Community Health Assessment 2019-2024
Community Health Improvement Plan 2019-2021

Tompkins County Health Department
Cayuga Medical Center
Ithaca, New York
December 27, 2019

CONTENTS

Executive Summary

Tompkins County is located at the southern tip of Cayuga Lake in the Finger Lakes region of New York State. It is part of the Southern Tier Economic Development Region, and is grouped by the New York State Department of Health (DOH) in the five-county Southern Tier region, along with Broome, Chenango, Delaware, and Tioga Counties. Tompkins jurisdictions include nine towns, seven villages, and one city, Ithaca. About 30% of the county's 104,000 population resides in the City of Ithaca.

There are three large post-secondary institutions within the county, Cornell University, Ithaca College, and Tompkins Cortland Community College. Total enrollment in college or grad school is 29,300, 28% of the county population. As a result, the county population is young, well educated, transient, and includes a significant foreign-born population. Nearly half of all households are non-family, and nearly half of all housing units are renter-occupied. The poverty rate among individuals living in non-family households is twice that of those in family households.

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, one 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. Focus groups conducted for the Community Health Assessment (CHA) indicates that healthcare is less accessible for people of color, and 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.

Collecting primary data directly from the community was new with the 2019-2024 CHA. Key among these was 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. Thirteen hundred surveys were initiated, and the median response rate across all questions was close to 1,100.

The results clearly demonstrate the influence that social determinants of health have on an individual's perception of their health.

To further support the survey results and add personal stories to the analysis, in depth interviews were held with 29 key stakeholders, and 32 community members participated in four focus groups, representing four constituencies: mothers, African Americans, college students, and rural residents.

A Steering Committee was convened to review and coalesce all data, and to propose what PA priorities and Focus Areas were in the best interest of the Tompkins County community. The committee included representatives from County Public Health, Mental Health, and Office for the Aging, Cayuga Health Systems, Health Planning Council, consultant Horn Research, Ithaca College, Cornell University, 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. The Fresh Snack Program, Farm to School, and Universal Breakfast are evidence-based programs that target food security among school children. Health care providers are implementing the Fruit & Vegetable Prescription program to adults with a chronic disease. Structural barriers to cancer screening will be met by improving how patients are reminded to act, and by adding clinics, using mobile clinics, and increasing clinic hours.

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, including in the home to support parents and young children in families at risk, in a clinical setting to teach individuals with persistent mental illness ways to build skills, and bring together those living with a chronic disease to learn and practice techniques to better manage their disease in a safe, social setting. These programs are SafeCare, PROS, and Harmonicas for Health, respectively.

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. While MHFA builds personal awareness and understanding of mental illness, the social environment must match and reinforce a culture of support without stigma. The CHIP intervention to "use thoughtful messaging…" will be implemented through social media, an anti-bullying taskforce, and County Youth Services' Action Plan.

Evaluating the impact of the goals, objectives, and interventions presented in this CHIP will take place through 2021. A steering committee will monitor short term process measures that track activities such as numbers of children served, schools involved, courses taught, and availability of certified practitioners. Community partners will have access to a reporting matrix that will be updated quarterly.

Community Health Assessment, 2019-2024

Description of 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)*

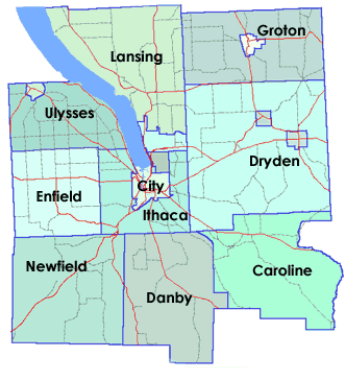

Figure 1

B02001: RACE 2012-2016 American Community Survey 5-Year Estimates	Population	White Alone	Black or African Am. Alone	Asian Alone	Hispanic or Latino
Tompkins County	104,268	80.7%	4.0%	10.2%	4.7%
Caroline town	3,387	91.9%	4.3%	0.7%	1.8%
Danby town	3,486	95.0%	1.7%	0.6%	0.6%
Dryden town	14,888	93.0%	2.5%	1.3%	2.5%
Enfield town	3,616	92.4%	0.6%	0.0%	2.8%
Groton town	6,085	94.4%	1.2%	2.4%	4.9%
Ithaca city	30,625	69.7%	7.2%	16.1%	7.1%
Ithaca town	20,398	71.8%	5.0%	16.8%	4.9%
Lansing town	11,427	79.8%	1.8%	15.0%	4.7%
Newfield town	5,309	93.7%	1.6%	1.8%	3.7%
Ulysses town	5,047	94.4%	0.3%	1.5%	3.0%

Figure 2

<u>Population</u>

While the U.S. Census Bureau's 2018 estimate population for Tompkins County is 102,793, all data in the following demographic profile is based on the Bureau's 2012-2016 5-year estimates, which marks the county population at 104,268.

The City of Ithaca and the surrounding Town of Ithaca account for nearly half (49%) of the county population. The Towns of Dryden and Lansing combined are another quarter of the population total, with the six remaining towns, all with population under 6,100, making up the final 26%. (Figure 2)

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 29,300 undergraduate, graduate, and professional students, 28% of the county population. *(Figure 3)*

S1401: SCHOOL ENROLLMENT (2012-2016 ACS 5-Yr Estimates)	Total	Pct of Enrolled pop	Pct total County pop
Total population	104,268		
Population age 3+ yrs. enrolled in school	41,980	(X)	40.3%
Kindergarten to 12th grade	11,528	27.5%	11.1%
High school: grade 9 to grade 12	3,631	8.6%	3.5%
College, undergraduate	22,905	54.6%	22.0%
Graduate, professional school	6,394	15.2%	6.1%
Pop enrolled in college or grad school	29,299	69.8%	28.1%
Population 18 to 24 years	28,624	(X)	27.5%
Enrolled in college or grad school	24,246	84.7%	23.3%

Figure 3

Much of the county's demographic profile reflects the college sector. The median age of Tompkins County residents is 30.3 years—the lowest in the state—with 28% of residents age 18–24 years. About 1-in-8 Tompkins County residents is age 65 or older (12%). [ACS S0101]

Tompkins County's population is well educated: 19 out of 20 (95%) residents age 25-plus are high school graduates, 52% have a Bachelor's degree, and 29% a graduate or professional degree. One-in-six (17%) work in education, training, and library occupations, 10% in computer, engineering, and science, and 7% in healthcare practitioner, technical, and support occupations. [ACS S1501, S2401]

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. Nearly one-in-seven (13%) residents lived outside the county the previous year. For both the City and Town of Ithaca, one-in-seven moved in from out of state within the past year (14% and 15%, of the respective populations). [ACS B07001]

S0501: SELECTED CHARACTERISTICS OF THE NATIVE AND FOREIGN-BORN POPULATIONS 2012-2016 ACS 5-Year Estimates	County Total	Native	Foreign born	Foreign born; Naturalized citizen	Foreign born; Not a U.S. citizen
Total population	104,268	90,935	13,333	4,329	9,004
Percent of total population	(X)	87%	13%	4%	9%
Median age (years)	30.3	30.6	28.8	46.9	25.7
Population age 3+ years enrolled in school	41,980	35,521	6,459	1,190	5,269
College or graduate school	70%	66%	89%	84%	91%
Population 25 years and over	59,666	51,900	7,766	3,071	4,695
Graduate or professional degree	29%	26%	55%	50%	59%
Population 5 years and over	99,857	86,690	13,167	4,317	8,850
Language other than English	14%	5%	69%	63%	71%
Speak English less than "very well"	3%	1%	21%	12%	26%

Figure 4

Thirteen percent of county residents are foreign born; about one-third of those are now naturalized citizens. Among the foreign born population age 5 and up,

69% speak a language other than English, and about one-in-five of that group are identified as speaking English "less than very well." That represents about 1,900 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 4)*

Households

Close to half (47%) 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 (45%) of all units. In Ithaca, nearly three out of four (74%) occupied units are rentals. (Figure 5)

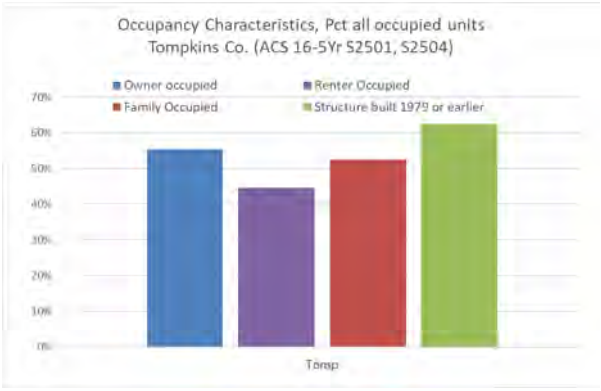

Figure 5

Among all households, owner-, renter-, and family-occupied, a clear majority of the housing stock is old; county-wide, 62.4% of structures were built before 1980. Within City of Ithaca only one-in-five occupied structures were built after lead paint was banned (21% built 1980 or after). 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 (30% and 29%, respectively). [ACS S2504]

Median household income is student influenced. In Ithaca city for example, the median for all households is $30,291, while for family households it is $72,321; family households are just 28% of all households in Ithaca city. In Tompkins County as a whole, half (53%) of all households are families, and the median family income is $76,278. The county median across all households, family and non, is $54,133. *(Figure 6)*

S1903: MEDIAN INCOME IN THE PAST 12 MONTHS (IN 2016 INFLATION-ADJUSTED DOLLARS)		
2012-2016 American Community Survey 5-Year Est.		
Tompkins County	Total	Median income
Households	38,269	$ 54,133
One race--		
White	83%	$ 58,936
Black or African American	3%	$ 30,826
Asian	11%	$ 29,959
Two or more races	2%	$ 28,829
Families	20,126	$ 76,278
With own children of householder under 18 years	41%	$ 67,957
With no own children of householder under 18 years	59%	$ 80,224
Married-couple families	78%	$ 90,940

Figure 6

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 20%. For county residents who identify as Black or African American alone,[1] the poverty rate is 36%; white alone is 16%. Among all residents under age 5, 21% are below the poverty level. [ACS S1701, S1903] *(Figure 7)* [2]

Ithaca city has the highest poverty rate in the county, 45% among all residents. The rate for city residents who identify as Black alone is 56%; for white alone, 36%; for all individuals under age 5, 38%. The Town of Caroline has the lowest overall poverty rate, at 7.4%. [ACS S1701] *(Figure 8)*

Among all households in Tompkins County, 53% are family households, 9% of which are below the poverty level. This is less than half the poverty rate across all households. Narrowing the population to families with a female householder, no husband present, and related children under age 5, the rate jumps to 51%. In Ithaca city, 19% of family households are below the poverty level, while 80% of families with female holder, no husband, and related kids under age 5 are below poverty. [ACS S1702] *(Figure 9)*

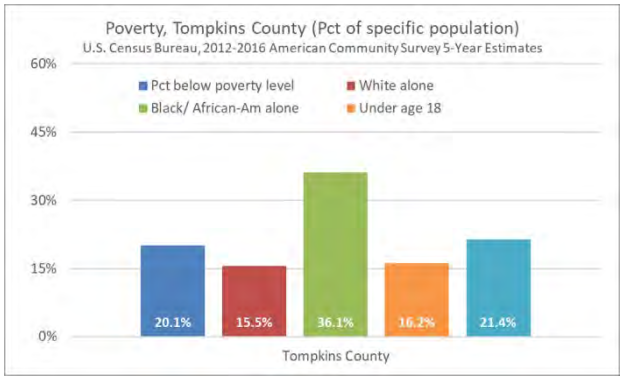

Figure 7

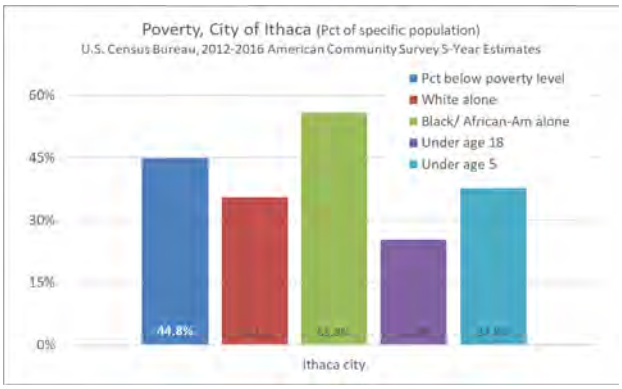

Figure 8

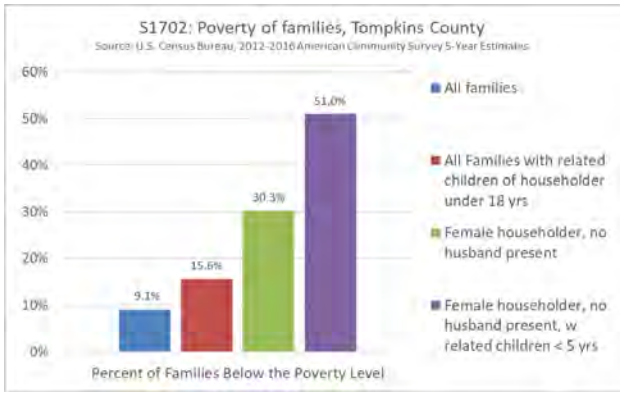

Figure 9

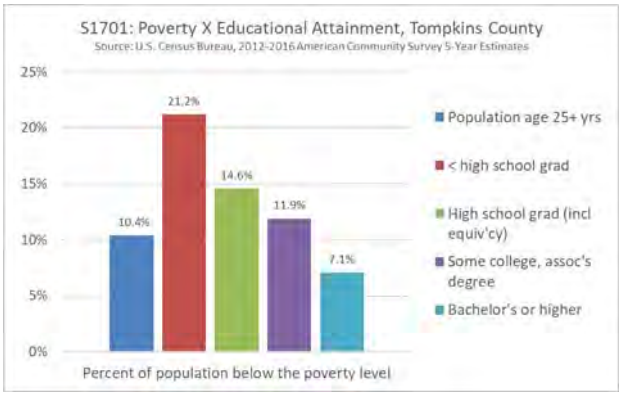

Figure 10

[1] Classifications of race are those identified by the U.S. Census. Refer to "Race" in the Census glossary, factfinder.census.gov/help/en/index.htm.

[2] Individuals for Whom Poverty Status is Determined – Poverty status was determined for all people except institutionalized people, people in military group quarters, people in college dormitories, and unrelated individuals under 15 years old. These groups were excluded from the numerator and denominator when calculating poverty rates.

Participation in the Supplemental Nutrition Assistance Program (SNAP) and medical assistance (Medicaid) programs are also key poverty indicators. One-in-ten Tompkins County households (9.5%) receive SNAP benefits, totaling just over 3,600 households. One thousand of those households include one or more people age 60+. [ACS S2201] *(Figure 11, 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. [Child Well-being Report, KWIC 2019] *(Figure 13)*

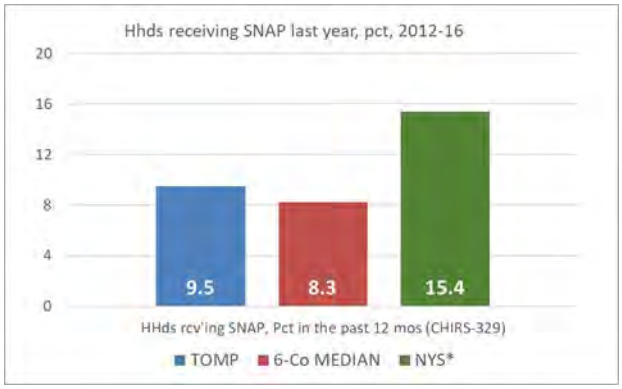

Figure 11

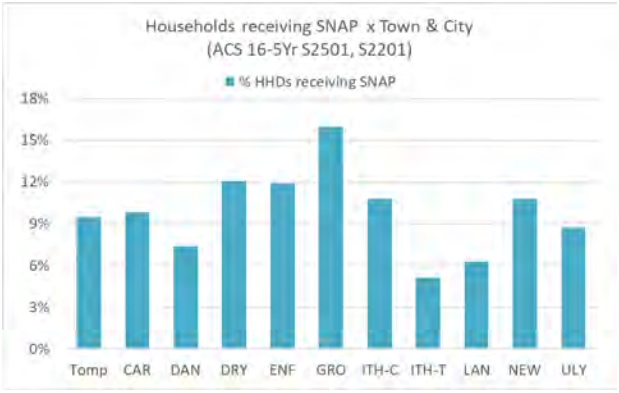

Figure 12

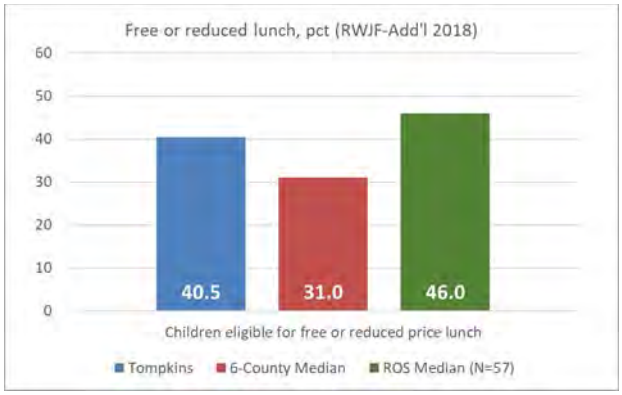

Figure 13

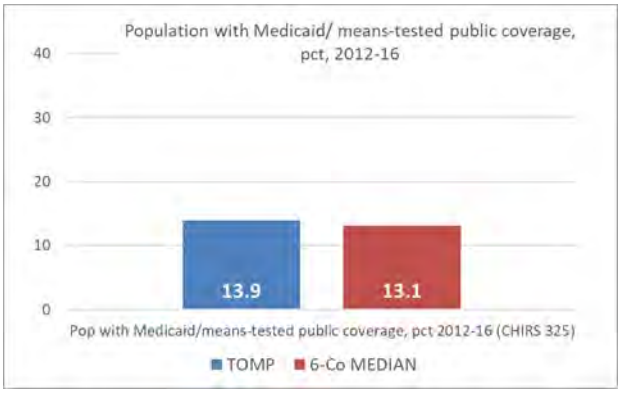

Figure 14

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) 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.

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 CHA is for years 2014 through 2016.

Comparing data with peer counties, or state and national averages is a common practice for understanding health status and setting realistic health goals. Frequently, these peer comparisons would be 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 is also referred to as the "Rest of State" or ROS.

