Cayuga Health

Community Health Needs Assessment & Community Service Plan 2025-2027

TOMPKINS COUNTY Whole Health

Public Health
Prevent. Promote. Protect.
Schuyler County, NY

Cayuga HEALTH
A Member of Centralus Health

Cayuga Health

Community Health Needs Assessment & Community Service Plan 2025-2027

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Cayuga Health's Community Health Needs Assessment and Community Service Plan 2025-2027 contains data representing Tompkins County and Schuyler County. The participating hospitals are Cayuga Medical Center at Ithaca and Schuyler Hospital, members of Cayuga Health. This document is submitted as the Schedule H Requirement of the Internal Revenue Service 990 tax form.

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About Cayuga Health

Cayuga Health is an integrated healthcare delivery network comprised of two safety net hospitals, a skilled nursing facility, an addiction recovery services provider, a home healthcare organization, a cancer resource center, an emergency medical services provider, a medical equipment company, and an affiliated employed provider group with locations in Tompkins, Schuyler, and Cortland counties.

Cayuga Health's extensive geographic reach and breadth of services enable it to provide comprehensive, community-centered, whole-person care to residents of Cayuga, Chemung, Cortland, Schuyler, Seneca, Tioga, and Tompkins counties. Cayuga Health has created structures to effectively share and leverage its resources, expertise, and overall capacity, which maximizes efficiency while also dramatically improving quality, accessibility, and continuity of care.

To ensure long-term sustainability and high-quality, affordable, and equitable health services for the communities we serve, in 2025, Cayuga Health and Arnot Health affiliated under Centralus Health. The establishment of Centralus Health, the organizational "grandparent" to both Cayuga Health and Arnot Health, has operationalized the affiliation of two essential, trusted, long-standing health systems, utilizing a purposefully designed, multifaceted organizational platform. Centralus Health employs over 6,000 individuals and more than 825 medical professionals/providers.

Cayuga Health is proud to be recognized for its commitment to high-quality, locally based care. In 2025, both hospitals – Cayuga Medical Center and Schuyler Hospital – were recognized by the Lown Institute Hospital Index. Cayuga Medical Center earned an "A" for Social Responsibility, Health Equity, Community Benefit, Inclusivity, and Avoiding Overuse. Meanwhile, Schuyler Hospital received an "A" in Health Equity, Community Benefit, and Inclusivity; the hospital also was ranked Number One in New York for Community Benefit and Racial Inclusivity among Critical Access Hospitals (CAHs).

Mission

To deliver high quality care, empower our teams to success and improve the wellbeing of the communities we serve.

Vision

To be a world class integrated delivery network that inclusively and cooperatively drives superior health outcomes and demonstrable community benefit.

Values

People-First: *We care for the whole person, knowing that prioritizing people creates stronger connections and better outcomes.*

Integrity: *Consistently doing what is right, fair, and just - even when it's difficult.*

Compassion: *Treating every person with kindness, dignity, and respect.*

Excellence: *We are committed to performing every task to the highest standard, believing that how we do anything reflects how we do everything.*

Stewardship*: We honor our mission by managing our resources wisely, ensuring we can serve our community today and for generations to come.*

Commitment to Community Health & Health Equity

At Cayuga Health, supporting health is what we do. Our commitment to serving and caring for our communities drives the passion and dedication of our physicians, nurses, staff, and volunteers. Across our region, we work to provide high-quality, accessible care for everyone and contribute to a strong, healthy, vibrant community where everyone can thrive.

We recognize that health is influenced by more than just the healthcare services we provide. It is deeply connected to the environment in which people live, work, and play, and not everyone has a fair shot at living their healthiest life. It's hard to be healthy without access to good jobs and schools, safe and affordable housing, good quality food, or reliable transportation. Our mission to serve our community is strongest when we work together with community partners to understand the barriers that people face and bring our resources and expertise together to create sustainable solutions.

Health equity means increasing opportunities for everyone to live the healthiest life possible, no matter who we are, where we live, or how much money we make. In October 2024, Cayuga Health announced the launch of the Center for Health Equity Transformation. The Center aims to support and guide improvements in our workplace, patient care services, and community conditions to support the best health and well-being for our staff, patients, and community.

Alongside the 2025 Community Health Needs Assessment and improvement planning process, the Cayuga Health Center for Health Equity Transformation has engaged in a strategic planning process. Our Community Service Plan and Health Equity Strategic Plan are linked in their purpose

to respond to the needs of our community, remove the barriers to health and well-being, and ensure that everyone has the best chance to live their healthiest lives.

As we embark on this critical work across the health system and the community, we build from the wisdom of The FrameWorks Institute's definition of health equity:

> Health equity means that all people have a fair and just opportunity to be as healthy as possible. Achieving health equity means that every person's health and well-being is valued fairly. We do this by addressing unfair practices and unjust conditions that can harm the health of specific groups in our community.[1]

Our Guiding Principles

The Center for Health Equity Transformation's core principles further guide our vision and our day to day work. We are dedicated to excellence in what we do, how we do it, and understanding the connections to health equity transformation within the health system and the community-at-large. We care deeply about improving systems that support the health and well-being of our staff, patients and community, and utilize the following principles to guide our continuous improvement processes:

> We are collaborative and curious.
> We actively seek opportunities to deeply understand health data *and* lived-experience.
> We seek and share information about equity in the health system.

Framing our Approach

We will focus upstream to remove the barriers to health and well-being, advance community health, and create sustainable changes in health equity transformation. Our colleagues, patients, community, and academic partners are essential partners in health equity transformation. Our Center for Health Equity Strategic Plan outlines five core strategies that will be implemented alongside the following Community Service Plan, strengthening our capacity as a health system and bringing best practices in health equity to life as a workplace, healthcare provider, and community partner.

1. Strengthen organizational culture, equitable policies, and practices
2. Improve employee experience and well-being
3. Improve patient experience and outcomes
4. Expand and support community and academic partnerships

[1] FrameWorks Institute. (2025). Talking about Health Equity

5. Facilitate equity-informed data collection, interpretation, and decision-making

Community Health Needs Assessment

Every three years, Cayuga Health works closely with local public health departments, Cornell Public Health, community partner organizations, and community members to collect data and invite input to identify the key issues that affect the health of people across the Cayuga Health service area. We have compiled that data to create the Community Health Needs Assessment (CHNA), summarizing the assets, conditions, and unmet needs in Tompkins County and Schuyler County. While the health system serves community members across the Southern Tier region, this CHNA focuses on Tompkins County and Schuyler County, home to Cayuga Medical Center and Schuyler Hospital, respectively.

The Tompkins County Community Health Assessment included here has been developed with the collaboration and shared leadership of Tompkins County Whole Health and the Tompkins County Community Health Improvement Steering Committee. Similarly, the Schuyler County Community Health Assessment included here has been developed in collaboration with the Schuyler County Public Health Department.

