empathy, and policies that limit their opportunities. (https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/sha/contributing_causes_of_health_challenges.pdf#page=2)

The objective for this goal uses the Opportunity Index and the Community Score as the data point (https://opportunityindex.org/). Tompkins County's Community Score is 57.4 (2022). The objective for NYS is to increase the Community Score by 7% to 61.3%. The Community dimension looks at factors affecting community health and civic life. Included are the percentage of teenagers not working and not in school, community safety, access to primary healthcare, incarceration, and availability of healthy foods. A score has been generated based on these indicators compared against the national average.

Intervention 1.2.1 refers to implementing evidence-based **home visiting programs**.

Tompkins CHIP partners will do the following:

- The Perinatal and Infant Community Health Collaboratives (PICHC) will conduct at least 60 home visits per month and 25 clients per CHW for birthing people and

implementation of elements of Stress-Free Zones to support people to make informed choices about their pregnancy.
- SafeCare will conduct 84 home visits and education modules annually for families enrolled in the program through Family Treatment Court.
- MOMS Plus will conduct at least 80 nursing home visits per month and 70 clients annually for pregnant people and those with infants.
- The Home Health Aide funded by Tompkins County Office for the Aging (COFA) will conduct 35 home visits annually to serve clients on a waiting list due to lack of agency aides (started in Nov 2021). This program serves individuals with low-income and minority target populations.

The process measures for the interventions above are related to the number of home visits conducted.

1.2.2 Implement Mental Health First Aid

Tompkins CHIP partners are continuing their efforts towards the expansion of Mental Health First Aid Training to target at-risk individuals and their families. By doing so, Tompkins CHIP partners hope to create and foster partnerships among families, service and health care providers to promote and support the early detection and recognition of mental health disorders and substance use. To strengthen its efforts, CHIP partners will continue to work alongside the Mental Health Assocation of Tompkins County, Franziska Racker Centers, local school districts, and local pediatricians and primary care providers.

PA intervention: 1.2.2 Implement Mental Health First Aid

Tompkins County CHIP partners will do the following:

- Training for employees and community members. Create a registry of local organizations, programs, and departments committed to training their staff. The process measure is based on number of trainings offered, number of people trained, and the number of local organizations where all or a majority of staff have completed the training course.

1.2.3 Policy and program interventions that promote inclusion, integration and competence.

Core to the new mission of Tompkins Whole Health, CHIP partners are working to promote inclusion, diversity, integration, and equity. Drawing on the expertise of those with lived experience to inform programs/services, and be included in decision-making processes.

Tompkins CHIP partners will do the following:

- Engage people with lived experience in program development and decision-making to form a Working Group that provides advisory and oversight support for Perinatal and

Infant Community Health Collaboratives (PICHC) Initiative in Tompkins County. The group will establish a quarterly meeting.

- In alignment with the Mental Health Local Services Plan (LSP), implement non-clinical supports, including the work of peers with lived experience, to address social determinants of health (access to medical dental, optical care) and promote health equity for minoritized communities, to support recovery and quality of life.
- Complete training for Whole Health (LHD) staff as part of a comprehensive Diversity, Equity, and Inclusion framework (eg. motivational interviewing, trauma-informed care, health literacy, cultural humility and SDOH).
- Complete at least 5 trainings in the community of the evidence-based OWLS organizational workplace and wellness program - Resilience to Thriving. Training of 1-2 more staff to facilitate this program. Coordinated by the Alcohol and Drug Council.
- Performance will be monitored with following measures:
    - # of people with lived experience who participate in the advisory group.
    - # of peer supports with lived experience
    - # of DEI trainings offered.
    - # of Resilience to Thriving and Ripple Effect community trainings offered.

The interventions above will address disparity including poverty, geographic location, and race/ethnicity.

Focus Area 2: Mental and Substance Use Disorders Prevention

Goal 2.2 Prevent opioid overdose deaths

Tompkins County continues to experience the effects of the overdose epidemic. After two years of decreasing overdose deaths, from 22 deaths in 2017 to 18 deaths 2018 and 17 deaths in 2019, numbers began to climb again with 19 deaths in 2020 and an all-time high of 25 deaths in 2021. Preliminary 2022 data shows numbers similar to 2021. Multiple factors affect the rate of overdose in our community, including the impact of the COVID-19 pandemic beginning in 2020 and the presence of fentanyl and sedatives in the illicit opioid supply. Fentanyl has been increasingly found in other types of illicit drugs as well, such as cocaine, methamphetamine, and illicitly manufactured pills, including benzodiazepines and other psychostimulants.