Figure 15

There is often a wide gap between Tompkins County health indicators and those of the contiguous counties, and little is gained by assessing our status and goals this way. So, in this document peer counties are selected using the *County Health Rankings*. 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. These indicators are then weighted and combined into an overall score for Health Outcomes, and another for Health Factors. Counties are then ranked statewide by these two scores. In the 2018 rankings, among 62 counties statewide, Tompkins County was #8 in Health Outcomes, and #5 in Health Factors.

The "peers" referenced here are the top six counties in the 2018 Health Factors rankings for NYS. They are Nassau (1), Putnam (4), Rockland (6), Saratoga (2), Tompkins (5), and Westchester (3). In nearly all cases, the median value for all 6 peer counties is reported, rather than the indicator values for each of the six counties individually. The Rest of State (ROS) value is also reported for many indicators. *(Figure 15)*

Community Survey

A Community Health Survey of Tompkins County residents was conducted via Survey Monkey, Feb. 25-Apr. 15, 2019. A total of 1,317 responses were initiated. There were 1,210 eligible respondents; those who identified as age 18 or over and living in Tompkins County were eligible. The average number of responses across 32 multiple choice questions was 1,088. Analysis of the results was by Lisa Horn of Horn Research, Slaterville Springs, N.Y.

Figure 16

Of the total respondents, the largest cohorts were from those age 35-44 (22%) and age 55-54 (22%). Respondents by race was: White (89%), Black (3%), Asian (3%), Latino (3%).

Residents from every municipality participated, with the City of Ithaca drawing the most responses (26%). Consistent with the county's population distribution, the next highest representation was Town of Ithaca (18%), Dryden (12%), and Lansing (11%). Nearly all respondents identified either as female (77%) or male (21%). Three-in-five respondents were employed full-time (61%), followed by part-time (12%), retired (15%), and full-time student (7%). A majority of respondents reported that they have private health insurance (72%).

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, Dental, Mental, and Overall. Ratings were: 1-Excellent, 2-Very Good, 3-Good, 4-Fair, 5-Poor. For that question, N=1,131

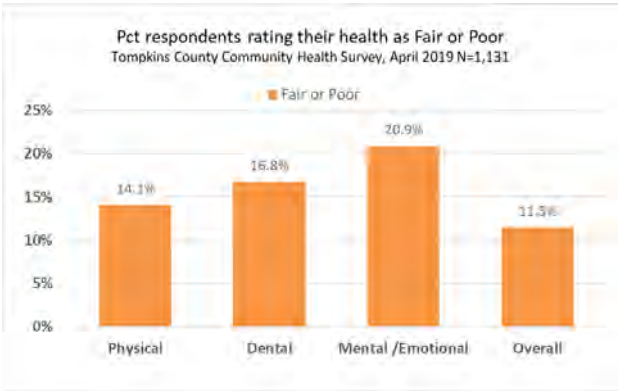

Figure 17

Across all respondents the mean rating was just under the midpoint of 2.5. The exception was how individuals rated their mental health, the mean for which was higher (less favorable) than for the other dimensions. Physical Health 2.47, Dental Health 2.45, Mental Health 2.59, Overall Health 2.47. Twenty-one percent of respondents rated their mental health either fair or poor, while only 12% ranked their overall health at one of those two unfavorable levels. Dental health was ranked fair or poor by 17% of respondents. *(Figure 17)*

Key Stakeholder Interviews:

In March 2019, 29 key informant/ stakeholder interviews were conducted by Horn Research. The stakeholders included community leaders, and non-profit organization and agency directors.

Focus Groups

Four focus groups were held with Tompkins County residents during the month of July 2019, with a total of 32 residents participating. Each participant received a $30 VISA gift card in appreciation for their assistance. The groups were targeted to include:

- Low-to-moderate income mothers
- African-American residents
- Low-income college students
- Low-income rural residents

The focus groups were conducted using a focus group guide intended to generate feedback on challenges related to, and ideas to address the following topic areas:

- healthy eating
- physical activity
- disease screening
- prenatal care
- mental health
- school-based health options

Priorities, Focus Areas, and Goals

The Senior Leadership teams from both the Health Department and Cayuga Medical Center (CMC) reviewed the PA Priority Areas and Focus Areas (each PA Priority includes multiple Focus Areas) and provided high-level 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 focus groups and stakeholder interviews were also aligned with the Focus Areas identified by Senior Leadership and other review processes.

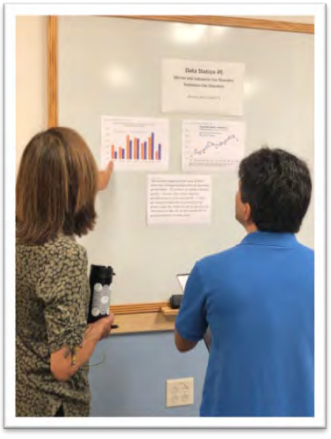

Figure 18

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 modestly higher than the 6 peer county median (22%), but clearly lower than for the ROS (27%). The statewide PA objective for obesity is to achieve 23% of the adult population. The comparison is similar for overweight adults and for diabetes indicators. Among Tompkins adults, 55% are overweight, which is about the same as the peer median, and about 3 points below the ROS. Physician diagnosed diabetes includes 6% of Tompkins adults; the peer median is 7% and ROS 8.5%. *(Figure 19)*

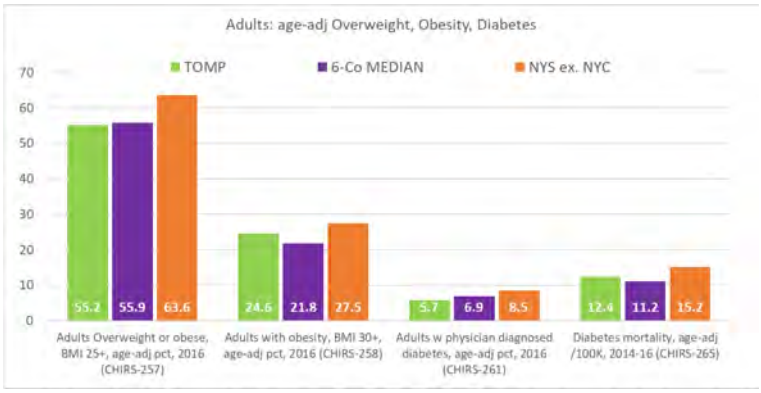

Figure 19

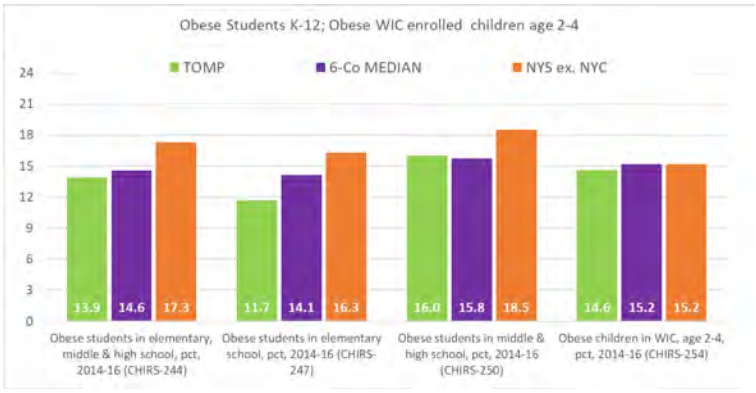

Figure 20

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 (12%) than among the peer counties (6-county median 14%). Tompkins catches up at the middle-school level, with both Tompkins and the 6-county median registering 16% of students as obese. ROS is a bit over 2 points higher for both indicators. The obesity rate among WIC children ages 2-4 years is about the same across all sample populations, 15%. *(Figure 20)*

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.

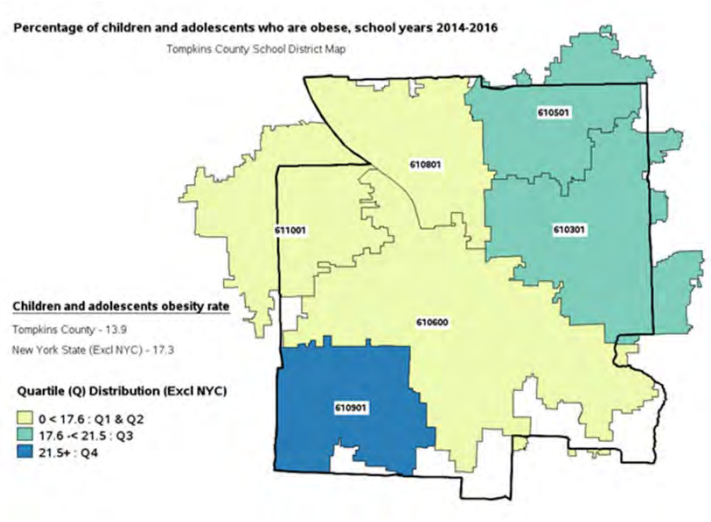

Figure 21

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 Dryden and Groton districts fall in the third quartile, while Newfield is in the fourth quartile for student obesity. *(Figure 21)*

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. A Prevention Agenda indicator reports the percent of the low-income population with low access to—living 2-plus miles from—a supermarket or large grocery store. In Tompkins County, 5.2% of the low income population qualifies as having low access to healthy foods. By comparison, the 6-county median is 3.5%, and the ROS value is 3.9%. The NYS CHIRS reports an indicator for the percent of the population with "no access to a reliable source of food last year."[3] By this measure, Tompkins again has food security numbers that are less favorable than the comparison data. The "no access to a reliable source of food…" rates are 14.0% of the Tompkins county population, 8.5% for the 6-county median, and 12.6 for the ROS. *(Figure 22, Figure 23)*

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. Tompkins gets a 7.7 on the index, which is less food secure than the 6-county's 9.0 and the ROS 8.2. *(Figure 24)*

[3] The FDA states that food security means access by all people at all times to enough food for an active, healthy life. Food insecurity suggests a lack of access. It is measured in a survey and the numerator is made up of respondents that report reduced quality, variety, or desirability of diet, as well as reports of multiple indications of disrupted eating patterns and reduced food intake.

When school is in session, school lunches and breakfast programs can provide a reliable 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. The 6-county median is 32%, and 41% throughout the ROS. *(Figure 25)*

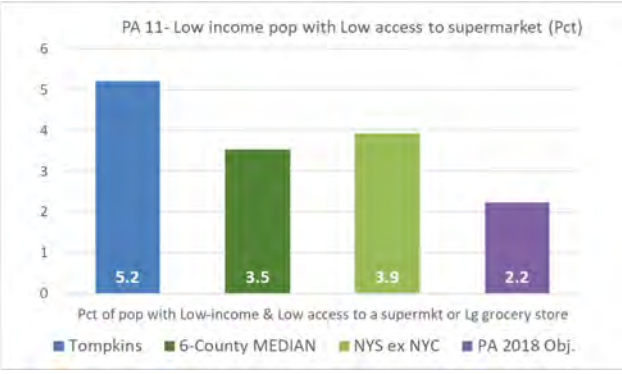

Figure 22

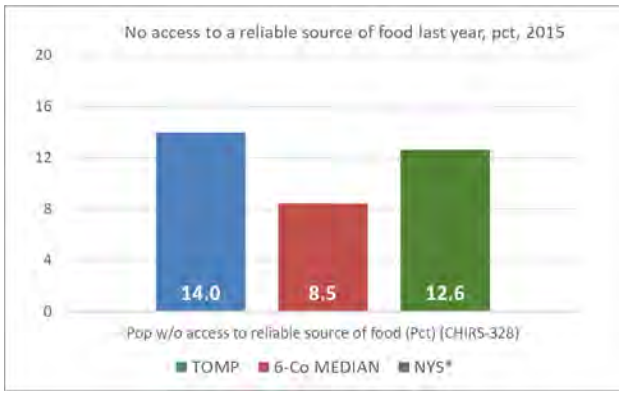

Figure 23

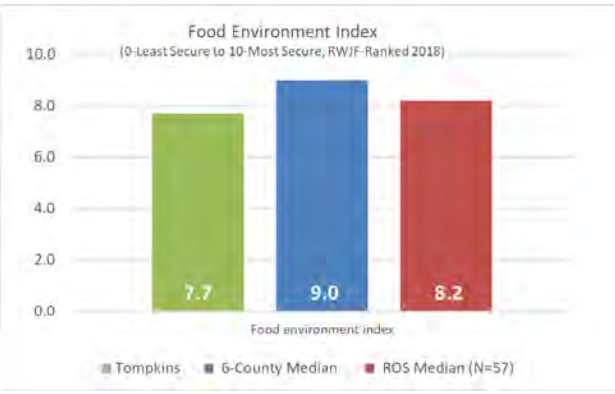

Figure 24

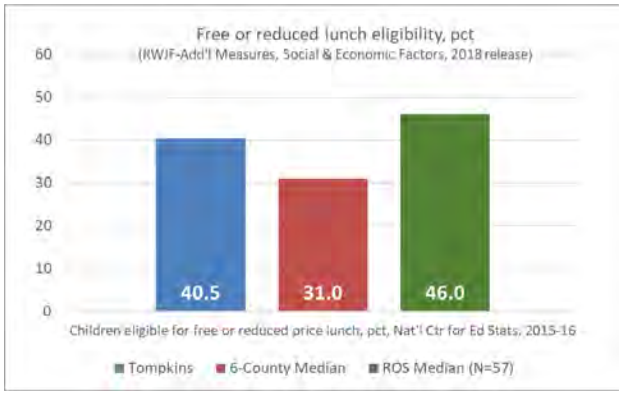

Figure 25

Community Survey

Residents whose responses indicated a level of food insecurity (11.7% of all respondents[4]) consider themselves in poorer health that those who are not food insecure. The mean score for each category among those not insecure was lower (more favorable) than the average of all respondents noted under "Community Survey" in the previous section, while scores for food insecure respondents was significantly higher (less favorable). For example, for Overall Health, the mean of the total was 2.47, among those not insecure 2.39, and among the food insecure 3.09. *(Figure 26)*

When asked to identify the barriers to eating healthy food as often as they would like, a quarter of respondents cited "Time," and one third cited "Cost" (25% and 33%, respectively.)

[4] Q22. How often do you not have enough food for your family? Sometimes 6.7%, Often 1.3%, Usually 1.1%, Always 2.6%

39% said they have no barriers. Respondents who said cost was a barrier were more likely to be employed, have lower educational attainment, have kids, and have lower income. None of the other options offered as healthy eating barriers were selected by more than 5% of the respondents (for example, "can't find foods they want," "transportation," "no storage/cooking facilities.")

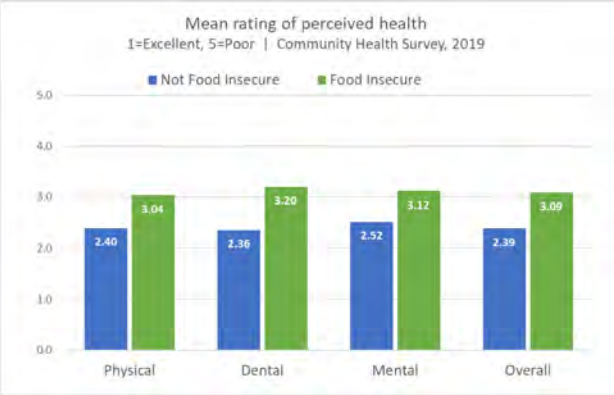

Figure 26

When asked to pick "the three most important factors that create a 'healthy community,'" 18% included "Parks and green space" and 13% checked "Easy to walk and bike."

In that same "important factors" question, 28% selected "Safe neighborhoods." A separate series of questions in the survey asked respondents to rate their home neighborhood in terms of safety, a place for children to play outdoors, and a place for adults to walk and be physically active. While 70% rated safety at the top, (Very safe), the top mark (Great) was only given by 40% for their neighborhood as a place for children to play outdoors, and 39% for a place for adults to walk and be active.

Those living in subsidized housing gave the worst rating for neighborhood safety, and next to the worst rating as a place for adult walkability and activity, only somewhat better that those who identified as being homeless.

Key Stakeholders

Key stakeholders noted that food insecurity is complicated by transportation challenges.

"And if you live in any of the outlying areas, Enfield, Caroline, Groton, the outskirts of Dryden, Candor, Newfield, getting to a place that sells healthy food isn't easy. […] The places where people can buy fresh produce, non-highly processed foods, […] It's a complicated process."

Stakeholders remarked on the prevalence of nutrition-related disease among older adults, low income residents, and in the African-American community.

"What we've heard from our nutritionists at pantries, there are a significant number of clients who are suffering from nutrition related disease. There is a lot of diabetes, obesity, high blood pressure. Agencies are saying the same thing."

"African Americans suffer more than other ethnicities with cardiovascular disease and diabetes […] It is a long standing issue in the community and continues to be."

Focus Groups

In each focus group, participants were asked to describe challenges to healthy eating and ideas to support healthy eating. When asked to describe what kinds of challenges people face in accessing healthier foods, the most commonly noted challenge was transportation.

"One nice thing about Trumansburg, there are sidewalks. Even to the grocery store, which is a little out of town [...] but when you start looking [...] other towns around here [...] access to grocery stores by walking is very tough."

Participants also noted that the high cost of food made it difficult to eat healthier foods.

"I got a salad at Wegmans and it was almost seven dollars. I was like, I could get five sandwiches at McDonald's for that."
"We go through a lot of ramen. With 6-7 people in a household, you do what you have to do."

Other challenges to healthy eating included a lack of knowledge and a lack of cooking and storage facilities.

"[...] at the pantry [...] so many folks who do not have the means to store or cook the food. [...] I keep can openers on hand for people who don't have a way to open their own cans. In certain residences in town you may have only access to a room, not even a kitchen or microwave, so they can only take food that is simple."

When asked what ideas they had for supporting healthy eating in their community, opportunities for people to gain more knowledge and skills was mentioned most frequently, particularly when being offered unfamiliar healthy foods. A need for a grocery store in their community, opportunities for more communication, and ideas for carpooling to stores were also noted.

"If there was an Aldi's right here in Dryden, that would be nice. I like getting groceries from there. It's cost efficient there."