Community Health Assessment, 2025-2030
Tompkins County, New York
December 2025

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SERVICE AREA: Tompkins County, NY

JOINT PLAN: Yes

PARTICIPATING ORGANIZATION: Cayuga Health/Centralus, Ithaca, NY
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CHA Steering Committee

- Tompkins County Whole Health
- Cayuga Health Partners
- Civic Ensemble
- Community Justice Center
- Cornell Cooperative Extension of Tompkins County
- Cornell University MPH Program
- Foodbank of the Southern Tier
- Human Services Coalition of Tompkins County
- Skorton Center at Cornell University
- Tompkins-Cortland Community College
- Tompkins County Office For the Aging
- Tompkins County Youth Services
- YMCA of Tompkins County

Tompkins County Whole Health
tompkinscountyny.gov/health

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GLOSSARY

Key Collaborators

ADT: Assessment Design Team; a cross-sector advisory group that helped design, refine, and disseminate the Community Health Survey

Cayuga Health: Key collaborating hospital and implementation partner in the CHA/CHIP process

CCHEq: Cornell Center for Health Equity

Cornell University Master of Public Health (MPH) Program: Key collaborators for collection and analysis of qualitative data

Steering Committee: The main leadership group guiding the CHA/CHIP process and ensuring alignment with community priorities comprising of 23 members from 11 different organizations

TCWH: Tompkins County Whole Health, our local Health Department and Mental Health Services

Key Terms and Definitions (adapted from the NYS Prevention Agenda Plan)

Anchor Institutions or backbone organizations: historically refer to universities and health care systems but can include any local organizations that have a significant geographic and/or economic presence, especially in lower-income communities. Anchor institutions can include financial institutions, arts and culture organizations, religious organizations, and utility companies.

Community Engagement: Collaboration in decision-making and information exchange between stakeholders and community members.

Domain: The 2025-2030 Prevention Agenda groups priorities into 5 major social drivers of health (in prior cycles, domains were called priorities). The current cycle of the Prevention Agenda bases its 5 domains on the 5 domains of social drivers of health defined by Healthy People 2030.

Ethnicity: A grouping of people based on having a shared culture (e.g., language, food, music, dress, values, and beliefs) related to common ancestry (usually from the same geographic area) and shared History.

Health: A state of optimal physical, mental, and social well-being.

Health care access: The timely use of personal health services to achieve the best possible health outcomes.

Health Disparities: Health differences that are closely linked to social, economic and/or environmental disadvantages that adversely affect groups of people who have systematically experienced greater obstacles to health.

Health Equity: Everyone in our community has fair and just opportunities to reach their best health and well-being.

Health inequity: Differences in health that are unnecessary, unfair, unjust, and avoidable, which inherently make individuals more underserved. Health inequities are rooted in different levels of access to the social drivers of health, and social injustices.

Health outcomes: A change in the health status of an individual, group or population that is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status.

Indicator: A specific metric or measure used to evaluate progress of a given initiative by quantifying intermediate outcomes, typically expressed as a number, percent, or rate.

Power: The ability to influence decisions, control resources, and shape outcomes within a community.

Race: Today, the term "race" is usually used to refer to a group of people descended from common ancestors (often from the same geographic area). However, it's important to note that racial categories and labels are considered social constructs that are not based in biology. The labels of race have historically been used to create advantages and disadvantages between these categories of people.

Rate: A standardized measure used to compare how often an event occurs in a population. It is calculated by dividing the number of events by the size of the population at risk and multiplying by a constant (such as 10,000 or 100,000). Rates within a population provide a means of making comparisons among many populations of different sizes.

Risk: Probability of an event, such as disease, injury, or death, occurring in a population over a specific period.

Root Causes: Fundamental, highest-level reasons that persist as part of a continued legacy of injustice and inequity.

Social Drivers of Health: Social Drivers of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age, that affect a wide range of health, functioning, and quality-of-life outcomes and risks. As defined by Healthy People 2030, SDOH can be grouped into 5 domains:

1. Economic Stability
2. Social and Community Context
3. Neighborhood and Built Environment
4. Health Care Access and Quality
5. Education Access and Quality

The 5 domains of the 2025-2030 Prevention Agenda align with this structure.

Stakeholder: Organizations and entities with external power, such as elected officials or educational institutions.

Systemic or structural racism: Racial discrimination that is built into policies, social structures, history, and culture. Examples of this might include racial discrimination that is built into education, health care, criminal justice, and other institutions.

Acronyms

BIPOC: Black, Indigenous, or People of Color

CHA/CHIP: Community Health Assessment and Community Health Improvement Plan

CHI: Community Health Improvement process

CoC: Continuum of Care

ED: Emergency department

EMS: Emergency Medical Services

LGBTQ+: Lesbian, Gay, Bisexual, Transgender, Queer and related identities

LSP: Local Services Plan; a required multi-year annual plan that guides local priorities and strategies for mental health, substance use, and developmental disability services.

MAPP 2.0: Mobilizing for Action through Planning and Partnerships; the national community health improvement framework developed by the National Association of County and City Health Officials (NACCHO)

NYSDOH: New York State Department of Health

OASAS: New York State Office of Addiction Services and Supports

PA: Prevention Agenda

ROS: Rest of State, referring to the population of New York State, excluding New York City

SAMHSA: Substance Abuse and Mental Health Services Administration (U.S. federal government program)

SDOH: Social Drivers of Health

SNAP: Supplemental Nutrition Assistance Program (U.S. federal government program)

WHO: World Health Organization

WIC: Women, Infants, and Children (U.S. federal government program)

EXECUTIVE SUMMARY

The 2025-2030 Tompkins County Community Health Assessment provides an integrated, equity centered understanding of community health grounded in the New York State Prevention Agenda and social drivers of health domains. Guided by Mobilizing for Action through Planning and Partnerships (MAPP) 2.0, the national community health improvement framework developed by the National Association of County and City Health Officials (NACCHO), the assessment synthesizes local, state and federal surveillance data, a countywide Community Health Survey, qualitative research, and extensive community engagement to examine the conditions that shape health across five PA domains: Economic Stability, Social and Community Context, Neighborhood and Built Environment, Health Care Access and Quality, and Education Access and Quality.

A central feature of this CHA is its commitment to collaboration. The Steering Committee provided overall direction, while the cross-sector Assessment Design Team shaped the Community Health Survey, dissemination plans, and interpretation of its findings. Cornell University's Master of Public Health Program also supported qualitative design and analysis. Community engagement was woven throughout the process, including a countywide visioning initiative. More than 250 residents contributed visioning input and more than 1,800 completed the Community Health Survey, helping to define the values, priorities, and lived experiences that frame this assessment.