The CDC outlines guiding principles and evidence-based strategies for communities to prevent opioid overdose, with collaboration as a key overarching strategy. Additional strategies for effective overdose prevention include: targeted naloxone distribution, access to medications for opioid use disorder (MOUD)/medication assisted treatment (MAT), academic detailing for the adoption of best practices in healthcare settings, and syringe service programs.

In order to prevent overdoses and overdose deaths, Tompkins County CHIP partners will increase community-wide collaboration in order to leverage and build upon existing resources in

our community, and to center the voices of people with lived experience. TCHW, CHS, and additional CHIP partners will expand access to evidence-based overdose prevention strategies and support for people at risk for overdose, improve the tracking and utilization of local data, and provide relevant training for healthcare and behavioral health staff.

Interventions include:

- 2.2.1 Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine
- 2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers
- 2.2.6 Integrate trauma informed approaches in training staff and implementing program and policy
- 2.2.4 Build support systems to care for opioid users or at risk of an overdose

Associated activities include:

- Convene cross-sectional stakeholders as part of Opioid Task Force to establish shared, community-wide goals using baseline database described above
- Complete a needs assessment and establish data baselines for opioid deaths, buprenorphine prescriptions, naloxone trainings and distribution, and trauma-informed care trainings for behavioral health and healthcare providers, to improve collaboration between sectors for tracking and reporting mechanisms
- Provide training to healthcare and behavioral health staff in trauma-informed care and how to reduce stigma associated with substance use disorders.
- Ensure naloxone availability across all Cayuga Health and Tompkins County Whole Health (LHD, LGU) healthcare settings and train at least 25% of staff in its use
- Increase access to existing services and addiction medicine education and consultation

Performance will be monitored with following measures:

- # of overdose deaths
- # of ED visits for overdose
- Demographics of ED visits for overdose
- Demographics of overdose deaths
- # community naloxone trainings

Goal 2.3 Prevent and address adverse childhood experiences

Ever increasing research demonstrates that Adverse Childhood Experiences (ACEs) are widely common and impact lifelong health and opportunities. As the CDC describes, ACEs are potentially traumatic events that occur in childhood. ACEs can include violence, abuse, and growing up in a family with mental health or substance use problems. Toxic stress from ACEs can change brain development and affect how the body responds to stress. ACEs are linked to

chronic health problems, mental illness, and substance misuse in adulthood. However, ACEs can be prevented. National estimates indicate that at least 61% of adults had at least one ACE and 16% had 4 or more types of ACEs.

Preventing ACEs can help children and adults thrive and potentially lower the risk of chronic physical and mental health conditions, improve education and employment outcomes, and prevent the intergenerational transmission of ACEs. Strategies can increase awareness, change how people think about ACEs, and help us understand how we can prevent ACEs and better support people with ACEs. By shifting the focus from individual responsibility to community solutions, we can reduce stigma and promote safe, stable, nurturing relationships and environments where children live, learn, and play.

Interventions include:

- 2.3.1 Integrate principles of trauma-informed approach in governance and leadership, policy, physical environment, engagement and involvement, cross sector collaboration, screening, assessment and treatment services, training and workforce development, progress monitoring and quality assurance, financing and evaluation.
- 2.3.3 Grow resilient communities through education, engagement, activation/mobilization and celebration.
- 2.3.4 Implement evidence-based home visiting programs: These programs provide structured visits by trained professionals and paraprofessionals to pregnant women and families, particularly those considered at-risk, necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn.

Associated activities include:

- Establish a new Community Health Integration Work Group with a cross-sector partners to develop a countywide strategy to increase Community Health Worker professional development opportunities, including training on trauma-informed approach.
- Pilot and document 3+ workflows, including person-centered resource navigation services following screening in health care settings.
- Schedule direct education and engagement opportunities for families to build and celebrate resilience skills, including 7 parenting education workshop series through Cornell Cooperative Extension Tompkins County.
- MOMS Plus will conduct at least 80 nursing home visits per month and 70 clients annually for pregnant and postpartum people and those with infants, using the evidence-based Survivor Mom’s Companion curriculum for expectant and new parents who have experienced trauma.

Performance will be monitored with following measures:

- # trainings offered including principles of trauma-informed approach
- # organizations with staff participating in trauma-informed approach trainings,
- # health care practices linking patients to person-centered resource navigation services

- # educational workshops and home visits to build parenting and resilience skills

Goal 2.5 Prevent suicides

Zero Suicide Model of Care

CHIP partners are largely involved in the Zero Suicide Initiative. In July of 2018, Tompkins County became one of the first counties in New York to adopt this model, and Cayuga Health implemented the model in early 2019. Tompkins County Zero Suicide Steering Committee, formed in November 2022, as part of the Suicide Prevention Coalition.