Focus Area 4: Preventive Care Management

Goal 4.1: Increase cancer screening rates for breast, cervical, and colorectal cancer

In 2016, cancer rose above heart disease to be the number one cause of death in Tompkins County; 164 deaths or 23% of the year total, a rate of 154 per 100,000. The cancer mortality rate in 2015 was 158/100K, and in 2014 it was 130/100K. *(Figure 27)*

Tompkins County	2014		2015		2016	
Total deaths	686		680		708	
Cancer deaths	139	20%	153	23%	164	23%
Heart disease	152	22%	161	24%	151	21%
Unintentional injury	41	6%	37	5%	45	6%
CLRD	35	5%	25	4%	38	5%
Stroke	32	5%	28	4%	33	5%
Pneumonia & Influenza	22	3%	34	5%		0%
Diabetes		0%		0%	15	2%
Alzheimers	29	4%	13	2%	15	2%

NYS Vital Statistics

Figure 27

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.

Tompkins County residents are not being screened at consistent rates across these cancers, with cancers primarily affecting women (cervical and breast) being screened at lower rates than colorectal, which impacts both male and female.

Among adults age 50-75, 84% are getting screened for colorectal cancer, a number considerably higher than the 6-county median (71%) or ROS (70%). However, only 75% of Tompkins women age 21-65 are receiving cervical cancer screening (6-county median 81%, ROS 87%) and 77% of Tompkins women age 50-74 are receiving breast cancer screening (6-county median 79%, ROS 80%). Just 56% of Tompkins women age 50-74 had a mammogram in the 2-plus year period between October 2014 and the end of the year 2016. That compares with the 6-county median of 63%, and 66% across the ROS. *(Figure 28, Figure 29, Figure 30, Figure 31)*

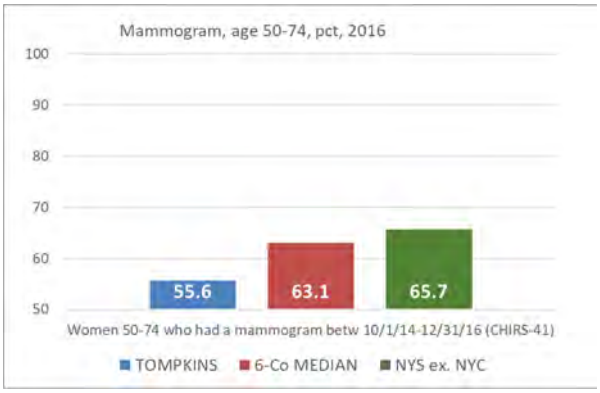

Figure 28

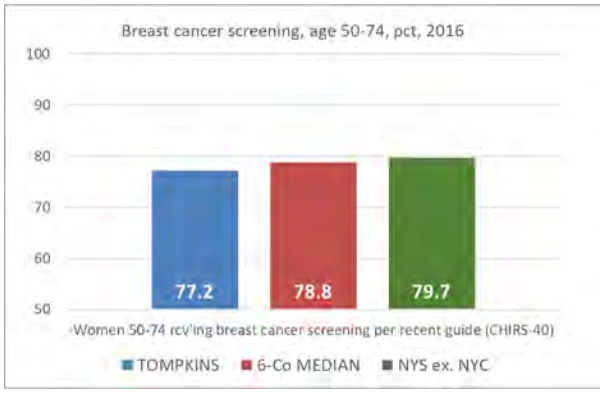

Figure 29

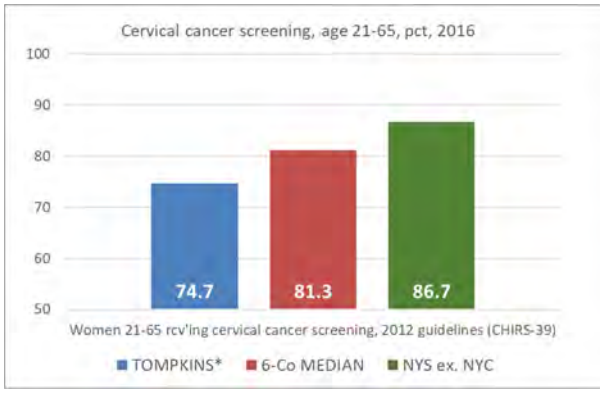

Figure 30

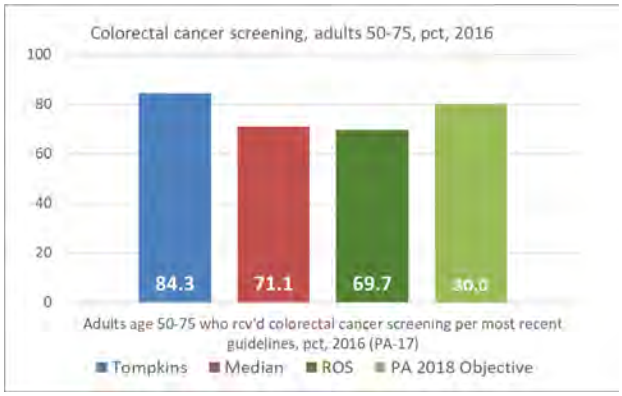

Figure 31

Focus Groups

Participants were asked to describe challenges for cancer screening, and ideas for increasing screening. They considered why county residents might not choose to be screened for diseases such as breast and cervical cancer; cost and lack of insurance coverage were noted as the main barriers to accessing screening.

"My mammogram, thank the lord, is free, but when you go to see the doctor to get the results of it, that's $35."

"A lot of people can't even get a physical every year. I personally haven't met my primary care doctor in two years. I've only gone to the OB/GYN because I had a daughter a year and a half ago. I've had physical therapy, but never met my PCP. Also, their office doesn't take Medicaid anyways."

Issues with providers that prevented them from accessing screening and preventive care services were also noted. Some participants said services were unavailable locally, while others commented on the quality of communication between providers and a lack of diversity in the provider network.

"I think and feel the lack of women of color and men of color who are health care providers [is an issue]. Particularly around mental health issues, but I think everything else too. I feel and believe I'd get a different response from a woman of color."

Fear was also cited as a big deterrent to accessing screenings.

"I think fear contributes a lot. I was just talking to a woman a few days ago whose husband is having a lot of bad symptoms but he's too afraid to go. Sometimes fear plays a huge piece of it."

For African-Americans, systemic racism is a significant barrier to accessing adequate disease screening.

"[…] when we do go to the doctors, instead of giving us 20 or 30 pills, take a few extra minutes and talk to us about lifestyle. That makes all the difference. That's a big part of it. The extra time to talk to people. When we do show up, educate us. And not in a demeaning way."

When asked to describe ideas for increasing disease screening, participants said they thought mobile opportunities for screening would be useful, but it is important to ensure information is available to residents in advance.

"I think if it was advertised ahead of time, I think people would come."

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 that were selected by the Steering Committee who oversaw the production of this CHA.

Following is a selection of PA chronic disease indicators that are of interest to the community, even though they do not directly relate to the selected goals. As with previous discussions, the peer counties are Nassau, Putnam, Rockland, Saratoga, Tompkins, and Westchester, and ROS refers to the value for all New York State, excluding the five NYC counties. Much of the data is from 2016; some are an average of years from 2012 to 2016. Each PA indicator has a reference number, from 1.0 to 44.0.

Individuals who have asthma are tracked in the PA by the rate of emergency department (ED) visits per 10,000 (/10K) of the specified population. In Tompkins, the overall asthma ED visit rate is 24 per 10K, which is lower than both the peer county median (31/10K) and the ROS (49/10K). Narrowing down to just the population of individuals age 0-4 years, the asthma ED visit rate in Tompkins is 79/10K, the peer median 74/10K, and ROS 117/10K individuals age 0-4 years. *(Figure 32)*

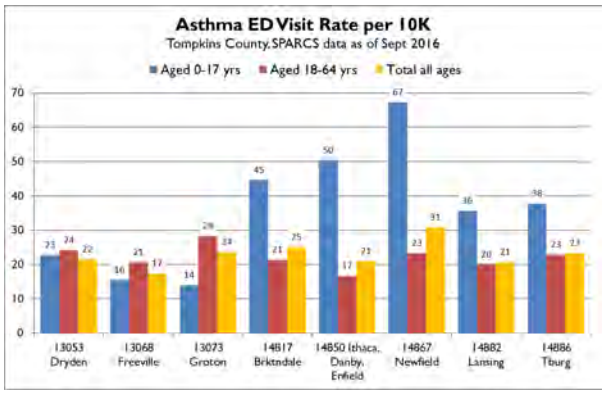

Figure 32

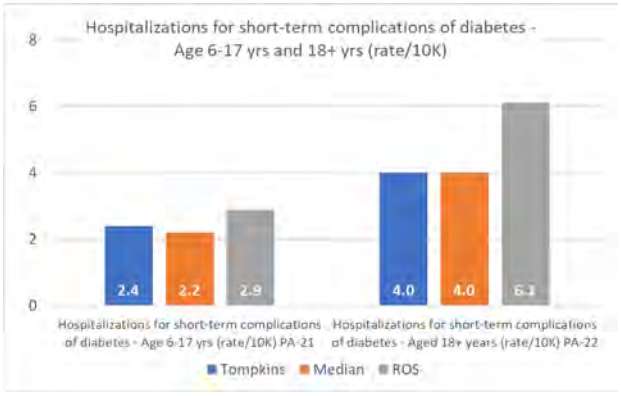

Figure 33

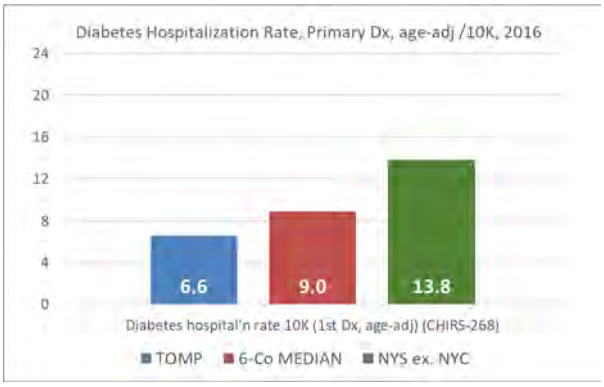

Figure 34

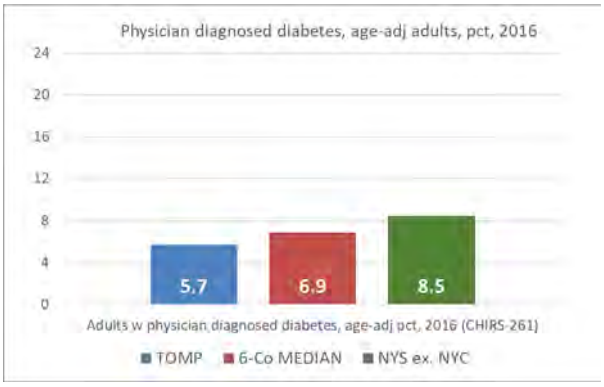

Figure 35

Hospitalization for heart attack in Tompkins, the peer median, and ROS are in a relatively narrow range. Age adjusted rates per 10,000 are 13.6, 13.5, and 14.8, respectively.

The same is true for hospitalization rates related to short-term complications of diabetes among the population ages 6-17 years. the rate for Tompkins was 2.4/10,000, the peer median 2.2/10K, and ROS 2.9/10K. Note that for Tompkins, the rate for ages 6-17 was tagged "unstable" because there were fewer than ten incidences. *(Figure 33, Figure 34, Figure 35)*

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 lists a total of 349 indicators (all PA indicators are included), just one of which 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 83% of adults, topping the peer median (76%) and ROS (75%). These are age-adjusted data from 2016. *(Figure 36)*

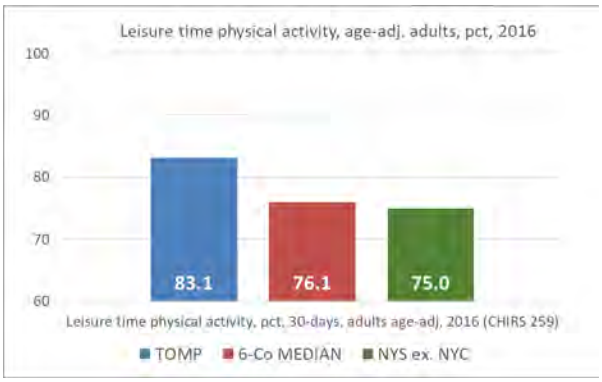

Figure 36

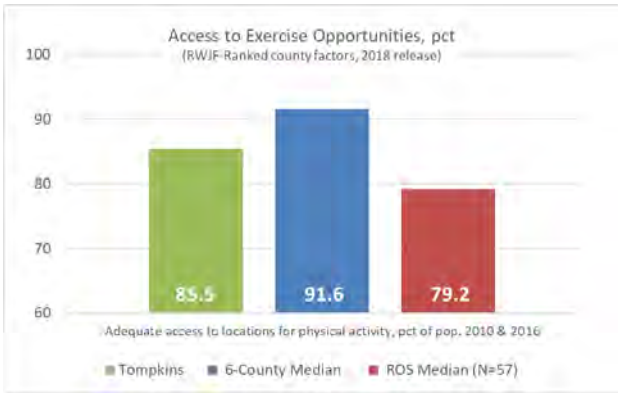

Figure 37

The Community Health Survey conducted in April 2019 included the question, "what are the barriers to getting as much physical activity as you would like?" "Time" was a common barrier to getting physical activity, with 45% of respondents selecting it from a list of options. Next on the list was "Local weather," which was

checked by 39% of respondents. “Physical limitations” was cited by 16.3%, and 16.2% picked “No barriers.”

Tobacco Use

While cigarette smoking among Tompkins County adults (17%) matches the ROS rate, it is higher than the peer county median of 13%. Smoking rates among adults with a disability is considerably higher, with statewide rates as much as twice that of adults without a disability.[5] In Tompkins County, smoking among adults with a disability is 40% higher than the general population. Statewide rates also show that adults with mental illness, and those with a lower income and /or lower education attainment smoke and use tobacco at a higher rate than those with higher income and a higher level of education. Data for the smoking rate among individuals with mental illness is not available for Tompkins County, however the rate for low income individuals is twice that of the general population. *(Figure 39)*

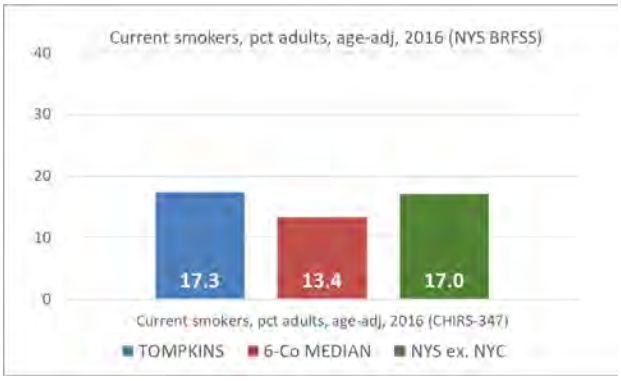

Figure 38

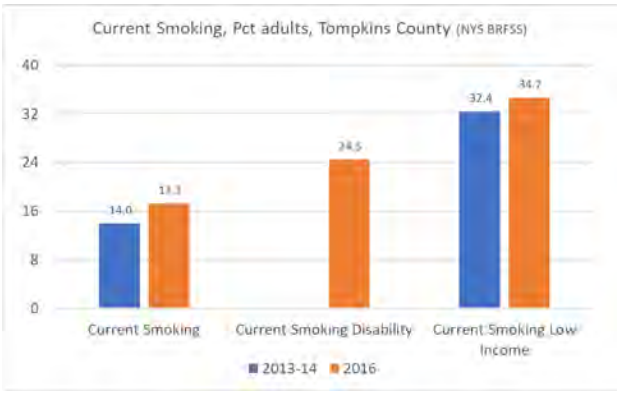

Figure 39

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, is 3.2% (2018). However, a review of each grade shows 30-day use among 12th graders at 7.7%, a steep increase from 3.2% for 10th graders, and 4.0% for students in grade 11. *(Figure 40)*

Youth use of electronic cigarettes (e-cigs) and other vaping devices has skyrocketed over the past 5 years, nationally and statewide. In Tompkins, 2018 was the first year that a question about vaping was asked on the biennial Communities That Care survey, administered to all students in grades 7 to 12 in all school districts. The average across all grades and all districts was 16% of students reported having used a vaping product at least once in the last 30 days. Tenth grade alone was 21%, 11th 20%, and among 12th graders, 26% were current vape users per the 30-day definition. *(Figure 41)*

[5] https://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume11/n3_ny_smoking_adults_w_disability.pdf

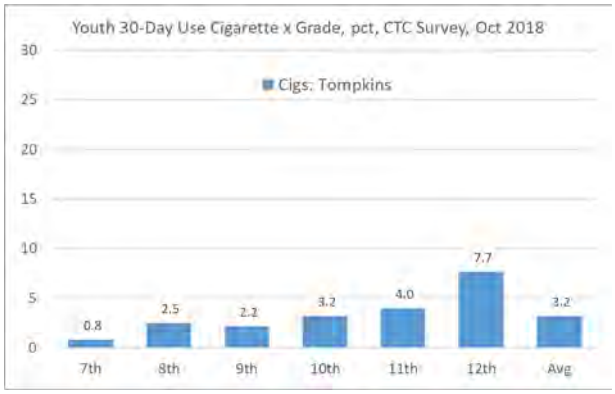

Figure 40

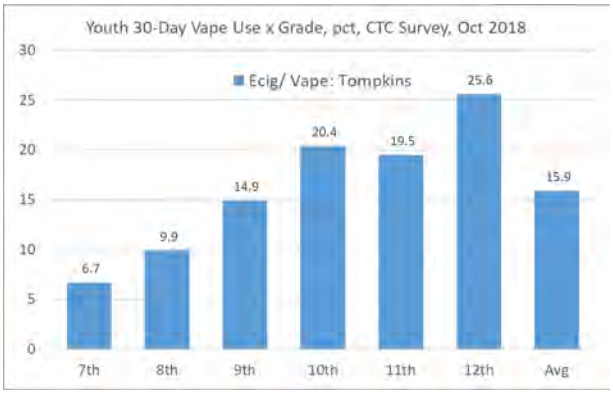

Figure 41

Prevention Agenda Priority: Promote Healthy Women, Infants, and Children

Focus Area 3: Child and Adolescent Health

Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships

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. Most of the KWIC data used in this report is from 2017, accessed at nyskwic.org in May 2019.

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.