The CHA integrates data across three MAPP 2.0 assessments (Community Partner Assessment, Community Status Assessment, and the Community Context Assessment). The Community Status Assessment examines quantitative indicators drawn from local, state and federal data systems, primarily sourced from the U.S. Census, NYSDOH, and the Community Health Survey as well as other community reports and service utilization. The Community Context Assessment explores lived experiences through qualitative interviews and local existing reports. The Community Partner Assessment highlights organizational strengths, available resources, and areas where system capacity is strained or unevenly distributed. Together, these three assessments create a multi-dimensional picture of health in Tompkins County that extends beyond traditional indicators.

While specific findings appear in the body of the report, the overarching conclusion is that health in Tompkins County is primarily shaped by social and economic conditions. Across all Prevention Agenda domains: Economic Stability, Social and Community Context, Neighborhood and Built Environment, Health Care Access and Quality, and Education Access and Quality, the assessment shows an interwoven set of challenges that reflect structural conditions. At the same time, the County demonstrates strong assets of robust academic and health partnerships, a deeply engaged nonprofit sector, expanding behavioral health and crisis response initiatives, and a shared community vision centered on belonging, connection, and equitable opportunity.

This CHA forms the foundation for the 2025-2030 Community Health Improvement Plan (CHIP), which will identify shared priorities and strategies that move Tompkins County toward a healthier, more equitable future.

DESCRIPTION OF THE COMMUNITY

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, Gayogo̱hó꞉nǫ', 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: Map of Tompkins County

Population

While the U.S. Census Bureau's 2024 estimated population for Tompkins County is 105,602, all data in the following demographic profile is based on the Bureau's American Community Survey (ACS) 2019-2023 5-year estimates, which marks the County population at 102,879.

The City of Ithaca and the surrounding Town of Ithaca account for nearly half (50.6%) of the County population. The Towns of Dryden and Lansing combined are another quarter (24.7%) of the population total, with the six remaining towns, all with a population under 5,637, making up the final 24.7%. *(Table 1)*

Population Totals and Percent XMunicipality and XRace

Tompkins County. Source: US Census ACS 5-year estimate B02001, 2023. *AIAN: American Indian and Alaska Native. *NHOPI: Native Hawaiian or Other Pacific Islander.

Muni	Total Population	Percent Total Population	White Alone	Black or African American Alone	Asian Alone	AIAN*	NHOPI*
Tompkins County	102,879	100.0%	76.8%	4.0%	9.5%	0.2%	0.0%
Caroline	3,285	3.2%	84.3%	0.5%	0.1%	0.0%	0.0%
Danby	3,360	3.3%	91.7%	1.6%	0.0%	0.0%	0.0%
Dryden	13,689	13.0%	89.2%	1.1%	0.4%	0.0%	0.0%
Enfield	3,323	3.2%	91.5%	0.1%	0.0%	0.0%	0.0%
Groton	5,636	5.5%	91.2%	0.9%	0.0%	0.0%	0.0%
Ithaca City	31,792	30.9%	65.1%	6.6%	4.7%	0.1%	0.0%
Ithaca Town	20,254	19.7%	68.5%	5.8%	3.0%	0.0%	0.0%
Lansing	11,717	11.4%	76.5%	4.4%	1.4%	0.0%	0.0%
Newfield	5,018	4.9%	94.1%	0.4%	0.0%	0.0%	0.0%
Ulysses	4,805	4.7%	93.7%	0.7%	0.0%	0.0%	0.0%

Table 1 Percent of population X race

Profile

Tompkins County is home to three institutions of higher education, Cornell University, Ithaca College, and Tompkins Cortland Community College. 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 36,213 undergraduate, graduate, and professional students, 35.2% of the County population.

Much of the County's demographic profile reflects the college sector. The median age of Tompkins County residents is 32.8 years—the lowest in the state—with 25.9% of residents age 18–24 years. About 1-in-6 Tompkins County residents are age 65 or older (17.3%). While the overall population has remained stable over the past decade, its age structure has shifted considerably. Between 2013 and 2023, the number of residents aged 0-19 declined by 12.3%. In contrast, the population aged 65 and older grew by 43.1%, now representing a significantly larger share of the community (US Census, 2013-2023). *(Figure 2)*

Tompkins County population has a number of residents with higher education: 95.7% residents aged 25-plus are high school graduates, 57.5% have a Bachelor's degree or higher, and 32.9% have a graduate or professional degree. The high school drop-out rate is low at 5.9%. Of the civilian population 16 years and over, 48% work in educational services, and health care and social assistance, 11.5% in professional, scientific, management, and administrative and waste management services, and 8.7% in arts, entertainment, and recreation, and accommodation and food services. *(Figure 3 & Figure 4)*

Transience is another characteristic of Tompkins County's higher education student population. This lack of population consistency challenges efforts to establish a broad awareness of public services for health, housing, and transportation. About 1-in-5 (15.3%) County residents lived outside the County the previous year. In the City and Town of Ithaca, 17.7% and 12.4% of the respective populations moved in from out of state within the past year.

About thirteen percent of County residents are foreign born; about 1-in-20 of those are now naturalized citizens. Among the foreign-born population aged 5 and up, 70.3% speak a language other than English, and about 1-in-4 of that group are identified as speaking English "less than very well." That represents about 6,324 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.