The model was developed to ensure that health care systems adopt a "suicide safe" approach and acknowledge that many suicidal individuals often fall through the cracks of this fragmented system. The adoption of this model at Cayuga Health has been a major step towards better identifying at risk individuals and enabling medical staff and providers with skill-sets to better screen and support patients. By utilizing this model of care, CMC hopes to merge physical healthcare medicine with mental healthcare medicine to ensure a more holistic approach to mental health management.

The Tompkins County Suicide Prevention Coalition is comprised of health agencies, community organizations, and individual members who share a determination to prevent suicide deaths in our community. It is a collective of volunteers that strives for diverse and inclusive representation and encourages collaboration for achieving goals. The Coalition draws inspiration and purpose from The Watershed Declaration of 2017, a call to action by Tompkins County mental health leaders to renew our community's commitment to suicide prevention.

Interventions include:

- 2.5.2 Strengthen access and delivery of suicide care - Zero Suicide. Hold 4 quarterly meetings of the TC Zero Suicide Steering Committee
- 2.5.3 Create protective environments: Reduce access to lethal means among persons at risk of suicide; integrate trauma informed approaches, reduce excessive alcohol use. Distribute 200 gunlocks throughout Tompkins County.

Performance will be monitored with following measures:

- Number of actions by the Tompkins County Zero Suicide Steering Committee
    - # gunlocks distributed

PROMOTE HEALTHY WOMEN, INFANTS, AND CHILDREN

"Improving the well-being of mothers, infants, and children is an important public health goal for the United States. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system." - Healthy People 2020

Focus Area 2. Perinatal & Infant Health

Perinatal refers to the period immediately before and after birth. These early weeks are an important period for addressing the health of both mothers and infants. Key perinatal and infant outcomes such as preterm birth (<37 weeks gestation), low birth weight (< 2.5 kg), and infant mortality (the death of an infant before age 1) are inseparably linked to maternal health outcomes. Babies born too early (especially before 32 weeks) have higher rates of death and disability, including breathing problems, feeding difficulties, cerebral palsy, developmental delay, vision problems and hearing problems. The short and long-term challenges associated with preterm births may also take an emotional toll and be a financial burden for families.(https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm#:~:text=Preterm%20birth%20is%20when%20a,2020%20to%2010.5%25%20in%202021.)

In NYS's report: *Chronic Disease, Contributing Causes of Health Challenges*, a life course approach is referenced to recognize that early experiences and exposures during critical periods of development may "program" a person's future health and development, including reproductive health. These experiences may include the accumulation of ACES and toxic stress over one's life course. The report notes that persistent disparities in maternal and infant heath are in part due to chronic, toxic stress related to "pervasive and systemic racism in the US." (https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/sha/contributing_causes_of_health_challenges.pdf#page=2)

While Tompkins County's overall preterm birth rate in 2018 (7.6%) met NYS' Maternal & Child Health objective (8.3%), differences in preterm birth rates by race are alarming. Between 2017-2019, the rate of preterm birth among Black women (18.1%) was about 250 percent higher than the rate of preterm birth among white women (7.0%).(https://www.health.ny.gov/statistics/community/minority/county/tompkins.htm)

Goal 2.1: Reduce infant mortality and morbidity.

To reduce the percentage of births that are preterm among Black women, Tompkins County CHIP partners will implement Intervention 2.1.2: Increase capacity and competencies of local maternal and infant home visiting programs.

Activities will include the following:

- Finalize a Perinatal and Infant Working Group to provide advisory and oversight support for the Perinatal and Infant Community Health Collaboratives (PICHC) Initiative in Tompkins County.
- Community Health Workers (4 CHWs) provide support through home visits to improve outcomes for perinatal and infant health.
  - Home visiting programs are a cornerstone of public health efforts to support pregnant and parenting families. An extensive body of research demonstrates that evidence-based home visiting programs improve numerous short- and long-term outcomes for mothers, infants, and families. In New York State, local home visiting programs have been engaged in a variety of efforts to build capacity and improve effectiveness in key areas, including: increasing referrals, client enrollment, and retention; extending the duration of breastfeeding; and increasing home visitors' knowledge and skills related to key topics such as intimate partner violence, substance use, mental health, smoking cessation, self-care, and post-partum/interconception care.
- Concurrent, ongoing redesign of the Tompkins County MOMS Plus+ program resulting in increased capacity to deliver maternal child health supportive services to residents of Tompkins County regardless of insurance status, with a focus on providing equitable access to care.

The process measures for the interventions above will be based on the participation rates in PICHC and MOMs Plus+, as well as the ongoing monitoring of infant mortality and morbidity rates.

Focus Area 4: Cross Cutting Healthy Women, Infants, and Children

Focus Area 4, cross cutting healthy women, infants, and children, applies the necessity to reduce inequities to provide the healthiest start for all children. Health inequity happens when social determinants become a barrier to individual health, whether that's housing, income, education, or social connections. In Tompkins County, people who identify as white have a higher rate of prenatal care than people who identify as a person of color.