In Tompkins County, 15.0% of children age birth to 17 live below the poverty level. The median for the 6 peer counties is just 9.3%, while 15.7% of children across the ROS are living below poverty. Among Tompkins children age 0-17, 3.5% receive public assistance. The peer county median is 1.4%, and ROS is 4.1%. *(Figure 42, Figure 43)*

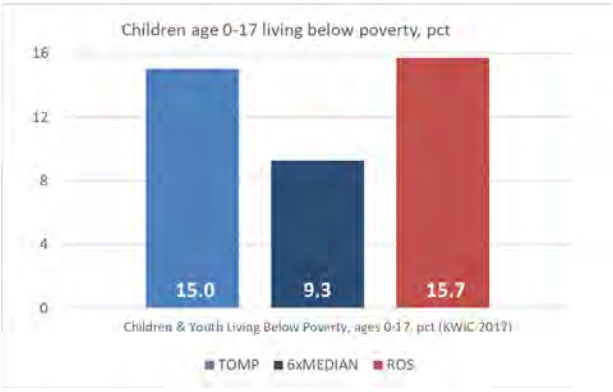

Figure 42

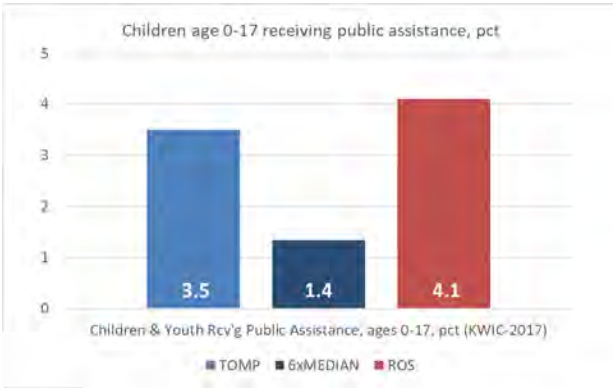

Figure 43

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. Fewer than half (46%) of Tompkins third graders meet the mark for ELA (peer county median 56%, ROS 49%). For math, 21% of eighth graders meet the learning standard (peer county median 27%, ROS 25%). *(Figure 44, Figure 45)*

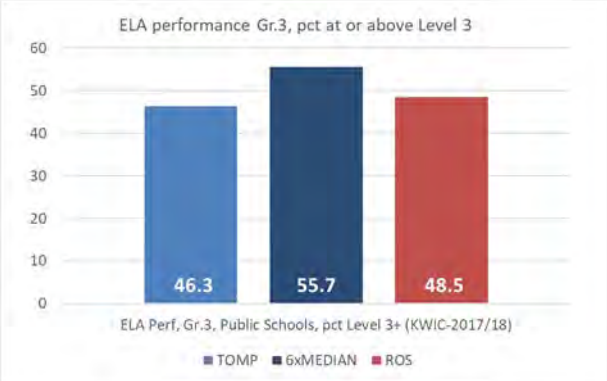

Figure 44

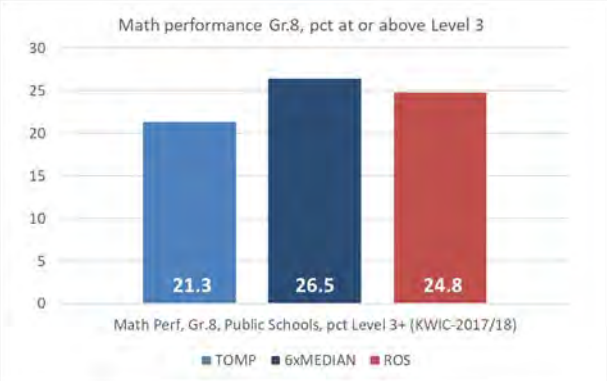

Figure 45

The "Civic Engagement" life area indicators in KWIC focus on juvenile and young adult arrests. The 2017 rate of property crime arrests of juveniles under age 16 in Tompkins is 15.8 per 10,000 youth of that age, down from 37.5 in 2010. The 2017 rate for the peer county median is 8.9/10K, and for the ROS is 17.1/10K youth under age 16. *(Figure 46)*

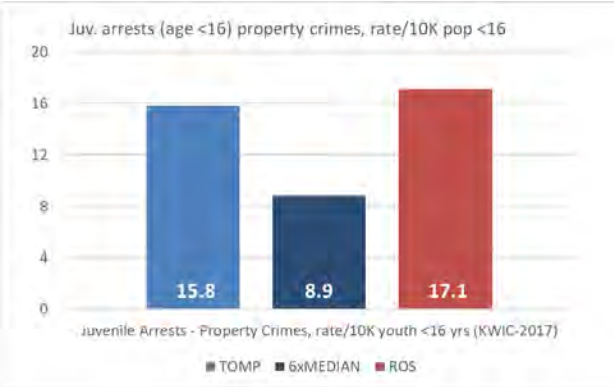

Figure 46

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. In Tompkins County, the 2017 rate for abuse/maltreatment reports is 18.6/1K youth, up from 8.5/1K in 2010. The Tompkins rate for children admitted to foster care has dropped, from 3.9/1K in 2010 to 1.8 /1K in 2017. Among individuals age birth to 21, 3.1/1K are in foster care. By comparison, 2017 rates for the peer county median and ROS are: child abuse/maltreatment, 8.6 and 16.8/1K individuals age 0-17; admitted to foster care, 0.5 and 1.5/1K age 0-17; children in foster care, 0.8 and 2.3/1K age 0-21. *(Figure 47, Figure 48, Figure 49)*

Self-inflicted injury hospitalizations among Tompkins County teens occur at a rate of 8.3 per 10,000 (/10K) residents age 15-19 (2016 data). The peer county median for ages 15-19 is 6.4/10K; 8.7/10K in the ROS. The suicide mortality rate for ages 10-19 is 4.0/100K in Tompkins, and 3.7/100K for both the peer median and the ROS (2012-2014 3-yr average). *(Figure 50)*

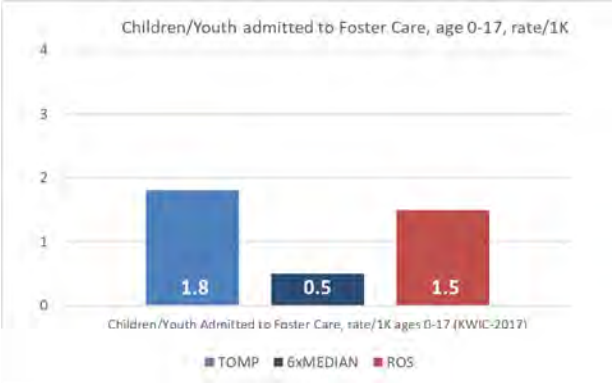

Figure 47

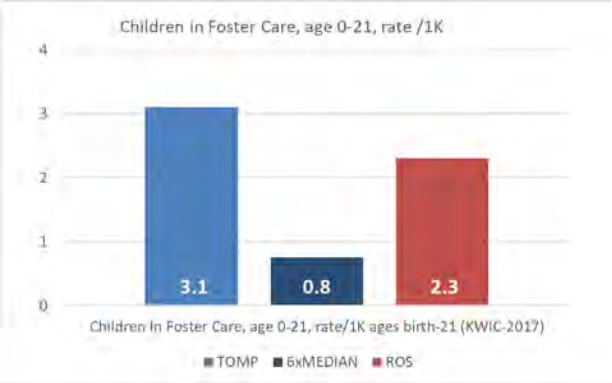

Figure 48

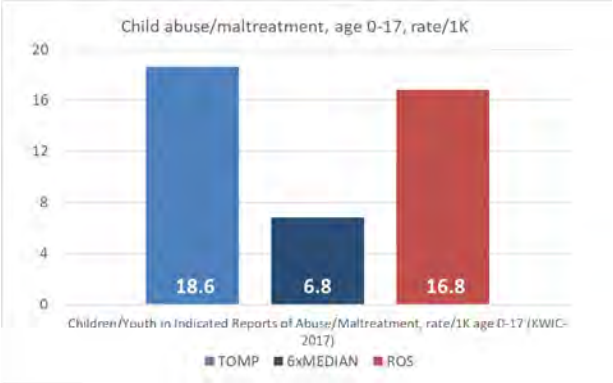

Figure 49

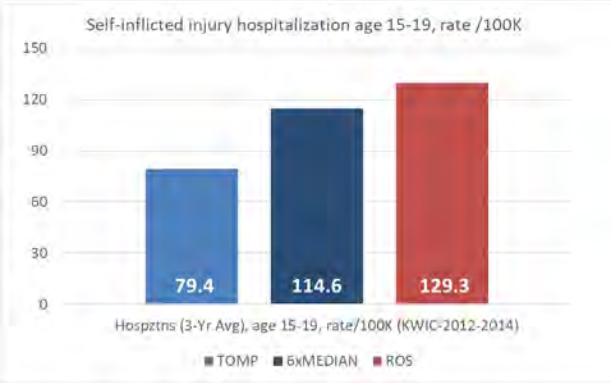

Figure 50

Key Stakeholders

Several stakeholders noted the lack of mental health providers is an issue in the county and a primary driver of identifying mental health as an unmet need.

"I know we need more child psychiatrists and psychologists. They've been recruiting people. Even getting prescribers, there aren't enough in this county to get through all the kids. Your appts are five mins long if that. They read notes and then prescribe."

Stakeholders indicated that the prevalence, impact, stigma, and the connection to social determinants of health were the primary reasons they selected mental health as an important health issue in the county.

[…] We're experiencing an epidemic of mental health problems – both in the community and as well as at the universities. People are showing up as freshmen with mental health issues, and try as they can right now the system is overburdened. There is more need than there are counselors. That's a concern."

A stakeholder remarked on family systems issues which affect mental health treatment.

"A lot is going on to lessen the stigma, but there is still stigma attached to mental health. And there is a lack of support from extended families around mental health. For example, I have a mom who wants help, but the grandmother may be saying there's nothing wrong with that child. There is lack of generational support around mental health. […] So some of our kids go year after year of not receiving any out of school mental health support and it gets deeper and harder for them. They not only don't have coping skills, but continue their negative habitual responses."

A number of stakeholders said that the mental, emotional and developmental health of children specifically is a top health issue in the county. Several stakeholders remarked on the prevalence of mental and emotional health problems among children.

"[…] youth are seeing a rise in anxiety and depression. And having to navigate that as a school district is challenging. Because while we provide a significant amount of emotional support and do some emotional learning, that's not our primary mission. […]"

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 within the county, but for the most part there is no pattern within or across any specific ZIP. [NYS Vital Statistics as of June 2018]

For example, Groton (13073) is slightly below the middle for premature births—the rate for 13073 is 8.9%, compared with the median of 8 ZIP codes in Tompkins at 9.3%—and for low birth weight (5.8%, median 6.2%). Groton is slightly above the middle for late or no prenatal care (3.5%, median 2.7%). Meanwhile, in Lansing the premature rate of 11% tops Groton, while LBW (3.5%) and late/no prenatal care (1.8%) is considerably below Groton. Tracking Medicaid or self-pay births, Groton has among the highest (47.1%) while Lansing has among the lowest (38.6%, median 41.6%). *(Figure 51, Figure 52)*

There is inequity in prenatal care by race in Tompkins County, and it appears to be widening. In NYS Vital Statistics 2016 data for births, whites were 25% more likely to have had early prenatal care than Blacks (83.4% and 66.7%, respectively). The rate of births with late or no

prenatal care is more than three times higher for Blacks (7.4%) that for whites (2.2%). The categories of Hispanic and "Other" are equally high, at 7.8% and 8.3%, respectively. [NYS Vital Statistics, <health.data.ny.gov>] *(Figure 53, Figure 54)*

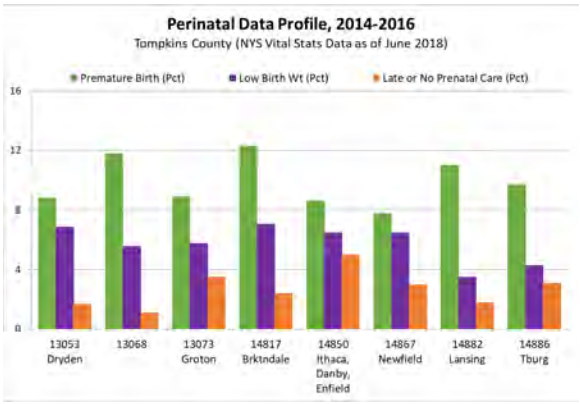

Figure 51

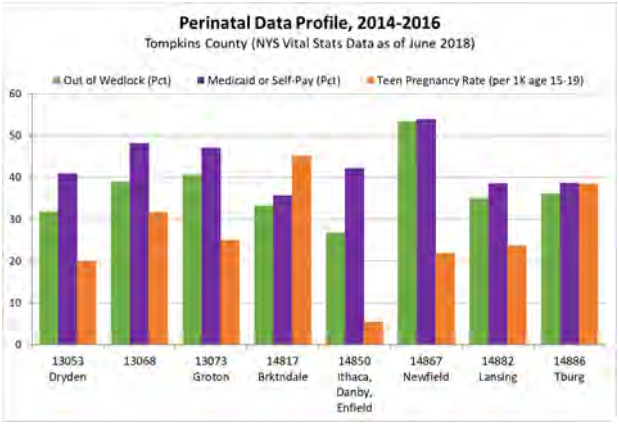

Figure 52

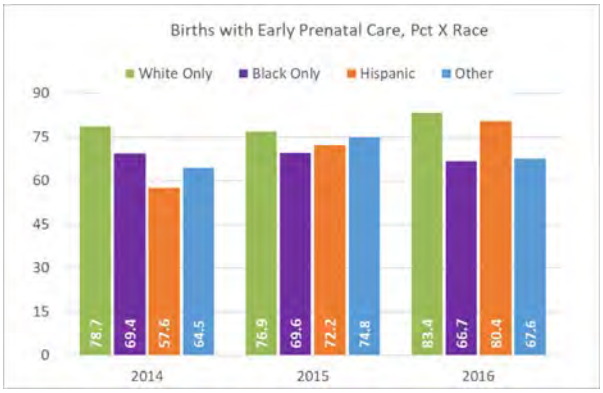

Figure 53

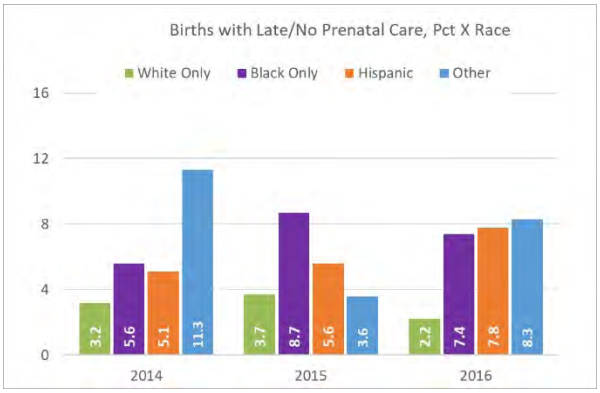

Figure 54

Key Stakeholders

Some stakeholders noted that social determinants of health such as housing and income insufficiency are tied to child emotional health.

"There are a lot of children that are in insecure housing in this area and I think that insecurity is manifesting itself in kids having challenges that they shouldn't have at that young of an age."

Stakeholders noted health disparities primarily related to income and age.

"[There is a] growing income disparity in the country and locally here in Ithaca, which is a unique place where you have rural, urban and suburban areas. It's a lot less homogenous and you see those health disparities clearly manifest."

Focus Group:

Participants were asked to describe the main barriers to prenatal care, and the types of solutions that would be most effective in ensuring women receive early prenatal care. The most frequently noted issue was a lack of access to providers, both due to wait times for appointments because OB/GYN practices are full, and a need for transportation support.

"Sometimes I think it's just hard to access services. My sister is pregnant now and is trying to work, and she's trying to not take time off so she can save her time off for when the baby comes. She was able to find a Saturday appointment but there aren't a lot of options like that. […] I think if they had [...] a clinic that came in once per month. If they offered some of that, women would come."

Participants said that some women may have a lack of knowledge about what to do, or a fear about dealing with a pregnancy.

"Some of it has to do with education, especially when you deal with younger people, [or] their first child. I'm sure in school they still educate young people, but maybe they don't. If you miss your period, there's a possibility you could become a mom. I think education is a big piece of it. If you missed your period, you need to go to a doctor, and you can deal with the prenatal thing."

Focus groups were also asked what kinds of health services they thought could be located at schools. They expressed both positive and negative views related to school-based health services. While participants said that having health services at school could overcome some insurance barriers and create consistency, they had concerns about confidentiality and stigma. There was a general approval of a mobile health care option that home-schooled students and adults could also access.

"[It] goes hand in hand with schools trying to push people toward healthier options. [They] give people healthy options to eat, but health [care], in general, is still not provided. I think that would help."

"TCA Head Start has a dentist come a few times a year. My kids don't have a dentist because they go there."

<u>Additional Women, Infants, and Children Prevention Agenda Indicators</u>

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 the number is 72%, well above the peer county median of 51%, and the ROS, also 51%. *(Figure 55, Figure 56)*

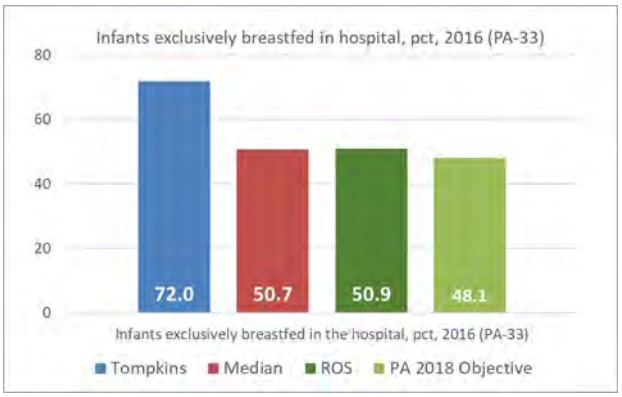

Figure 55

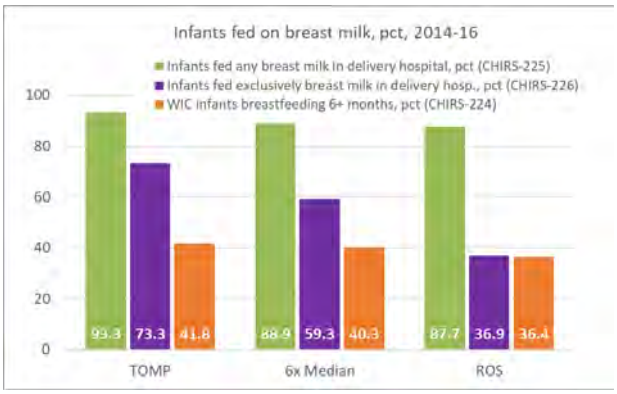

Figure 56

Importantly, the PA also breaks the "exclusively breastfed" indicator out by race and financial status, both of which are markers of health equity. For example, the ratio of Black non-Hispanics to White non-Hispanics is 0.8, meaning this Black population is 20% less likely to have exclusively breastfed their infant in the hospital. The peer county median for this ratio is 0.7, and the ROS is 0.6. The rate for full parity would be 1.0.