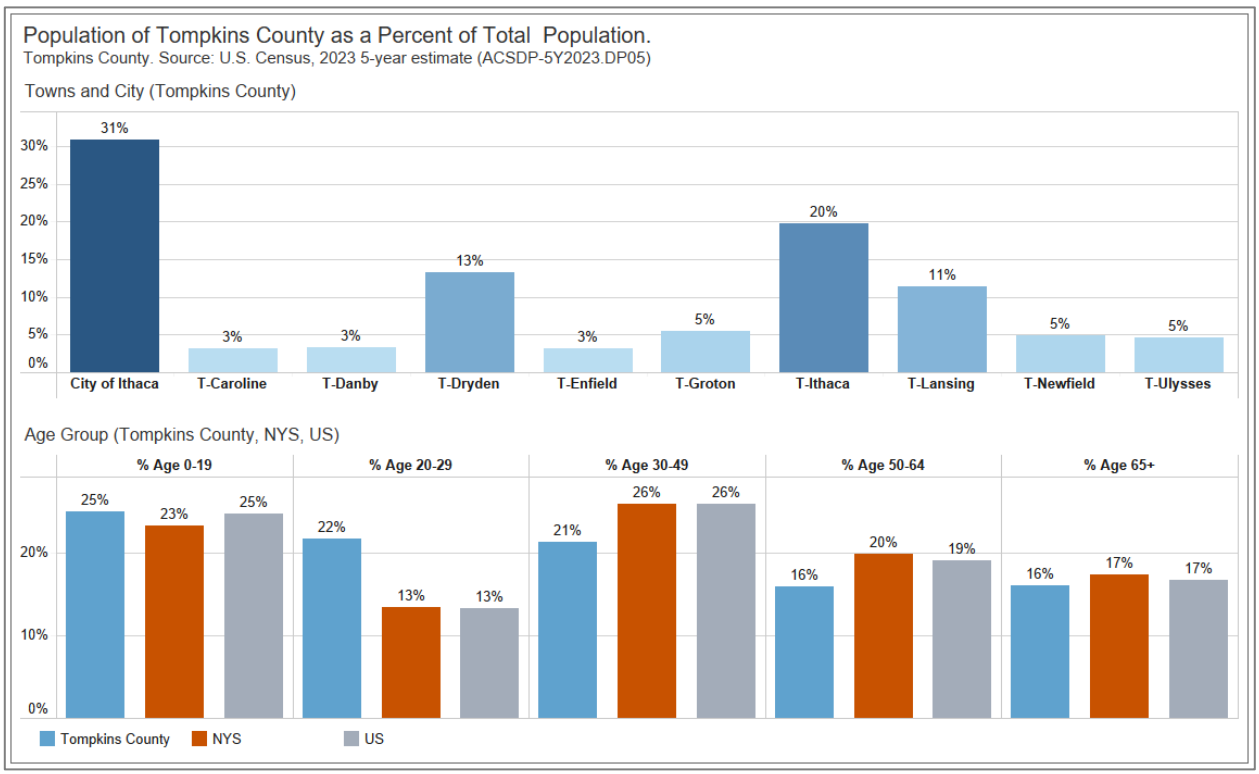

Figure 2 Percent of population X municipality and X age

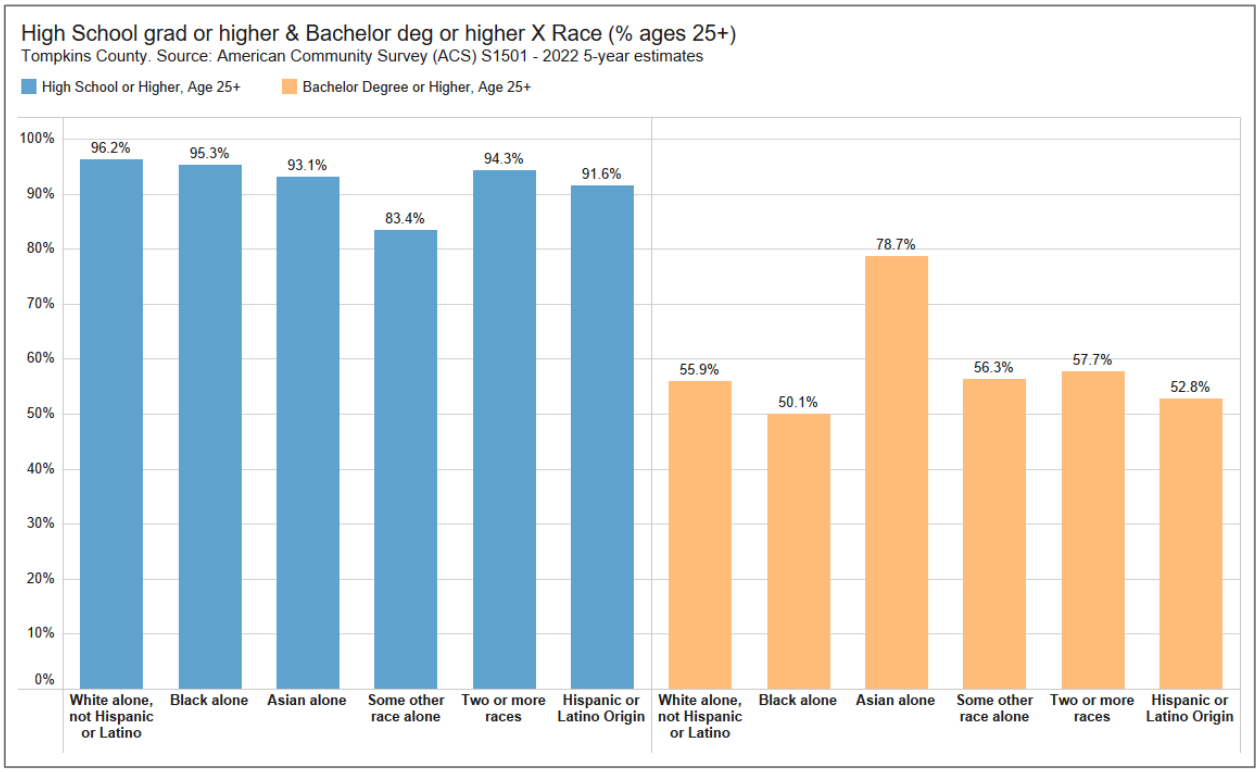

Figure 3 Education attainment X race

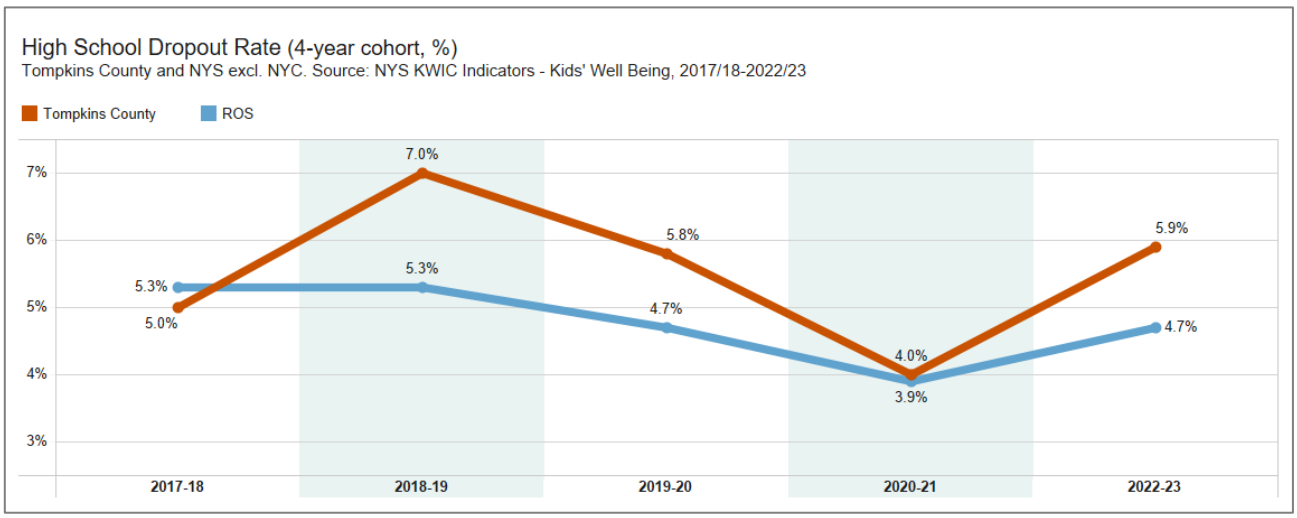

Figure 4 High school dropout rate

Households

Close to half (51.5%) of Tompkins County households are non-family households (consists of a householder living alone or where the householder shares the home exclusively with people to whom they are not related). In the 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 (45.8%) of all units. In the City of Ithaca, nearly three out of four (74.9%) occupied units are rentals. *(Figure 5)*

Among all households, owner-, renter-, and family-occupied, a clear majority of the housing stock is old; County-wide, 36% (or 16,498) homes were built before 1960 and over 27% (or 12,491) homes were built before 1940. Within the City of Ithaca, that number rises to nearly two out of three (62.8%) occupied structures built before 1980, when lead paint was still in use. Across the County, 8% of occupied units are a mobile home or other type of housing (Tompkins County Planning and Development, 2022). 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 (24% and 38.7%, respectively).