Goal 4.1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations.

Intervention 4.1: Enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families across the life course.

Tompkins CHIP partners will do the following:

- Local Health Department engaging with at least 20 key partners to emphasize insurance enrollment, supports for birthing families, and parenting skills, among other needs.
- Establish a baseline for indicators to measure changes in disparities in maternal and child health outcomes.
- Increase patient demographic data collection at Cayuga Health and 42 outpatient practices via the "We Ask Because We Care" campaign, improving Cayuga Health's ability to identify and address disparities (including in maternal and child health outcomes as cited above).

Performance will be monitored with following measures:

- Number of partners with TCWH PICHC and MOMS Plus+ Programs, maternal and child insurance rates, Child Health Plus enrollment rates as percent of eligibility

The interventions above address disparity including poverty, geographic location, race, ethnicity, and insurance status.

Additional Activities for Promote Healthy Infants, Women and Children

- Identify opportunities to improve patient experience with lactation education, increasing breastfeeding initiation and duration through lactation education quality improvement project with Cayuga Birthplace.
- Provide new optometry services for children at the Ithaca Free Clinic (IFC) beginning January 2023. Develop a Monitoring & Evaluation strategy to assess IFC's optometry service utilization. Develop 10 partnerships to refer patients to the program.

GEOGRAPHIC AREAS OF FOCUS

These interventions will impact Cayuga Health's combined service area (SA); CHS's Service Area System is composed of urban and rural communities that includes the counties of Tompkins and Schuyler, with sections of Cayuga, Cortland, Tioga, Chemung and Yates. The service area has a total population of approximately 212,000 individuals. Tompkins Whole Health service area includes the entirety of Tompkins County, population of 102,000.

Local Health Department resources to address the need

Tompkins County Whole Health will continue its commitment to addressing the root causes of disparities and social determinants of health through training for staff, facilitating supportive environments and providing services and programs to the community, and convening partners to better address complex issues facing our community. Whole Health will utilize existing staff, outreach programs and partnerships with community partners.

Hospital resources to address the need

In addressing the prevention and management of chronic diseases and continuing its commitment to promoting well-being, specifically surrounding mental health and substance use disorders, Cayuga Health will continue to utilize its existing staff members, outreach programs and initiatives, and its partnerships with external organizations.

Maintaining engagement, tracking progress, making corrections.

This CHIP was developed with and depends on the ongoing involvement of multiple agencies and workgroups. Through these workgroups and other collaborations, many of these stakeholders are in contact with TCWH, CHS, and each other on a regular or periodic basis. This provides multiple opportunities for engagement where tracking and discussion of course corrections can take place.

On a formal basis, the Director of TCWH's Health Promotion Program is the Chair of the CHIP Steering Committee, which will serve as a primary mechanism to monitor the CHIP and maintain engagement. A subset of the Steering Committee, including key partners and Public Health Graduate Fellows will develop a plan for quarterly tracking and review of data. In order to capture stakeholders who are not part of the Steering Committee, the Chair and key partners will provide updates and annual presentations to the Health Planning Council and other community forums as requested. At the same time, all interventions will be updated quarterly by direct contact with involved partners. These activities will themselves be tracked in a document that is accessible to the public via the TCWH website.

Presentation, access, and availability of the CHIP

Tompkins County Whole Health and Cayuga Health will work with the Health Planning Council (Rural Health Network) to develop an accessible visual version of the Executive Summary and highlights of the CHA/CHIP on the TCWH website and for dissemination to the public in Winter 2023. This guide, along with the entire CHA/CHIP, and relevant appendices will be available on the TCWH website. Links will be provided to any partner organizations who want to promote on their website or through social media.

Presentations will be requested at the following venues:

- Health Planning Council
- Cayuga Health Partners
- Tompkins County Legislature, Health and Human Services Committee
- City of Ithaca Common Council
- Human Services Coalition Forum
- Tompkins County Council of Governments
- Tompkins County Chamber of Commerce
- Rotary Club of Ithaca
- Faith-based partners

In addition, a press release will be issued to the TCWH media list. Notification will be posted on the local Human Services listserv, which is the primary accessible channel to the local nonprofit community. Information about the CHA/CHIP will be disseminated through Whole Health's GovDelivery platform with almost 30,000 subscribers. These notices will remind the public of access to the CHA/ CHIP online and invite groups to request presentations. TCWH will continue to present the CHA/CHIP process in related courses in the Cornell MPH Program and at Ithaca College, as requested. A subset of the CHIP Steering Committee will convene in early 2023 to develop a detailed communications plan for further dissemination.