A ratio is also given for Medicaid births compared with non-Medicaid births. Here, the ratio for Tompkins is 0.7; mothers enrolled in Medicaid are 30% less likely to have exclusively breastfed, or, for every 10 non-Medicaid birth infants exclusively breastfed, only 7 Medicaid birth infants were exclusively breastfed. (3-year average 2014-2016, PA#33.1-33.3.)

Dental care is important, but not tracked in a comprehensive manner. The PA looks at evidence of untreated tooth decay among third grade children. The most recent data, a three-year average from 2009-2011, records Tompkins with 17% of third graders showing evidence of untreated tooth decay. This is more favorable than the peer median of 21%, or ROS with 24%. Stepping out of the PA, the CHIRS includes the percent of third graders who reported taking fluoride tablets regularly (also 2009-2011 average). In Tompkins, 88% reported participating in this prevention step, again bettering the peer county median (46%) and the ROS (42%). (PA#37, CHIRS #280.) *(Figure 57, Figure 58)*

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, the peers, and the ROS show roughly the same level of participation, with 76%, 76%, and 73% of children, respectively. The similarity continues when the indicator is reported by age; in Tompkins, 86% of children age 0-15 months, and 86% age 3-6 years. The Tompkins rate drops to 68% for children age 12-21 years. (Data are 2016, PA#35-35.3.) *(Figure 59)*

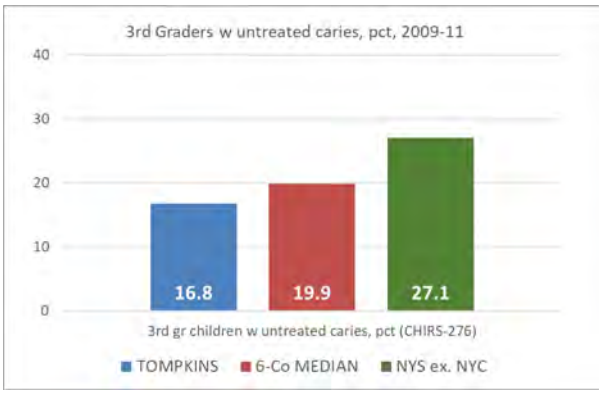

Figure 57

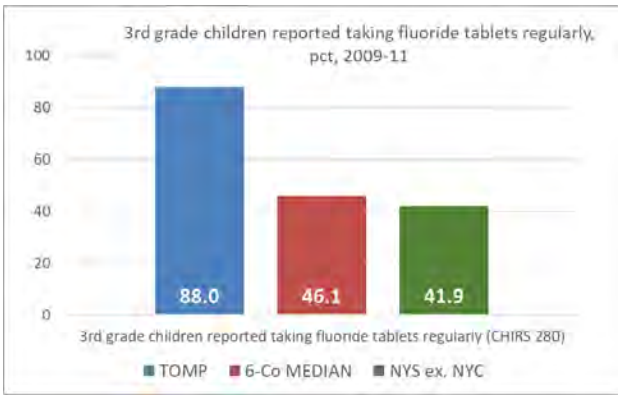

Figure 58

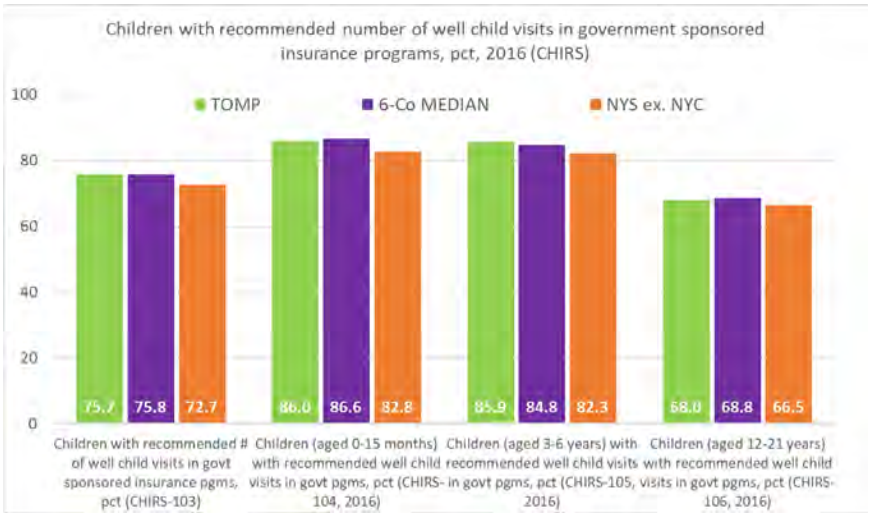

Figure 59

Health inequity is also evident when the rate of unintended pregnancies is reported as a ratio of Black non-Hispanics to White non-Hispanics, and Medicaid births to non-Medicaid births. The former ratio (Black to White) has been suppressed for Tompkins County, meaning that the data do not meet the reporting criteria.

For the latter, Tompkins has 2.6 Medicaid births from an unintended pregnancy to every one non-Medicaid birth from an unintended pregnancy, the third highest in the state, and part of the fourth quartile statewide (blue shaded counties in Figure 60) meaning 75% of counties are closer to parity. The gap is similar in the peer

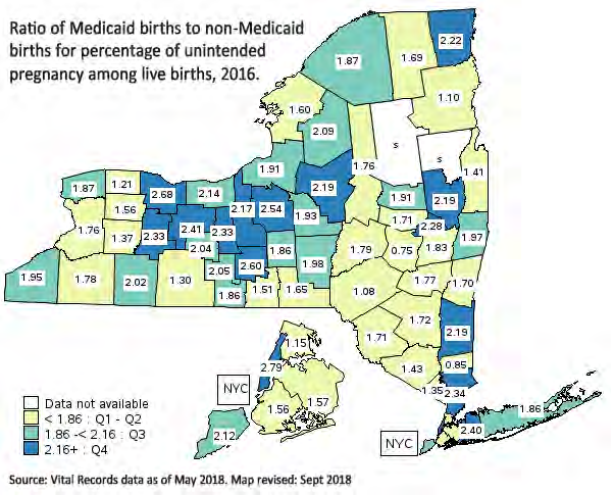

Figure 60

counties (median 2.3), and in the ROS (2.0). The PA 2018 objective was 1.54 The rate of unintended pregnancies among all live births for Tompkins is 22%, the peer median is 19%, and ROS is 25%. (2016, PA#39-39.3.)

In Tompkins County, 95% of women age 18-64, and 96% of children under age 19 had health insurance. The peer county median are 95% and 97%, respectively. (2016, PA#40 & #36.) *(Figure 61, Figure 62)*

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 Communities That Care (CTC) survey administered bi-annually in all Tompkins County school districts, asks 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 2018 survey, 36% of all students (all grades) answered "yes or YES, I have felt depressed or sad…" The number was pretty consistent across the grades individually, except 10th grade where 42% responded "Yes" to one degree or the other. *(Figure 63)*

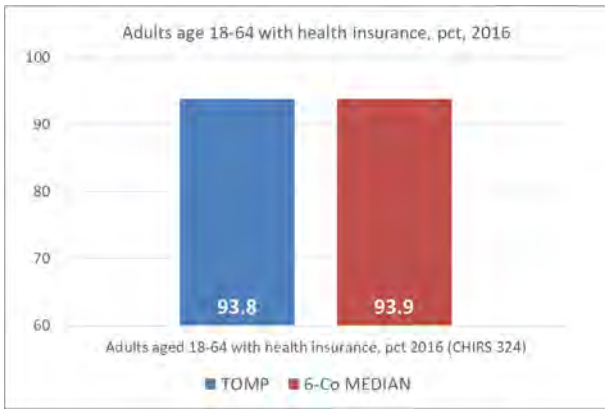

Figure 61

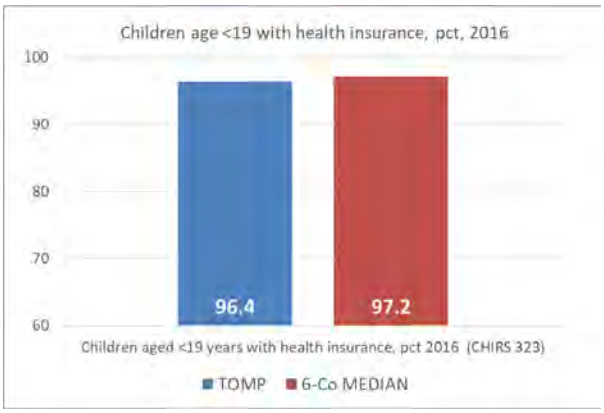

Figure 62

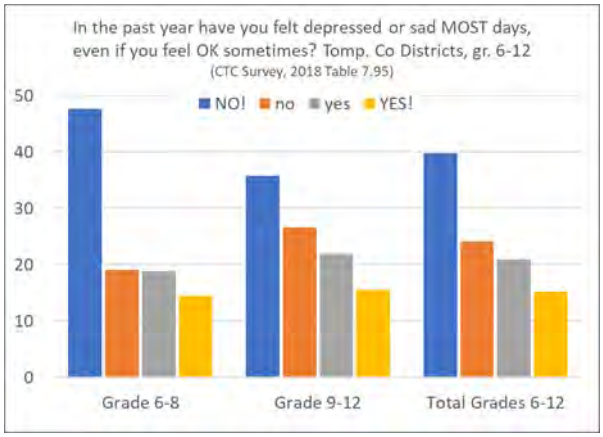

Figure 63

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.

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. Sample size varies among counties; in Tompkins around 450 surveys were completed in the most recent survey, 2016. As such, the margins of error are high for all indicators, and smaller differences compared among counties or years are likely not statistically significant.

The mental health and substance use questions in the BRFSS include behaviors about depressive disorder, poor mental health days, and binge drinking. Among the 6 peer counties, Tompkins recorded the highest rate of adults who report poor mental health for 14 or more days in the last 30, 12.0% (2016). The peer median that year was 9.5%, and ROS 11.2%. Furthermore, comparing results from the 2013-14 survey with 2016 suggests an increase in the percent of Tompkins adults reporting poor mental health, from 6.8% to 12.0%. The rate in half the peer counties decreased, while the increase in the other two was not as sharp as Tompkins. The peer median was unchanged at 9.5%. *(Figure 64)*

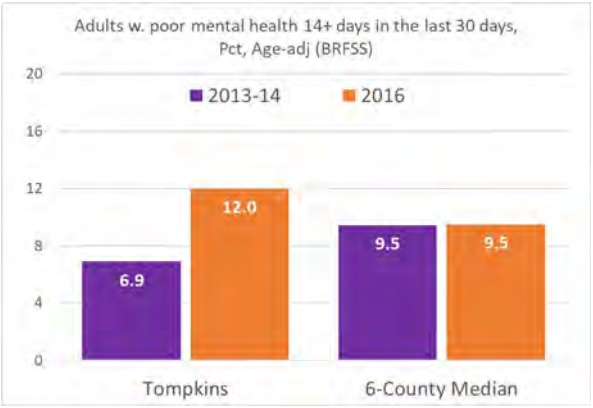

Figure 64

"Well-Being" is a new term within the Prevention Agenda mental health priority, and specifically Focus Area 1, "Promote Well-Being." It is defined 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. 1.3, 4/25/2019, p.207]

The Prevention Agenda indicators for evaluating well-being are the BRFSS question asking adults about their poor mental health days, and the companion youth risk survey (YRBS) question asking youth grades 9-12 if they felt sad or hopeless. The interventions suggested in the PA for building well-being are primarily related to social determinants of health, such as improving housing, creating and sustaining healthy public spaces, and establishing caring and trusted social relationships.

Key Stakeholders

Stakeholders did not agree whether they believed the community is aware of the issues surrounding mental health in the county. Some stakeholders believe there is high awareness and a will to address the issues, while others said that there were only pockets of awareness and discussion is limited to service providers.

"I do think there are a lot of conversations around mental health. I know the school district is keenly focused on it as well as other groups working to reduce barriers to access and reduce stigma. It's not hard to convene a group of stakeholders around these topics, what is difficult is the best strategy or best resources."

"I feel like it's not talked about. It's not normalized in my experience."

Focus Groups

Participants were asked to describe whether there has been an increase in emotional and mental health issues in their community, and if so, why. They were also asked to describe how both adults and children have been impacted by these issues, and potential solutions for addressing those challenges.

The lack of providers was most cited as a primary challenge to mental health care in the county. Some said a lack of culturally appropriate providers was of particular concern. Others noted that insurance often doesn't cover mental health care, presenting a substantial barrier to care.

"I've noticed there's not a lot of available counselors or places you can go in this area. […] I have to go all the way to Binghamton to get counseling because they're booked or they don't take my insurance and that's just crazy."

"What's important is that mental health [care is available] in the school system. [There is a] need for properly trained and racially sensitive counselors."

Participants said there are issues with the quality of mental health support that's available and poor referral to resources from providers.

"It takes so much courage already to start calling and when you call and they don't call you back. I reached out to my midwife when I was at a point that I have to get help and she sent me a list that basically said 'here is everyone's name'. You have to find out if they take your insurance, if they actually specialize in postpartum. I think I called a couple of people on the list, but never heard back from any of them. Eventually I talked to my physical therapist and she recommended someone and that's who I'm seeing right now. It's so hard to start the first step."

"I don't think the people who go to this school even know that there's a place that they can go to talk to [somebody]. Last semester I was having some emotional issues and I wanted to talk to a psychiatrist so I asked my friends and coworkers if there was a psychiatrist on campus and no one knew… We have one, but people just don't know."

Social media and challenges with parenting were noted as key issues related to child mental health.

"Most parents who have kids [with] mental health issues probably have mental health issues themselves. If they're not getting help themselves, they're going to feel awkward taking their kids."

Participants offered several ideas for increasing awareness and offering information on resources in a variety of venues. They also suggested providing more emotional communication skills training to residents.

"Encouraging those in your life that are internalizing their pain to not [continue that behavior]. Be an example, I guess. Being there for them is really important."

Focus Area 2: Prevent Mental and Substance Use Disorders

Goal 2.4: Reduce the prevalence of major depressive disorders

The BRFSS questionnaire asks a series of questions that begin, "Has a doctor, nurse, or other health professional EVER told you that you had…?" When asked this about depressive disorders, major or minor, 15% of Tompkins adults affirmed they had been told this (2016, question 6.10). The median value for the peer counties is 9.4%. This question about depressive disorders was not included in the 2013-14 survey. *(Figure 65)*

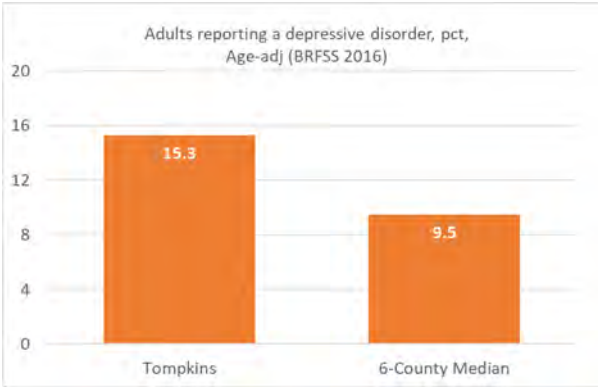

Figure 65

The most widely used hard data indicator for a population's mental health status is suicide

mortality rate per 100,000 residents. In Tompkins, the 3-year (2014-16) average rate is 8.9 suicide deaths /100K; the 6 peer county median was 6.7/100K. Both are below the ROS, 9.6/100K, but still exceed the Prevention Agenda 2018 objective of 5.9/100K population. *(Figure 66)*

Two additional PA indicators covering mental health and substance abuse are: adults reporting poor mental health during 14 of the last 30 days, and adults binge drinking the last month. Adults reporting poor mental health was cited for Goal 1.1 *(Figure 64 above and* Figure 67 *below)*. In Tompkins, 17% of adults reported binge drinking in the last month; the peer county median is 20%, ROS 19%, and 2018 objective 18%. *(Figure 69)*

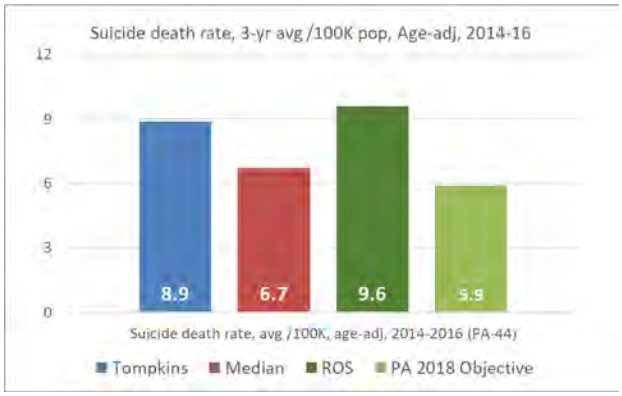

Figure 66

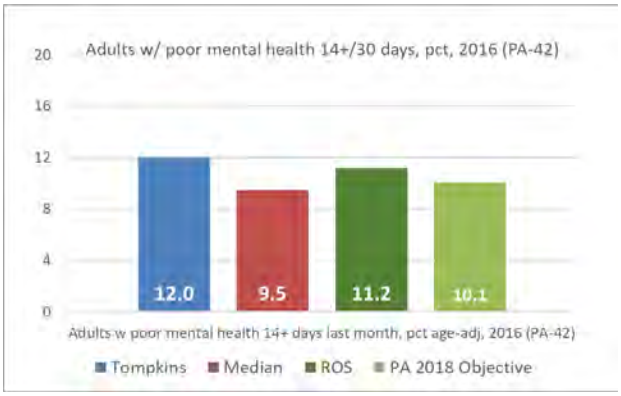

Figure 67

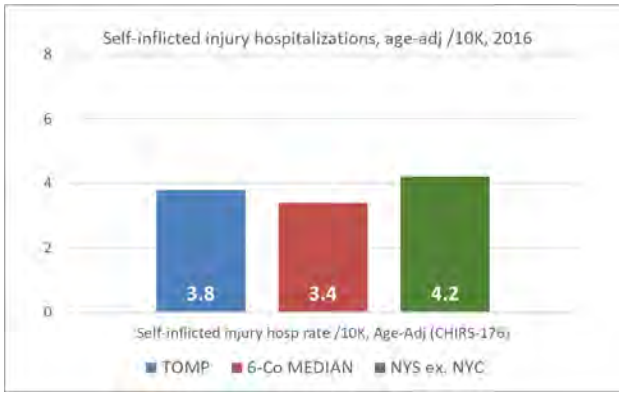

Figure 68

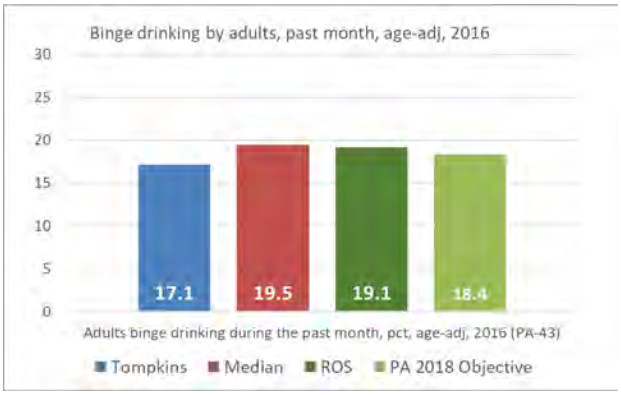

Figure 69

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 risen in recent years, with Gonorrhea cases doubling from 55 cases in 2015 to 110 cases in 2018. The rate per 100,000 (/100K) among male residents age 15-44 (2014-16 avg.) was 171/100K, considerably higher than both the peer county median of 103/100K, or the ROS of 120/100K. Among Tompkins County females, the Gonorrhea rate is a more modest 56/100K, similar to the peer median, 56/100K, and ROS, 67/100K. *(Figure 70, Figure 71)*