Median household income is student influenced. In Ithaca city for example, the median for all households is $48,617, while for family households it is $122,065; family households are just 29.1% of all households in Ithaca city. In Tompkins County as a whole, nearly half (48.5%) of all households are families, and the median family income is $111,825. The County median across all households, family and non-family, is $73,012. *(Figure 6)*

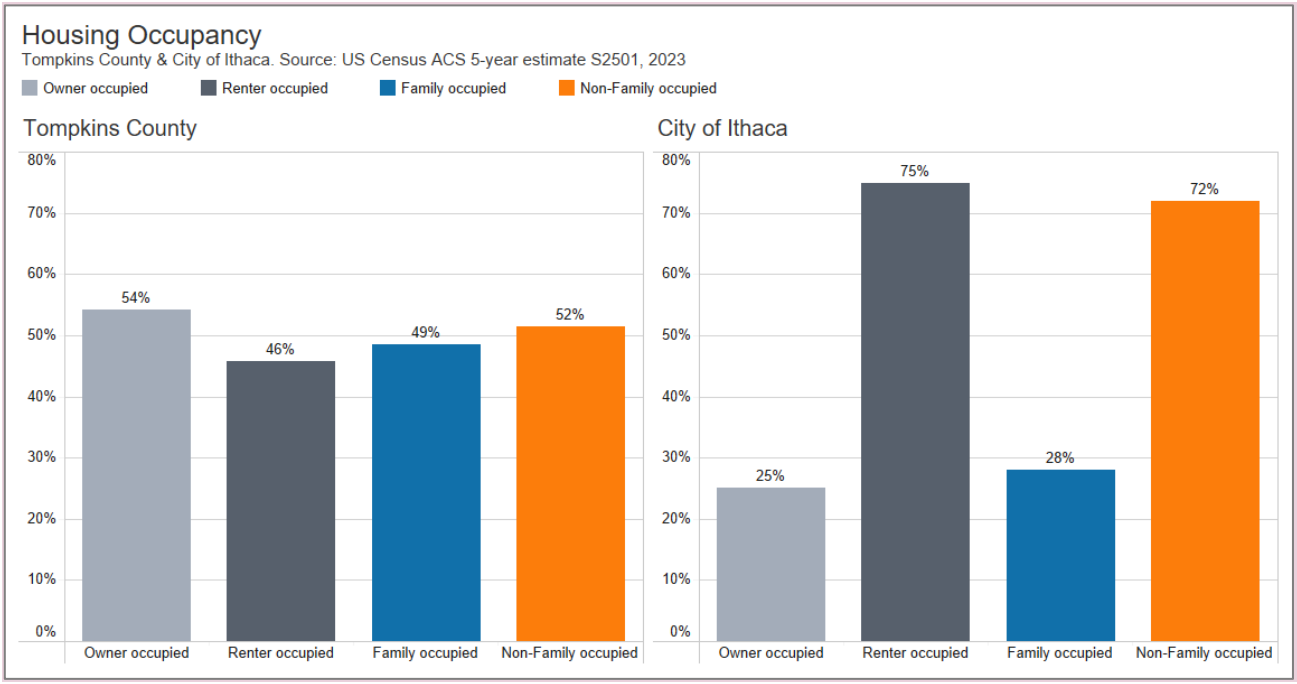

Figure 5 Housing occupancy

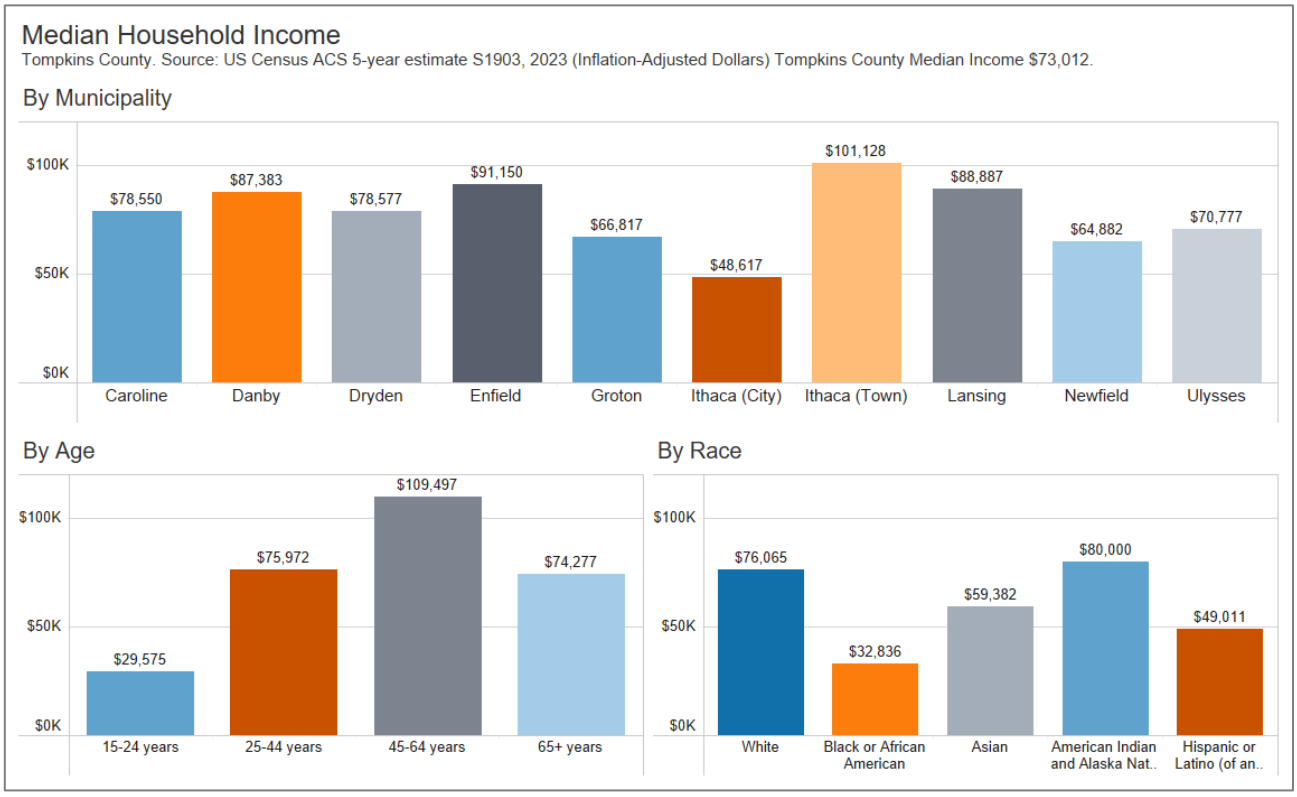

Figure 6 Median household income

General Health Status

Self-rated health data indicate an average physical health score of 3.35 and an average mental health score of 3.26 on a five-point scale, where 0 represents poor health and 5 represents excellent health. Physical health ratings were relatively consistent across age groups, while mental health