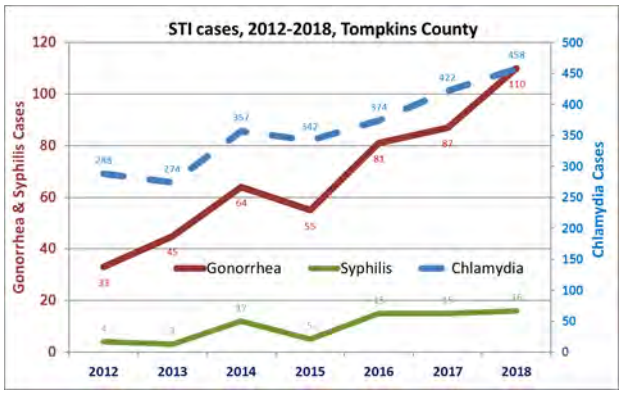

Figure 70

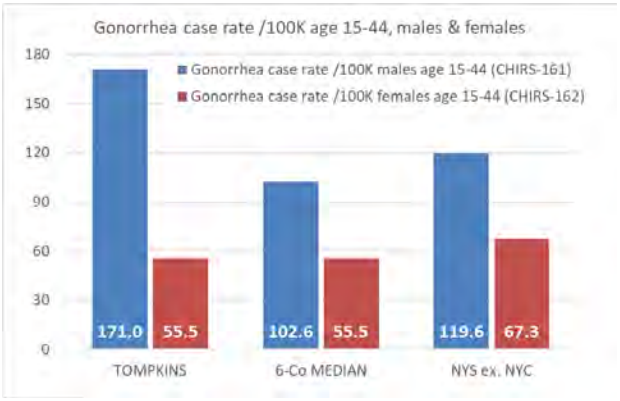

Figure 71

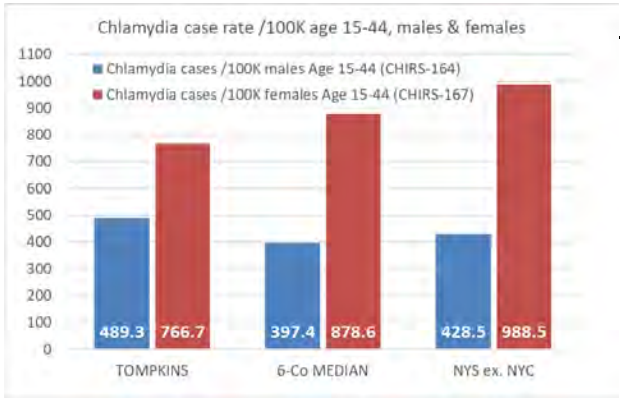

Figure 72

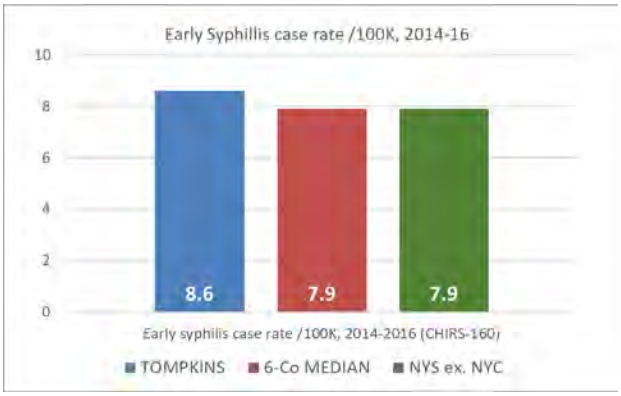

Figure 73

Chlamydia cases in Tompkins County residents age 15-44 rose less dramatically from 2015 to 2018, 342 cases to 458 cases, a 34% increase. Chlamydia is more prevalent in females than in males, though the gender difference in Tompkins is less than for the peer median or the ROS. The ratio of cases in females to cases in males is 1.6:1 in Tompkins, 2.2:1 in the peer counties, and 2.3:1 in the ROS (2014-16 avg., rate/100K). Female Chlamydia case rates per 100K were, Tompkins 767, peer county median 879, ROS 989 (2014-16 avg.)

The NYS Bureau of Sexual Health and Epidemiology reports Syphilis cases at three stages: Primary & Secondary, Early Latent, and Late & Late Latent. Because year-to-year variability can be so dramatic, the Tompkins County trend shown in *Figure 70* is a total of all cases; 3 cases to 12 from 2013 to 2014, and 5 to 15 from 2015 to 2016. The 16 cases in 2018 represents a rate of 15.3 /100K. *(Figure 70)*

The indicator reported in the CHIRS is for early syphilis cases as an average rate per 100,000 over 3 years (2016-2016). This helps smooth out the variability discussed above, to give a clearer picture across populations and geographies. For our comparison, Tompkins is 8.6 early syphilis cases /100K, the peer county median is 7.9/100K, and ROS also 7.9/100K population. *(Figure 73)*

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 5.1/100K. The peer county median is 6.1/100K, and the ROS is 6.9/100K. Data are 3-year average, 2014-2016.

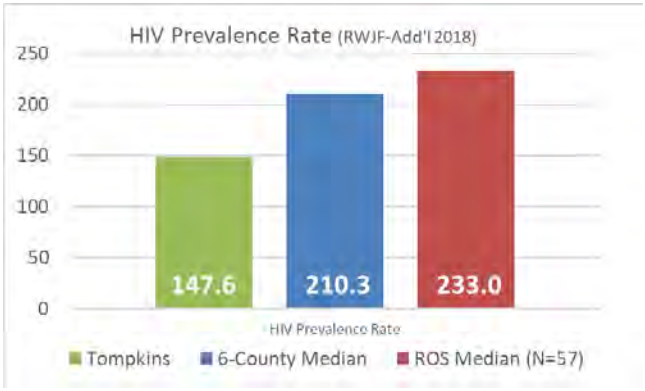

Figure 74

The PA reports three immunization/vaccine indicators, one for children under age 3, one for adolescent females, and one for adults age 65-plus. In Tompkins, 70% of children age 19-35 months have received the 4:3:1:3:3:1:4 immunization series, notably higher than the peer county median of 63%, or the ROS of 64%, however still below the Prevention Agenda 2018 objective of 80%.

Adolescent females age 13-17 are followed by whether or not they receive 3 or more doses of HPV vaccine, and here the comparison rates are more closely aligned, yet still below the state objective. In Tompkins, 43% of girls age 13-17 got 3-plus doses of HPV vaccine; the peer median is 38%, and the ROS 42%. The state PA objective is 50%. *(Figure 75, Figure 76)*

Finally, adults age 65-plus are the indicator for flu immunizations: among this population, in Tompkins 67% get a flu shot, the peer counties median is 63%, ROS 60%, and the PA 2018 objective is 70%.

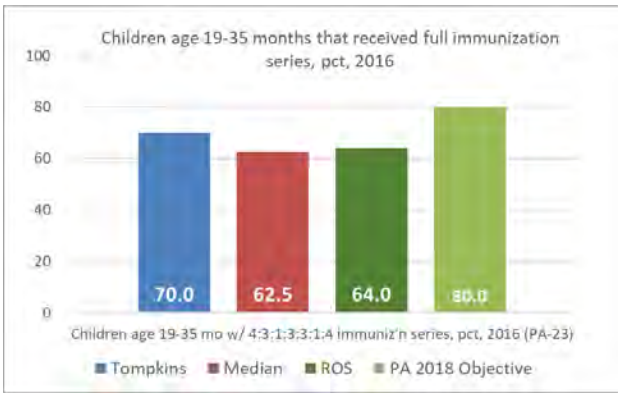

Figure 75

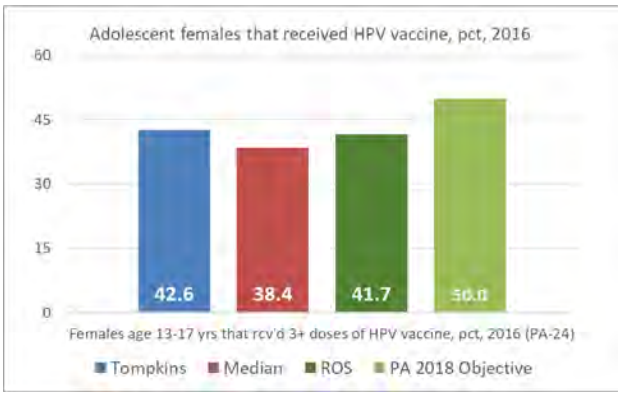

Figure 76

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 rate is 164/10K age 65+. The peer county median is 177/10K, and the ROS is 189/10K (2014 data).

Emergency Department (ED) visits due to falls among children age 1-4 is also reported in the PA as a rate per 10,000 residents of that age. The rate for Tompkins is 406/10K, the peer county median is about the same at 413/10K, and the ROS is 443/10K children age 1-4.

Reducing the number of assault-related hospitalizations is a factor contributing to a healthy and safe environment, and is recorded in the PA as a rate per 10,000 residents. While this number is relatively low; 1.0, 1.2, and 2.4 for Tompkins, the peer county median, and the ROS, respectively, the ratio of occurrences among the black population compared to the white population is noteworthy. For Tompkins County, there are 9.3 assault-related hospitalizations among Black non-Hispanic residents for every one among White non-Hispanics. The peer county median ratio is 6.3-to-one, and the ROS is 7.7. The data is a 3-year average 2012-2014. The Tompkins data is noted as unstable due to being based on fewer than 10 events during one of the years in one of the populations.

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. The PA monitors the efficacy of the program by comparing the number of asthma triggers identified in the initial home visit to the number identified in a revisit, usually 6-12 months later. In Tompkins County, 41% of homes had fewer triggers at the second (revisit) assessment. The peer county median was 7% of homes showing fewer triggers at a revisit, and the ROS was 21%. The PA 2018 objective was to have one quarter of home revisits revealing fewer asthma triggers.

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." [Public meeting on 5 year review 6/3/19: Principles and Policies handout, Proposed New Action Items handout.]

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.[6]

In the ten year period 2008-2017, there were 345 crashes involving pedestrians, three-quarters of which (78.6%) resulted in injuries. There were 15 pedestrian fatalities. Failure to yield right of way, driver inattention, and pedestrian's error/ confusion were the most prevalent contributing factors in pedestrian crashes in Tompkins County. The City of Ithaca has adopted a Vision Zero Action Plan. Vision Zero[7] is a methodology to eliminate traffic fatalities and severe injuries occurring on the roadway network. Vision Zero is a non-traditional approach to safety that requires a shift in how communities approach decisions, actions, attitudes and safe mobility.

Over the same period, 2008-2017, there were 240 traffic crashes involving bicyclists in Tompkins County. There was just one fatality, which occurred in 2013. The most prevalent contributing factors in bicycle crashes were failure to yield right of way, driver inattention, and bicyclist's error/ confusion. Pedestrian and bicycle data are from the ITCTC Crash Summary Report released in May 2018.

[6] tompkinscountyny.gov/files2/itctc/statistics/Final_CrashReport_052418.pdf
[7] https://visionzeronetwork.org/

Equity and Disparities

Achieving greater levels of health equity and reducing health disparities is a cornerstone of community health improvement. One way 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 65) is two and one-half more prevalent within the Black non-Hispanic population than it is within the White non-Hispanic population, and twice as prevalent for Hispanics compared to White non-Hispanics. The rate of preventable hospitalizations among Blacks is 1.5 times that for Whites. For the entire population, 23% of deaths are premature (peer county median is 21%, ROS is 22%), and the rate of preventable hospitalizations is 59 per 10,000 (age-adjusted, age 18+; peer median 82/10K, ROS 107/10K).

Two PA indicators tracking basic access to care are, adults with a regular health care provider, and adults with health insurance. In both cases, Tompkins and the peer county median are essentially the same.

Regarding a health care provider, 83% of Tompkins adults report they have a regular provider (BRFSS 2016). The corresponding peer median is 84%, and ROS comes in with 84%. For Tompkins this is a slight drop from the 87% reported in the 2013-2014 BRFSS. While this is still within the margin of error, the difference represents about 4,000 fewer adults having a regular provider.

The rate of adults age 18-64 with health insurance is 94% in Tompkins, and the peer county median is also 94% (2016). The rate for ROS is not available.

While not included in the PA, the CHIRS reports rates for the population with Medicaid or means-tested public coverage, and the rate of children under age 19 with health insurance. As with adults, Tompkins and the peers are close to being equal, and ROS data is not available. Among the population of children under age 19, in Tompkins 96% have insurance, and the peer county median is 97%. The rate of those in the general population with means-tested public coverage, including Medicaid, is 14% in Tompkins, and the peer county median is 13% (avg 2012-2016).

Incarceration

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]."[8] *Figure 77* shows an 18-month jail census.

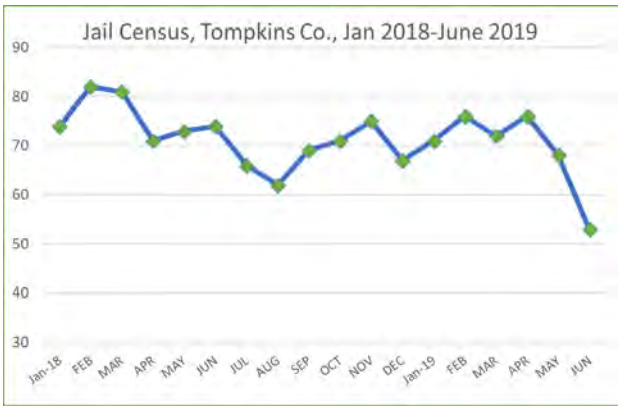

Figure 77

Community Survey

Results from the Community Health Survey, described on *Page 11*, in the Health Status section demonstrated how disparities and inequity may appear to be predictive 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 of health were Physical, Dental, Mental, and Overall. Ratings were 1 (excellent) to 5 (poor). N=1,131. 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.

Unemployed respondents, people of color, and people reporting a long-term illness or disability rated their health worse on all four dimensions (categories). Gender differences were found for mental health, with females being less favorable about their mental health than did males. Mental health was also the only category that showed differences by age; those ages 18-44 scored their less favorably than those ages 45 and up. Additional survey outcomes related to social determinants and disparities is reviewed in the *Main Health Challenges* section, page *44*.

Key Stakeholders

A stakeholder said that social determinants of health can create additional burdens which make it difficult to access care. One stakeholder described challenges with patients being discharged from care providers.

"Patients get kicked out of a practice due to non-compliance with attendance or non-payment of bills. [They might] get a barrage of notices to what's listed as their residence. But this is assuming the patient got that, could read it, and fully understood what it meant […] They often don't realize they've been discharged until they try to make an appointment and then find out."

[8] Source: CRG Inc., An assessment of the future of the Tompkins County jail. Prepared for the Tompkins County Legislature, July 2017. PDF accessed Oct. 2019.

Stakeholders had varying views on the awareness and will to address health disparities in the county.

"The community did not want to incarcerate our population and that's a huge focus and especially incarcerating our behavioral health population. That was a huge disparity and not resiliency focused. The county literally gave […] funding for a position. As far as I can find, no other community in the whole state is offering that."

Stakeholders noted that disease self-management is directly tied to health literacy especially among older adults, people with low incomes, and people with language barriers.

"Especially with the low-income people, they have a very hard time understanding their disease and how to manage their disease. I think we all have to remember to do our teaching with health literacy in mind."

"But if there's a language barrier, then it's even more difficult. There's more access to home health without as many regulations, but Visiting Nurse Services said they couldn't communicate and then just were done."

Dental and pediatric dental were ranked the second most important unmet need by stakeholders. The most significant issue related to dental care in the county is the lack of Medicaid providers and funding for dental.

"We see those […] issues very significantly with the older adult population. More people are requesting please don't send apples because they can't chew them […] they don't have teeth. I don't know the level of challenge with kids. Cost and access to affordable dental care is probably the same for them. But it really impacts older adults and how it affects their nutrition."

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.

One goal of Healthy People 2020 (HP2020) is, "Create social and physical environments that promote good health for all." The HP2020 framework includes five key areas of social determinants of health:

- Neighborhood and built environment (i.e., the housing, environmental conditions, and safety of a person's neighborhood)
- Health and health care
- Social and community context (i.e., family structure, community civic participation, and perceptions of discrimination and equality)
- Education
- Economic stability

Figure 78

Within each of these broad areas, such as poverty, housing, social support, discrimination, quality of schools, health care access, and transportation, social determinants influence health-related disparities. This framework establishes a common language that will be referred to throughout this report.[9]

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 March 2019, the Health Department conducted a community survey to determine how residents would rate their own health in four dimensions:

[9] [Sources: healthypeople/gov, HP2020, CDC]

physical, dental, mental, and overall health. Generally speaking, respondents (N=1,124) rated their health about in the middle of a five-point scale, with 1=Excellent and 5=Poor.

However, significant differences were found linking how respondents rated their personal health with how they answered questions related to housing, food security, access to health care and transportation, and other recognized social determinants of health.

- Homeownership status was related to better perceptions of health while people who reported being homeless or living in subsidized housing had poorer perceptions of their health.
- People with transportation issues report significantly poorer perception of health on all four dimensions.
- Food insecure respondents report significantly poorer perception of health on all four dimensions.
- Positive ratings for neighborhood safety and opportunities for children to play and adults to be active outdoors is associated with respondents' positive perception of health on all four domains.
- Respondents' perception of their health was related to the type of insurance they had with people with Medicaid and those without reporting the worst health on all dimensions.
- Respondents who reported low doctor use gave a worse rating for dental, mental and overall health, though not for physical health.
- One in five (20.8%) survey respondents said they always feel stressed about paying for care in at least one of the following areas: medical, dental, mental health, substance use, and prescriptions. Those respondents report significantly poorer health on all four dimensions.

Socio-economic status and racial and ethnic minority status was also associated with respondents' perception of their health.

- On average, persons of color gave themselves a worse rating than did those who did not identify as a person of color for all categories; physical, dental, mental, and overall health.
- Respondents reporting a lower household income rated their health less favorably. Those whose household income (HHI) was under $50,000 rated their overall health as worse than the mean of all respondents, and those HHI was over $50K rated their overall health at, or better than the mean of all respondents.
- Those who identified as being unemployed rated their health worse on all four dimensions.
- Respondents whose age was between 18 and 44 scored their mental health less favorably than those ages 45 and up.
- Lower educational attainment was associated with poorer perception of health on all four dimensions
- Those who reported having a long-term illness or disability rated their health worse on all four dimensions.

- Where respondents live in the county was related to all four dimensions of health. Most notably, Groton residents, on average, reported the poorest physical health, dental health, and overall health, while Ithaca City residents reported the poorest mental health. At the other end, Cayuga Heights residents reported the best ratings in all four categories.

Other County Departments

While the concept of social determinants has been well documented for years, it has now been fully integrated into Prevention Agenda with the 2019-2024 revision. And, the March 2019 survey is the first conducted by TCHD, which 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 Mental Health 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.

[10] Source: http://tompkinscountyny.gov/files2/planning/ComprehensivePlan/Principles%20and%20Policies%20Review%205-20-19.pdf Accessed Oct. 2019

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]

Mental Health

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 (TCMH) Department.

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, TCMH 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.

[11] Source: http://tompkinscountyny.gov/files2/cofa/Age%20Friendly%20Plan%20Final%2012.23.16.pdf. Accessed Oct. 2019.

In the Goals section of the TCMH 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 TCMH 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. TCMH 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.

With regard to LGU engagement with local partners during implementation of goals and interventions, the TCMH plan notes that Tompkins County has been "piloting integration of the mental health and health department leadership under one Commissioner with increasing collaboration between the departments." However, the TCMH plan identifies "inconsistency in regulation, guidance, billing and licensures for OASAS, OMH, OPWDD & DOH programs and services" as an impediment to collaborative work on Prevention Agenda goals and interventions.

The TCMH 2020 Local Services Plan does not have a goal related to heroin and opioid programs and services, noting that, "This need is already included in crisis, housing, SUD residential, and other areas of this plan." The plan further states, "Tompkins County is concerned about population health in the current opioid crisis and finding reduction in overdose. A full spectrum of supports and services are being explored to address this issue such as diversion and medication assisted treatment. Positive outcomes are reflective of increased training and availability of Naltrexone."[12]

[12] Source: http://www.clmhd.org/img/pdfs/brochure_zldmzlq3ef.pdf Accessed Oct. 2019

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 Health Department (TCHD)

A full-service health department 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. Its mission: To strive to achieve a healthy community by protecting, and promoting public health through education, training, advocacy, and the provision of services.

TCHD provides pre- and post-natal care through the Medicaid Obstetrical and Maternal Services (MOMS) program and through pre- and postnatal home visits for at risk families. The Supplemental Nutrition Program for Women Infants and Children (WIC) is a federally funded program provided by TCHD. 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 launched eWIC, and electronic debit card system in Fall 2018.

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 (age 21, effective 7/1/2017).

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, denormalize tobacco use, and reduce youth initiation through outreach, policy, and environmental change.

HPP provides the Diabetes Prevention Program in collaboration with the Cayuga Center for Healthy Living, and 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. Harmonicas for Health is a 6-week program for individuals with COPD and other respiratory disease. Participants learn to play the harmonica to practice breathing exercises.

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.

The Health Department 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 System, is a 212-bed Federally-designated Sole Community Hospital. In 2018, Cayuga Medical Center provided approximately 7,500 inpatient discharges, 7,900 inpatient and outpatient surgeries, 29,600 emergency visits, 44,300 urgent care visits, and 15,500 hematology/oncology visits. Approximately 63% of CMC's total inpatient discharges were for patients with Medicare or Medicaid; 2.2% were for patients without insurance. CMC offers a Financial Assistance Policy, which helps to ensure that patients with limited income or no insurance can access health care services. Tompkins County represents the majority of CMC's primary service area and is where most of the patient population receiving services at the hospital reside.

Approximately 215 physicians (4:1 specialists to primary care) serve Tompkins County. Several specialties locally identified to be in short supply include family practice, pulmonology, obstetrics/gynecology, dermatology, neurology, vascular surgery, neurosurgery. The NYS Regents Shortage Areas identifies pathology and physical and rehabilitative medicine in addition to the local needs assessment. CMC is listed as a hospital eligible for primary care and non-primary care shortage area designation. Tompkins County's Medicaid-eligible population is designated as a HPSA for primary and dental care.

Cayuga Health Partners (CHP) -

A collaborative partnership between Cayuga Area Physicians' Alliance (CAPA) and Cayuga Medical Center; encompassing more than 40 primary and specialty care practices. As a clinically integrated network, CAP incorporates evidence-based best practices and innovative data exchange in a way that aligns physician incentives, while driving network enhancements to achieve optimal health outcomes at an affordable cost.

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 Mental Health Department -

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. See also page *47* in the *Main Health Challenges* section, above.

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 group of 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. CNC has a shared workplan and is continuing to refine measures and indicators using a common reporting document. 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. Providing advisory support for Farm to School collective purchasing and expanding universal breakfast in school settings are priorities for CNC.

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

TCHD will host the Lourdes Mammography Van in May 2020 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.

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

Other Initiatives

Collective Impact

- Cradle to Career
- Childhood Nutrition – TCHD, Cornell MPH, CCE, Greenstar
- My Brother's Keeper

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 distributed and presented to existing coalitions, groups, and committees throughout the county. The document was produced by the Health Promotion Program of the Tompkins County Health Department and the Planning Department of Cayuga Medical Center.

Data Collection

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

- U.S. Census Bureau 2012-2016 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 2014 through 2016.
    - 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 Health Factors rankings for New York State are Nassau (1), Putnam (4), Rockland (6), Saratoga (2), Tompkins (5), and Westchester (3). These were the basis of comparison with Tompkins County. *(See also Aggregated Data, page 10)*

Senior Leadership

The Senior Leadership teams from both the Health Department and Cayuga Medical Center (CMC) provided input during the early stages of the project as Priorities and Focus Areas were considered. TCHD (April 2019) and CMC (June 2019) leadership teams reviewed the Prevention Agenda Priority Areas and Focus Areas and provided high-level recommendations about what should be investigated further during the CHA process and review of data. These discussions and recommendations were used to structure the CHA and the data collected from secondary sources. The focus groups and stakeholder interviews aligned with these focus areas.

Steering Committee

A meeting was convened by the Health Department in March 2018 to discuss collaborative planning among County Departments and key partners. These agencies included, Tompkins County Health, Mental Health, Youth Services, Office for the Aging, and Planning Department Directors. Partner organizations included, Human Services Coalition, Cayuga Medical Center, Cornell MPH Program, Lakeview Health Services, and Racker Centers.

At the March 2018 meeting, the Prevention Agenda priority areas were reviewed and there was discussion about how to improve our multi-sector planning effort to best support community health and inform community action. There was initial discussion about how to develop collective goals across agencies and departments to strategically address social determinants of health.

In February 2019, the local firm Horn Research was hired to collect and compile primary data using key informant interviews and focus groups. A steering committee was convened by TCHD following the hiring of Horn Research. The committee included representatives from TCHD, Cayuga Medical Center, Health Planning Council (Human Services Coalition), County Office for the Aging, County Mental Health Services, Horn Research, TCHD Board of Health, Ithaca College Department of Health Promotion and Physical Education, and Cornell Master of Public Health program. This committee met in person monthly and communicated via email, phone, and Google Drive regularly throughout the process.

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

In March 2019, TCHD launched a Community Health Survey, modeled on the Common Ground Health *My Health Story 2018* survey. The goal of the survey was to assess community members' perceptions of their current health status, and seek insight on how certain social determinants might influence that status. Survey responses would also inform focus group topic areas. Survey development was supported by input from community representatives, including the Early Childhood Development Council, Cornell Cooperative Extension Nutrition Advisory Committee, Multicultural Resource Center, and technical support from the Cornell MPH program, Human Services Coalition, and Horn Research.

The survey was open for 6 weeks (March through mid-April 2019) and received 1,317 responses from Tompkins County residents.

The survey instrument was distributed widely through an electronic link on the TCHD website, social media (Facebook and Twitter), the Human Services Coalition email Listserv, the Downtown Ithaca Alliance, and Chamber of Commerce. The survey link was spread through our three higher education institutions on various listservs (Cornell, Ithaca College, and TC3). 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.

All Tompkins County public libraries were notified and sent a package of fliers and posters to promote the survey. Paper surveys and fliers were delivered to medical offices, including the VA Clinic and REACH Medical. Paper surveys were available at food pantries and Loaves and Fishes. Foodnet Meals on Wheels distributed paper surveys with meals to 50 households throughout the County with self-addressed envelopes. Emails were sent to the Newfield and Groton school district superintendents, Principals of Caroline and Enfield Elementary Schools, and the Ithaca High School PTA. The Human Services Coalition assisted with the distribution of the survey. The survey instrument will be available as an Appendix.

Key Informant Interviews

Twenty-six stakeholders representing different sectors participated in a qualitative telephone interview during March and April of 2019. Stakeholders were asked to complete a brief pre-interview survey where they selected from a list the three most important: health issues facing the county, unmet needs, and social determinants of health that negatively and positively impact the county.

The pre-interview survey results were (N=26):

- The most important health issues identified were: 1) Drug and alcohol misuse, 2) Mental health issues, and 3) Health disparities between populations.
- The top unmet health needs were: 1) Mental health care, 2) Dental/pediatric dental care, and 3) Long-term care and nursing homes.
- The social determinants most negatively impacting the county were: 1) Poverty and income insufficiency, 2) Lack of transportation, and 3) Housing instability.
- The social determinants that positively impact the county were: 1) Strong network of community-based services, 2) Strong economy, and 3) Green spaces and walkable community.

In the follow-up qualitative interviews, stakeholders were asked to describe the thinking behind their selections and their perception of the community's awareness of and willingness to address those issues. In addition, stakeholders were asked to identify areas where prevention programming has been successful, and the types of programs and initiatives they would most like to see implemented. The full report will be available as an Appendix.

Focus Groups

In July 2019, four focus groups were conducted by Horn Research. The four locations were: Jillian's Drawers in City of Ithaca, Calvary Baptist Church in the City of Ithaca, Tompkins Cortland Community College in Dryden, and Groton Public Library in Groton. A total of 32 individuals participated.

All four groups were asked the same set of questions:

- What kinds of effort do you think would be most effective in ensuring people in your community have access to healthier foods?
- What do you think are the reasons women in your community don't access health screenings and tests?
- What do you think are the main barriers to women receiving early prenatal care?
- Why do you think there has been an increase in emotional and mental health issues in the community? Is this something you've seen within your community?

Tompkins County Board of Health

The Health Department's Board of Health was updated during 2018-2019. The Board membership includes a representative from the County Legislature.

Tompkins County Health Planning Council and Tompkins Health Network

The Health Planning Council was updated at their monthly meetings during 2018-19. The member organizations helped promote the Community Health Survey and several members were interviewed as a stakeholder. A summary of the CHA and initial priorities for the CHIP were presented at the October 9, 2019 meeting. A Community Health and Access subcommittee of the Health Planning Council will be convened to monitor and evaluate progress on the CHIP.

Community Health Improvement Plan, 2019-2021

THE PREVENTION AGENDA (PA)[13] [14] 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 2019-2021 addressed are:

1. Prevent Chronic Disease, Focus Area 1: Healthy Eating and Food Security
2. Prevent Chronic Disease, Focus Area 4: Preventive Care and Management
3. Promote Healthy Women, Infants, and Children, Focus Area 4: Cross cutting healthy women, infants, and children
4. Promote Well-Being and Prevent Mental and Substance Use Disorders, Focus Area 1: Promote Well-Being

Disparities and Health Equity

Poverty is the most consistent inequity underlying the unmet needs in the selected Focus Areas. And, because services and resources tend to be clustered in just a few geographic areas of the county, spatial accessibility to resources—just being able to get to a pharmacy or provider's office on time—also creates inequity. Limited options for transportation impacts both those living in rural areas and those living within the City of Ithaca, as do work schedules and child care options.

It is also evident from data presented in the Community Health Assessment (CHA) that racial inequity exists and contributes to challenges with health access and delivery of services. These disparities are a result of a system of inequity: wide income gaps, systemic racism, a culturally diverse and transient community, and variation in standard of care. The interventions described here are intended to develop and promote a more equitable delivery of services that reach the standard the community aspires to.

[13] www.health.ny.gov/prevention/prevention_agenda/2019-2024/ (Accessed Dec 2019)
[14] NYS Prevention Agenda 2019-2024. Download the full document as a PDF (3.5MB, 256pp)

Process and Criteria

In February 2019, Horn Research of Slaterville Springs was retained as a consultant for the data collection process of the Community Health Assessment (CHA), and a Steering Committee was convened by TCHD. The committee included representatives from TCHD, Cayuga Health Systems (Cayuga Medical Center), Health Planning Council (Human Services Coalition), County Office for the Aging, County Mental Health Services, Horn Research, Tompkins County Board of Health, Ithaca College Department of Health Promotion and Physical Education, Cornell Master of Public Health program, Cornell Cooperative Extension of Tompkins County. This committee met in person monthly and communicated via email, phone, and Google Drive throughout the process.

To inform the decision-making process for selecting the CHIP focus areas, the steering committee drew on their professional expertise, their extensive review of secondary and primary data, and their personal experience as residents of Tompkins County. In August 2019, the steering committee met to conduct a "data walk" to review multiple sources of data for seven focus areas determined to be of most interest during the CHA process. The participants circulated in small groups to discuss the various data and answer reflection questions about each station. The questions included: what are the disparities, what are the connections to available resources/programs/services, how will we know if we are succeeding, and what surprises you about the information?

Following the data walk, there was a whole group discussion and a brief survey was sent out through which steering committee members were asked to choose two priorities. Based on this survey, the focus areas listed above were selected for the CHIP.

The proposed focus areas and supporting data were presented at the September 2019 Health Planning Council meeting, after which there was discussion, comments, and feedback. The Health Planning Council represents over 20 community organizations in Tompkins 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-1.1: Increase access to healthy and affordable foods and beverages CD-1.2 Increase skills and knowledge to support healthy food and beverage choices 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.	Poverty; Residence/ geography; Race
Promote Healthy Women, Infants, & Children	HWIC-4: Cross Cutting Healthy Women, Infants, & Children	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 recipient); Race; Residence /geography
Promote Well-Being & Prevent MH and SU 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

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

Hospital Actions and Impacts

During the 2019-2021 timeframe, Cayuga Health System (CHS) will work towards addressing numerous health needs discussed in the CHNA. These needs include: the prevention and management of chronic diseases, specifically screening for breast, cervical, and colorectal cancers, and the promotion of well-being and prevention of mental and substance use disorders. Many of these interventions have been and will continue to be led solely by the Health System, while others will be a collaborative effort with other local organizations. The following describes interventions and initiatives CHS is involved in and their intended impact on the community at large.

Chronic Disease Preventive Care and Management: Cancer Screening and Early Detection

To ensure patients are receiving timely and appropriate care, specifically in regard to cancer prevention and management, Cayuga Health System has been heavily involved public initiatives and interventions.

Year-over-year, the health system is involved in numerous outreach initiatives, and since 2016, CHS has been involved in over 70 initiatives. Each year, CHS's prevention and screening program shifts its focus to target a specific cancer prevention goal. Over the past three years, the program has focused on events and initiatives surrounding breast health and screening, colon cancer screening and preventative care, and melanoma screening and preventative care. Key events have included the following:

Community Wellness Health Fair

This event utilized laptop computers with internet access for community members to complete the National Cancer Institute Breast Cancer Risk Assessment Tool. Upon completion of this event, 100% of participants reported that they learned something helpful, including increased cancer awareness, what a derma scan is, signs of pre-diabetes, preventing type 2 diabetes, when to know it's time for colonoscopy, and how and where to access the many different programs that are available at the Cayuga Center of Healthy Living and at Cayuga Medical Center. Similarly, 86% of participants reported that they will make changes in their health behaviors; these include breast health, limiting sun exposure, increasing exercise, healthier eating, weight loss, and improved nutrition.

Bottom Boogie Event

The Blue Bottom Boogie event was held at the Shops of Ithaca Mall in 2016, 2017 and 2018 with collaboration from the Cayuga Medical Center Endoscopy, Cayuga Cancer Center, the American Cancer Society, the Cancer Resource Center of the Finger Lakes, and the Cancer Treatment Services Program of Tompkins Cortland County. These events focus on the

importance of colorectal preventive care and screening and discuss the 80 by 2018 colorectal initiative. This event is well attended and has reached a vast number of community members in our service area. Eight-five percent of people surveyed after this event believed they learned helpful information including colon prep information, information on risk factors and treatment, treatments options and the importance of preventative screenings, and the different types of colon cancer and family genetics. Seventy-two percent of individuals reported they had a recent colonoscopy and 34% report that they are interested in getting a colon cancer screening.

Silver Service Lecture at Kendall at Ithaca

These events occur on an annual basis at Kendall at Ithaca in Ithaca, New York and are led by Cayuga Medical Center's Oncology Nurse Navigator. The focus of these events is on identifying risk factors, cancer prevention and screening education for both detection and prevention of cancer among elder residents. Each year, approximately 20 residents attend the informational event.

Removing Structural Barriers through Carpenter Park

Through the development of Carpenter Park — a multi-functional facility which will house a medical office building to be operated by Cayuga Health System — in 2020 and 2021, CHS will be directly addressing structural barriers to health care. With its convenient and walkable location from downtown Ithaca, Carpenter Park will better serve Ithaca's lower income and Medicaid population by providing a wide variety of services including women's health screening.