tended to improve with age. Both measures increased with higher income levels, suggesting the close relationship between financial stability and perceived well-being. Individuals experiencing difficulty meeting basic needs reported notably lower physical and mental health, underscoring the influence of economic strain on overall health status (Community Health Survey, 2025). *(Figure 7)*

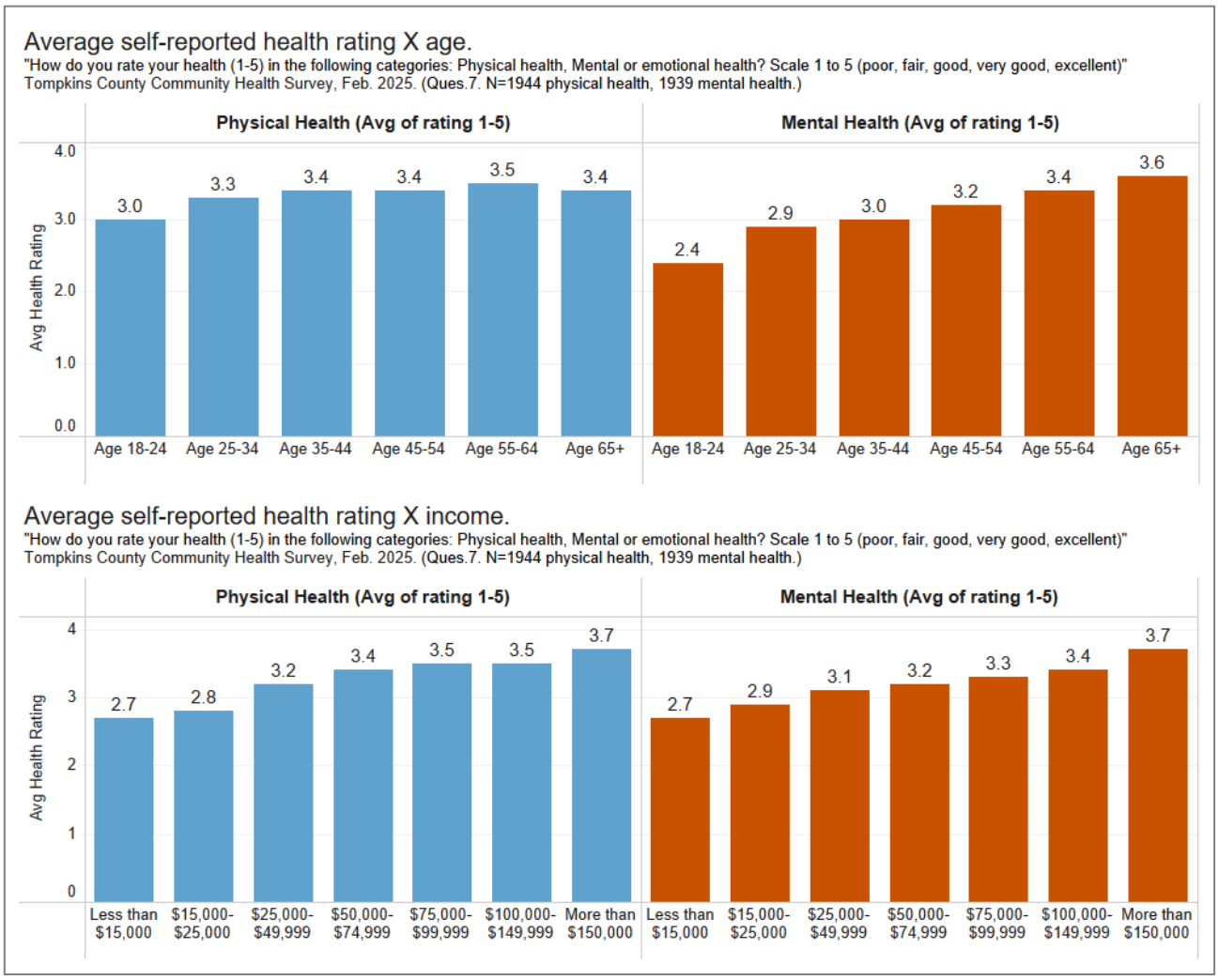

Figure 7 Self-reported health ratings

Overall life expectancy in Tompkins County is 80.9 years. Premature mortality indicators show that the percentage of deaths occurring before age 65 has ranged from 25% to 23% over the past decade (Vital Records, 2025). Adults report an average of 3.9 poor physical health days and 5.2 poor mental health days in the past 30 days (County Health Rankings, 2022). Health insurance coverage is high, with 94.7% of adults insured. The County's uninsured rate has remained consistently below state and national levels for more than a decade. *(Figure 8)*

Approximately 12% of residents report having a disability. Disability prevalence varies across racial groups, with rates ranging from 7.5% to 14.4%, and higher reported rates among Native Hawaiian/Pacific Islander and American Indian/Alaska Native residents. *(Figure 9)*