Promote Well-Being and Prevent Substance Use Disorders

Mental Health First Aid

Also discussed in the 2016 CHIP, CHS is continuing its efforts towards the expansion of Mental Health First Aid Training to target at-risk individuals and their families. By doing so, CHS hopes to create and kindle 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, CHS will continue to work alongside Franziska Racker Centers, local school districts, and local pediatricians and primary care providers.

Screening Models and Protocols

Much like screening for cancer, screening patients for mental health and/or substance use disorders can play a major role in the long-term health and well-being of those individuals. Screening saves lives. At Cayuga Health System, many screening models and protocols are used to best determine the appropriate route of care for patients.

The ***Columbia-Suicide Severity Rating Scale (C-SSRS)*** is a frequently used tool by Cayuga Medical Center's Behavioral Services Unit. When a patient is referred to the unit for evaluation, especially when s/he is referred from the Emergency Department, C-SSRS is used to evaluate an individual's risk of suicide. Using a series of simple questions, medical staff and providers are able to better identify whether a patient is at risk for suicide, assess the severity of the patient's mental health status, and determine the level of support and care the patient needs.

Another commonly utilized and effective screening model used at Cayuga Medical Center to screen patients for substance use is the ***CAGE-AID Questionnaire***. This questionnaire is used by CHS's BSU staff to test for alcohol and substance abuse and dependence in adults. While this tool is not used to prevent or diagnose the diseases, it is extremely helpful in indicating whether or not a problem exists. Once a problem is identified, providers are better able to formulate a personalized and appropriate care/treatment plan that is specific to that patient.

Zero Suicide Model of Care

Cayuga Medical Center medical staff and leadership 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 Medical Center implemented the model in early 2019. 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 Medical Center 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.

Behavioral Services Unit Transportation Program

Patients who are discharged from the Behavioral Services Unit (BSU) at Cayuga Medical Center are often times in need of follow-up care with providers at Tompkins County Mental Health. Many of these patients miss their appointments due to lack of transportation or failure to comply with medical orders. To better support this patient population and ensure their safe and timely arrival to their mental health appointments, the BSU at Cayuga Medical Center launched a Transportation pilot program in June, 2019. By leveraging ride-share technology, BSU Licensed Social Workers schedule rides for patients several days prior to the patient's appointment. Since the inception of this program, 20 patients have been enrolled for transportation assistance. Of the 20 patients, 13, or 65 percent successfully made it to their scheduled follow-up appointment. Four of the 20 enrolled patients canceled their appointment but successfully rescheduled and attended; the remaining 3 patients cancelled and did not attend their appointment. With a total of 17 of 20 enrolled patients attending their follow-up mental health appointment, the BSU was able to increase their attendance rate from 50 percent to 85 percent.

Geographic areas of focus

These interventions will impact Cayuga Health System's combined service area (SA); CHS's Service Area System is a mixture 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.

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 System will continue to utilize its existing staff members, outreach programs and initiatives, and its partnerships with external organizations.

Local Health Department Actions and Impacts

During the 2019-2021 period, the Tompkins County Health Department will work to address the health needs identified as priorities in the CHIP. These include: 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. Many of these interventions will be a collaborative effort with CHS, other County departments, and community organizations. The following describes interventions and initiatives currently underway in addition to new strategies, and their intended impact on the community at large.

Prevent Chronic Disease: Healthy Eating and Food Security

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.

As revealed through data in the Community Health Assessment (CHA), food security is a real issue for a significant segment of the Tompkins County population. While this is new information for the CHA, many community-based organizations, social service providers, schools, and programs have initiatives underway to address this challenge.

Two programs that exist in schools are the Fresh Snack Program, part of the Youth Farm Project, and the Farm to School Program. Both support the Prevention Agenda (PA) objective to increase consumption of fruits and vegetables among children. Fresh Snack is currently being piloted in six of eight elementary schools in the Ithaca City School District, and the CHIP sets a target of the program being active in all 8 ICSD elementary schools over the next year, and in three more districts by 2021.

Farm to School is a NYS-funded grant program that works to increase the amount of locally sourced food purchased and served by school meal programs. The grant objectives are to bring healthier foods to children, while at the same time providing a market and distribution network for local farms. Farm to School aims to have districts reach 30% of food sales from NYS producers. Cornell Cooperative Extension (CCE) is the lead agency for the grant in Tompkins County.

The Tompkins CHIP progress measure is for at least one district to reach the 30% mark in the first year, two districts by the end of the second year, and all districts sourcing 30% of food service products locally by 2021.

A third intervention in the objective for improving children's consumption of healthy foods — and assuring that children do not start the day hungry — is Universal Breakfast, a program that makes a nutritious breakfast available to all school students. Currently, this program is operating in two of Tompkins County's rural districts, plus two schools in the Ithaca District. Progress by 2021 is to have the program active in all Ithaca elementary schools. Refer to the workplan matrix for more information and updates.

Obesity

Reducing adult and childhood obesity continues to be an objective of the Prevention Agenda (PA) and preventing related chronic disease. From 2008–2016, the average rate of obesity among Tompkins County adults increased, most recently rising above the PA goal (in 2016, Tompkins 24%, goal 23%). Food security is fundamentally driven by structural determinants — economics, built environment, entrenched and often inequitable systems. Add to that cultural influences and a marketplace focused on fast food, and the environment is one that facilitates high rates of obesity.

One program that uses an existing system to help direct individuals to a healthier pace is called Fruit and Vegetable Prescription (FV Rx). FV Rx is being piloted through a partnership of Cayuga Center for Healthy Living (Cayuga Health System), CCE-Tompkins, Healthy Food for All, Cayuga Medical Associates, and the Cornell University MPH program. In the program, the healthcare provider gives participants a prescription (Rx) for fresh fruits and vegetables, which they can redeem through a CSA share. For additional program information, visit healthyfoodforall.org/fvrx/. Refer to the workplan matrix for projected outcomes and updates.

Change is often more successful when support and encouragement are given in a different setting, or by role models and peers. Community Obesity Prevention Training is a strategy that provides nutrition education and obesity prevention training to partner agencies and local human services staff. The goal is to encourage partner agencies working with the SNAP population to become role models and SNAP-Ed champions for change. Cornell Cooperative Extension of Tompkins County (CCE-TC) has secured a grant to implement the program locally. Implementation will begin in Spring 2020.

CCE-TC also facilitates training for CATCH, the Coordinated Approach to Child Health, an evidence-based program that includes school-based obesity prevention. Currently in Tompkins County only the Newfield School District has adopted the program, and the projected outcome for year 2 of the CHIP is to engage at least one additional district in the CATCH program. Visit catchinfo.org for more about the program, or the CDC's CATCH Training site.

Prevent Chronic Disease: Preventive Care and Management

Cayuga Health System (CHS) will lead the public initiatives and interventions related to this Focus Area. The Health Department will convene community partners to further support this effort. In the CHIP, CHS concentrates on prevention with interventions designed to increase screening rates for breast, cervical, and colorectal cancers.

It is easy for individuals to lose track of their schedule for cancer screening, so reminders from the provider are common and important. The CHS oncology department currently sends a series of screening reminder letters to patients for follow-up screening care, specifically breast and lung screening. Cayuga Health Partners (CHP) care coordination team receive reports from provider offices about patients who are overdue for breast, colorectal or cervical cancer screenings, and then follow-up with phone calls to those patients. However, the means by which people communicate is changing, so CHS and other partners will identify additional modes for sending reminders to schedule a cancer screening. In years two and three, the CHIP adds a focus to target underrepresented groups to address inequities in who gets screened on time.

Remembering a screening appointment is an obvious first step, but sometimes less apparent are the structural barriers, such as time and place, that make it hard or impossible to make prevention a reality. Flexible clinic hours, more sites, and avoiding the necessity of a follow-up appointment are all interventions recommended in the Prevention Agenda. The CHIP workplan projected outcome for year 2 is to have the Lourdes Hospital mobile mammography van set up in at least five different Tompkins locations. For a more permanent solution, the CHS Carpenter Park expansion project is expected to provide a new, downtown location for cancer screening services.

Promote Healthy Women, Infants, and Children: 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, people with lower income or fewer years of education are less likely to report that they are in good health, and mothers who give birth due to an unintended pregnancy are more than 2-1/2 times more likely than not to be enrolled in Medicaid.

Medicaid Obstetrical and Maternal Services (MOMS)

The Prevention Agenda (PA) goal for Focus Area 4 is to "Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations." The MOMS program, Medicaid Obstetrical and Maternal

Services, has been ongoing at the Tompkins County Health Department since 2000, though enrollment has been on a steady decline since 2015. Assessment of options for expanding MOMS got underway in year one (2019) of this CHIP, and will continue as strategies are rolled out. These include collaborating outreach with Cayuga Birthplace of the Cayuga Health System (CHS), pediatric and ob-gyn practices, Midwives, Family Treatment Court, and the county Department of Social Services to reach participants for this program.

The program is expanding services in a pilot capacity to serve beyond the Medicaid population. The proposed changes include group education and increased outreach to providers, the Birthplace at Cayuga Medical Center, and non-traditional partners. Evidence-based screening tools used in MOMS include: Aubrey Assessment (includes psychosocial risk), Edinburgh Postnatal Depression Scale (EPDS), AUDIT (drug and alcohol use), and DAST (drug/substance use).

MOMS assist low-income pregnant women with Medicaid application, obtaining prenatal care, and referrals to WIC and other community services. Nurses provide home visits to offer education on pregnancy, nutrition, childbirth preparation, lactation and infant care, growth and development. Nurses are certified lactation counselors.

School-Based Health Program (SBH)

CHS is considering opportunities to partner with local school districts and engage in school-based health programs for children. Actions over the three-year CHIP are to convene a steering committee to review and assess available SBH models, evaluate funding options, establish a team, training, and evaluation plan for implementation, and initiate the program in at least one school district. Other partners include Cradle to Career, TC Youth Services, Local School Districts, and TCHD. For more information about school-based health programs, visit The Community Guide page Health Equity: School-Based Health Centers online.

Promote Well-Being and Prevent Mental and Substance Use Disorders

Focus Area 1: Promote Well-Being

"Well-Being" is a new term within the Prevention Agenda mental health priority. In Focus Area 1, "Promote Well-Being," it is defined 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. 1.3, 4/25/2019, p.207]

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

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 2016 in Tompkins County is 12% of adults, up from 7% for 2013-14.

SafeCare®

Goal 1.1 under the Promote Well-Being Focus Area is to "Strengthen opportunities to build well-being and resilience across the lifespan," and one of the recommended interventions within that goal is to "Implement evidence-based home visiting programs." Home visiting programs offer skills and resources to families that assist in raising children who are physically, socially, and emotionally healthy and ready to learn.

SafeCare®[15] is an evidence-based, behavioral parent-training program for parents of children ages 0-5 who have been reported for child neglect. The program is delivered by SafeCare-certified Community Health Nurses via 18 weekly home visits covering three scripted educational modules: Health, Safety, and Parent-Infant or Parent-Child Interaction. The Health Department has achieved annual SafeCare accreditation since 2017 and received the National Association of City & County Health Officials (NACCHO) model practice award in 2019.

In its first three years of implementation, SafeCare® has improved the family reunification rate from 42% to 82%. With the success of this program the Health Department is piloting an expansion, SafeCare Select, to include families who are not referred by Family Treatment Court, but are considered at-risk of child abuse or maltreatment. The progress of this program will continue to be monitored and specific modules from the SafeCare program will be used with the goal of the expanded program to reduce crisis calls/reports by 10%. See the CHIP matrix for details and updates.

Nurse Care Manager

The Nurse Care Manager Program (NCMP) utilizes housing—specifically, affordable housing where low-income elders live independently—as a vehicle for delivering patient-centered, comprehensive, quality health care. The program bridges medical care while addressing social determinants of health in low income senior housing. Visiting Nurse Service (VNS) of Ithaca and Tompkins County has implemented the program in Tompkins County through which nurses are embedded in low-income housing authorities. The program provides care that allows elders to stay at home, and allows the care provider to address uncoordinated

[15] https://safecare.publichealth.gsu.edu/ (accessed Dec 2019)

and fragmented care, and demonstrate impact on social determinants of health. The program will expand beyond Ithaca Housing Authority in year 2.

Harmonicas for Health

Social isolation can influence the mental health of individuals living with a chronic disease, especially seniors and the elderly. Protective factors such as social support, self-care, and self-esteem can counter the potential impact of social isolation and improve or maintain mental health and resilience.

Harmonicas for Health (H4H) is a classroom-style program for individuals with asthma or chronic lung disease such as COPD. Each course is six weekly classes where 12-15 individuals work as a group to learn to play the harmonica. The action of breathing through pursed lips is a common breathing exercise for individuals with reduced lung capacity, and playing the harmonica is a good way to practice.

Three six-week H4H courses were held in year one of the CHIP, with a total of about 50 participants. Two of the courses were held at a central location in Ithaca, and one was in a rural village. The plan for year two and three is to increase the number of courses to four, and branch out to additional rural locations. A tool for six- and twelve month follow-up will be developed, as well as a sustainability plan. Expanding the current partnership with Cayuga Health System (CHS) as an ongoing part of respiratory rehabilitation will be explored.

PROS

TC Mental Health offers Personalized Recovery Oriented Services (PROS), a comprehensive recovery oriented program for adult individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support, and rehabilitation in a manner that facilitates the individual's recovery.

Intergenerational Programs

Resilience and well-being may be strengthened through intergenerational activities, and the County Office for the Aging (COFA) and TC Youth Services (TCYS) are collaborating to plan events as described in COFA's Age-friendly Plan, Aging Center for Excellence, and the TCYS Achieving Youth Results (AYR) Community Action Plan. Intergenerational Programs training was held in year 1, and project planning and development will be done in year 2 and implemented in year 3.

Housing Improvement, Affordability, and Stability

The TC Mental Health Local Services Plan 2020 includes the priority goal, "Increase supply of OMH, OASAS, & OPWDD housing services to meet the increasing demand by developing new housing options licensed or supported by OMH, OASAS, and OPWDD as well as other

unique transitional and crisis housing options in Tompkins." TCHD will partner with and support TCMH to assist in moving forward with this goal.

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

The objective for this goal turns to the Opportunity Index, using the Community Score as the data point (https://opportunityindex.org/). Tompkins County's Community Score is 58.8. The Community dimension looks into 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.

Mental Health First Aid (MHFA)

Goal 1.1 under the Promote Well-Being Focus Area is to "Facilitate supportive environments that promote respect and dignity for people of all ages." Reducing the stigma that is historically associated with poor mental health and mental illness requires that communities 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.

Mental Health First Aid is an 8-hour course to teach practitioners and lay people how to respond when someone is in crisis. Identified as the trainer agency in the 2016-2018 CHIP, the Mental Health Association in Tompkins County (MHATC) continues to increase the number of certified MHFA instructors. In addition to the standard adult course, the MHATC offers specific modules; MHFA for Higher Education, Youth, and MHFA for Older Adults and Later Life Issues. MHATC also plans to offer the First Responders module of the course.

There are currently six certified instructors, including one for Youth MHFA. The instructors span three agencies, Tompkins County Mental Health, Racker Centers, and MHATC. The CHIP proposes a workgroup to develop a county-wide strategy to coordinate trainers and community cohesion. Outreach to employers will increase the number of workplaces whose staff has a broad base of individuals who have taken the course. Cayuga Health System (CHS) is also expanding its MHFA program *(see page 70).*

Public Health + Mental Health Merger

In December 2019, the Tompkins County Legislature voted to merge the county health and mental health departments. In year 1, Public Health staff participated in the Kresge Foundation program, Emerging Leaders in Public Health, to develop a transformative role for the future of public health, including how to assume Chief Health Strategist, address social determinants of health, and increase community engagement. As the department merger takes shape a model will be developed in year 2 for forming a community advisory board.

Thoughtful messaging

Among the five Social Determinants of Health (SDoH) described in the CHA, four are relatively tangible: Economic Stability, Education, Health and Health Care, and Neighborhood and Built Environment. As suggested in the CHA and elsewhere in this CHIP, the fifth SDoH, Social and Community Context, is less tangible. Messaging—the way things are said—is key to building or tearing down the social environment in which we live. It can seep into every corner and impact a person's well-being both in real time and over months and years. The words that are used can both open the community to residents who perceive themselves as being on the margin, and close. They can counter stigma, or enforce it.

Two initiatives have been launched in Tompkins County to develop collaborative efforts among multiple agencies that will spread awareness, understanding, and use of language in a thoughtful and well considered way. Be The One (established 2018) is transmitting the message that "everyone needs a safe, stable, nurturing relationship," which in turn fuels a more nurturing community. The Anti-Bullying Taskforce's (est. 2019) vision is for a bullying-free Tompkins County, an outcome which is only possible when community partners, schools, and government are working together and communicating in synch.

Access to health care is also impacted by communication; a common language depends on both the consumer and the provider being health literate. Health literacy skills help reduce confusion around treatment and improve service delivery; providers have a greater capacity to deliver their messages so consumers understand, and consumers are better able to ask the right questions and understand their choices. The Care Compass Network (CCN) funded Master Trainer education in year 1 yielding two trainers, each of whom will offer at least two 6-hour courses for health care staff in year 2.

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 TCHD, CHS, and each other on a regular or periodic basis. This provides multiple opportunities for engagement where informal tracking and discussion of course corrections can take place.

On a formal basis, the Director of TCHD's Health Promotion Program is the Chair for the Community Health and Access Committee, a subcommittee of the Health Planning Council, which will serve as a primary mechanism to monitor the CHIP and maintain engagement. In order to capture stakeholders who are not part of the Health and Access Committee, the CHA/ CHIP Steering Committee, or modified iteration of, will meet or correspond quarterly. 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 TCHD website.

Presentation, access, and availability of the CHIP

The Tompkins County Health Department and Cayuga Health System 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 for dissemination to the public in Winter 2020. This document, along with the entire CHA, CHIP, and relevant appendices will be available on the TCHD website. Links will be provided to any partner organizations who want to promote on their website or 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

In addition, a press release will be issued and notification posted periodically on the local Human Services listserv, which is the primary accessible channel to the local nonprofit community. These notices will remind readers of access to the CHA/ CHIP online, and invite groups to request presentations. TCHD will continue to present the CHA/CHIP process in related courses in the Cornell MPH Program and at Ithaca College, as requested.