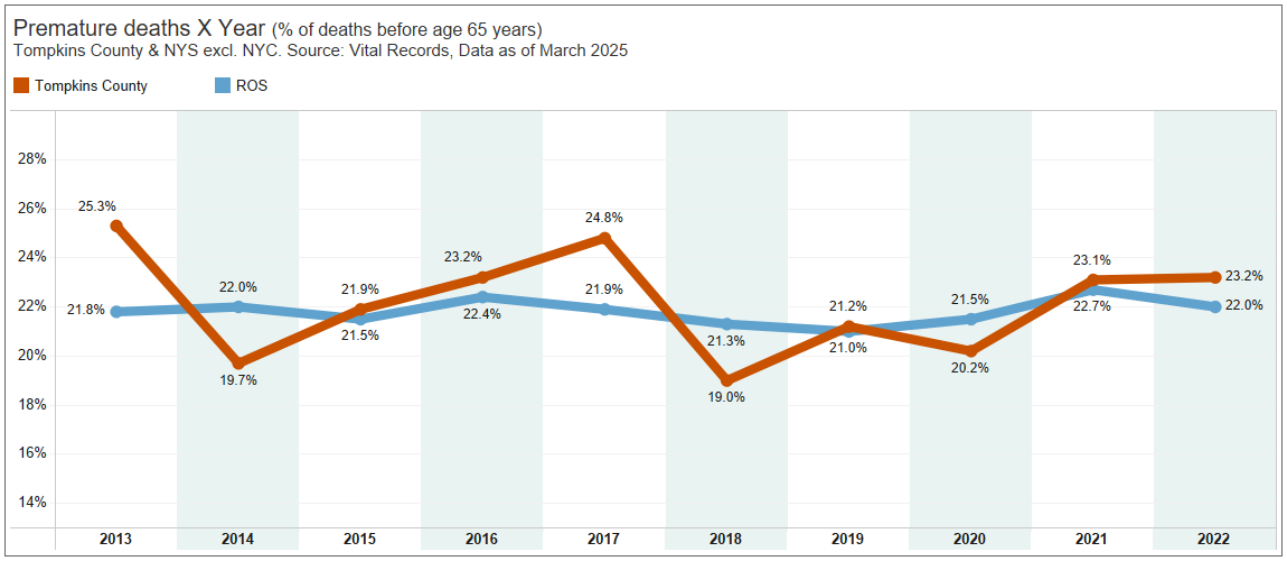

Figure 8 Premature deaths X year

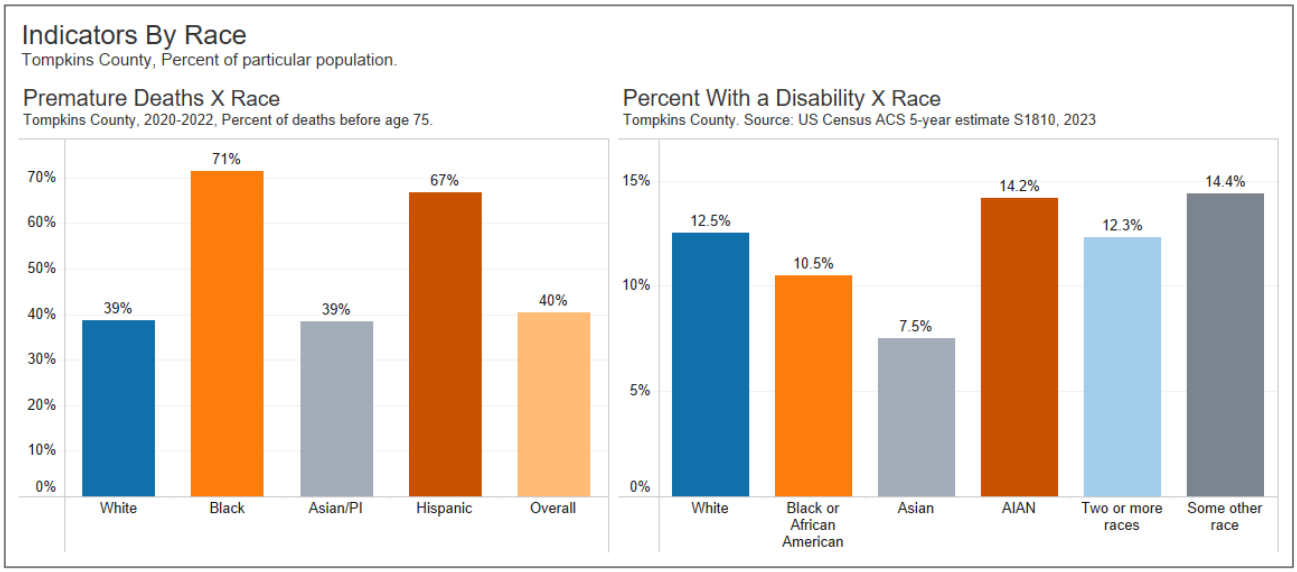

Figure 9 Indicators by race

Unemployment data show that Tompkins County's overall unemployment rate is 5.3%, compared with 6.2% statewide and 5.2% nationally. Rates vary across racial groups, ranging from 4.7% among White residents to 15.3% among Black residents, with intermediate levels among other groups (Table: Unemployment by Race). Unemployment rates also differ across municipalities, from less than 1% in Enfield and under 2% in Caroline and Danby, to more than 7% in the City of Ithaca and Ulysses. *(Figure 10)*

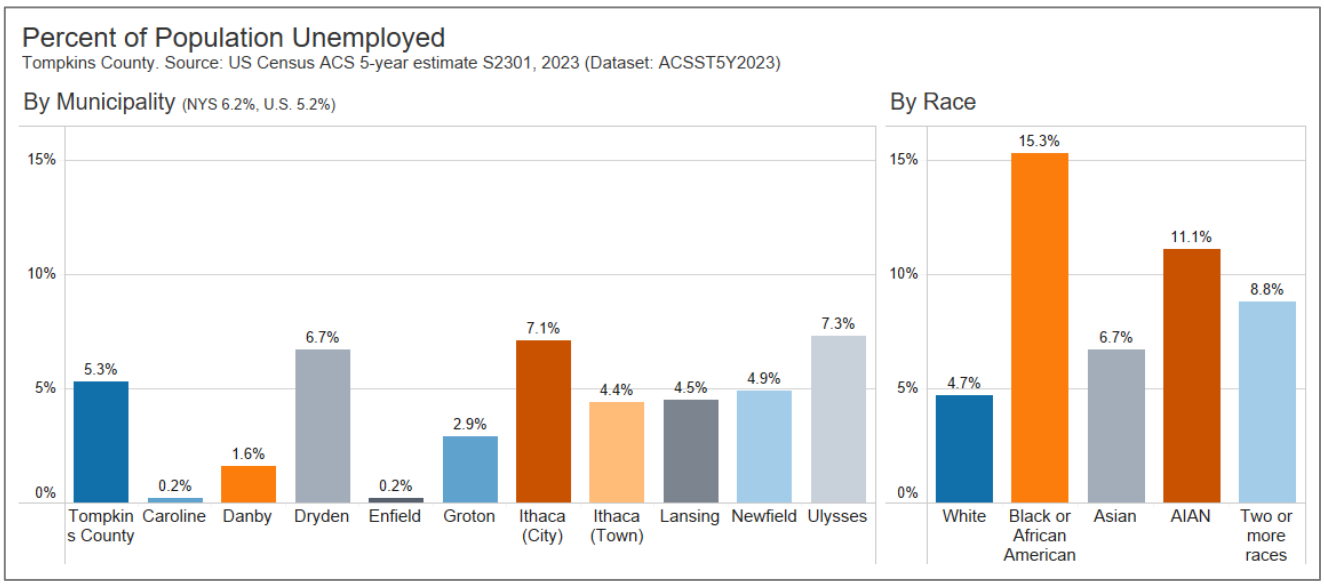

Figure 10 Percent of population unemployed

HEALTH STATUS OF THE POPULATION AND DISTRIBUTION OF HEALTH ISSUES

Tompkins County Whole Health (TCWH) recognizes that the NYS Prevention Agenda (PA) commonly uses the term social determinants of health to describe the conditions that shape health outcomes. For the purposes of this CHA, we use the term social drivers of health to emphasize the dynamic conditions that influence health and wellbeing, while maintaining alignment with the PA framework. This reflects our commitment to describing the conditions that influence health as actionable and changeable rather than fixed.

In the pursuit of a more community-driven approach, the National Association of County and City Health Officials (NACCHO) published updated guidance for the Mobilizing for Action through Planning and Partnerships framework (MAPP 2.0) in 2023. MAPP 2.0 is designed to align local resources and strengths with the goals and visions of community members, emphasizing engagement at every step– from where data comes from, to how it is interpreted, to how priorities are ultimately set. TCWH developed the latest Community Health Assessment and Community Health Improvement Plan (CHA/CHIP) using this updated framework.

As outlined in NACCHO's 182-page handbook, MAPP 2.0 includes three phases, each intended to strengthen community voice and center health equity:

- Build the Community Health Improvement Foundation: establishes shared values, structures, and relationships needed to guide the process.
- Tell the Community Story: collects and synthesizes information about community health through three assessments.
- Continuously Improve the Community: uses the findings to select priorities, implement strategies, and monitor progress.

Within the "Tell the Community Story" phase, three brief assessments help create a comprehensive understanding of local conditions:

- Community Partner Assessment: explores the capacity, strengths, and priorities of organizations and sectors working in the community.
- Community Status Assessment: examines quantitative health indicators, demographic trends, and socioeconomic conditions.
- Community Context Assessment: gathers lived experiences, qualitative input, and local history to understand the deeper factors shaping health.

Together, these components provide a new scaffold for CHA/CHIP development, one that intentionally centers health equity, community power, and collective action.

The overarching goal of the Community Health Assessment or the CHA is to move the community "upstream" in addressing health inequities by examining not just health behaviors and outcomes,

but also the underlying social drivers of health (SDOH) and systems of power, privilege, and oppression that shape them. Through this community-driven process, TCWH sought to understand not only the overall health of the County but also who is experiencing disparities across health, socioeconomic, and environmental outcomes.

By drawing on primary (survey) data, secondary data, as well as qualitative data, the CHA aims to provide a holistic picture of community health and identify areas that require deeper exploration or intervention.

Aggregated Data and Data Collection Methods

A significant amount of data for health indicators is available in databases maintained by the New York State Department of Health (NYSDOH). These include the Community Health Indicator Reports (CHIRS), County Health Indicators by Race and Ethnicity (CHIRE) and the 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. Apart from these, data has also been pulled from various local data sources and needs assessment reports.

The 2025-2030 PA takes a comprehensive approach, focusing on the wide range of factors that impact health beyond traditional medical care, disease prevention, and public health systems. It identifies 24 key priorities aimed at improving health outcomes and tackling underlying social issues such as poverty, education, housing, and access to quality healthcare which are all essential to reducing health inequities.

These 24 priorities are organized into five domains, aligned with the Healthy People 2030 framework for Social Drivers of Health:

1. Economic Stability
2. Social and Community Context
3. Neighborhood and Built Environment
4. Health Care Access and Quality
5. Education Access and Quality

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

- U.S. Census Bureau American Community Survey 2016-2020 5-year estimates.
- New York State Department of Health (NYSDOH)
    - Community Health Indicator Reports (CHIRS) is close to 350 data points organized into 15 categories, including cancer, cardiovascular disease, child and adolescent health, injury, occupational health, health status, and tobacco, alcohol, and other substance abuse. Most of the CHIRS data available for this CHA is from years 2017 through 2019.
    - County Health Indicators by Race and Ethnicity (CHIRE)
    - PA dashboard.
    - 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),

Statewide Perinatal Data System (SPDS), and the Statewide Planning and Research Cooperative Systems (SPARCS).

- Robert Wood Johnson Foundation (RWJF) collaborates with the University of Wisconsin to publish annual County Health Rankings, a comparison of proprietary indicators across every U.S. County.
- Cornell University MPH professor and students, assisted with qualitative data collection and data coding.

Comparing data with state and national averages is a common practice for understanding health status and setting realistic health goals. Often, these comparisons are made with a statewide number. In NYS, statewide data are typically provided for "Entire State" and /or for "NYS Except NYC." The latter, also referred to as the "Rest of State" or ROS, is a common point of comparison in this CHA.

Alongside these state-level data systems, local data sources were essential in contextualizing health trends and identifying community-specific inequities. Local data points for this assessment include:

- TCWH Community Health Survey and Program Reports including the Community Health Survey (2025) and Oral Health Report (2024) which provide locally collected quantitative data on health status, access to care, and service use.
- The Community Context Assessment (CCA): Experiences of Birthing Parents in Tompkins County (referred to as the Maternal and Child Health Report, 2025), which offers in-depth qualitative insights into birthing residents' health experiences, barriers to care, and lived experiences across systems.
- The Horn Research and Consulting Needs Assessment (2022) and Tompkins County Planning and Development Reports contributed housing, economic stability, and homelessness indicators.
- Health system data were drawn from the Cayuga Health Partners Health Equity Dashboard (2023).
- Local Services Plan (for mental health, substance use, and developmental disability services) supplied service access/utilization metrics and race-disaggregated outcome data.
- Additional locally grounded sources included Cornell Cooperative Extension and Village at Ithaca's Youth Mental Health Report (2025), the Tompkins County Office for the Aging Senior Survey (2023), and Tompkins Food Future (2022), which provided community-level perspectives on food security, behavioral health, and education outcomes.

Together, these local datasets complement state surveillance systems by providing community-grounded insights that reflect lived experience, service system realities, and context-specific inequities.

Community Health Survey

As a part of the Community Status Assessment (CSA) from MAPP 2.0 (Telling the Community Story), TCWH launched its Community Health Survey on January 23, 2025, which remained open until

February 28, 2025. The goal of the survey was to collect comprehensive data on various health indicators and social drivers of health (SDOH) within the community.

A well-coordinated promotional campaign supported the survey, leveraging multiple channels such as printed flyers and social media posts to increase participation. The promotional material was specifically adapted for different platforms, ensuring broad outreach across various community groups. Additionally, a dissemination plan was set in motion, where key stakeholders and collaborators (mentioned in detail in the next section) were tasked with taking ownership of at least five locations or agencies to help distribute the survey and encourage participation. This community-centered approach ensured that the survey reached diverse populations in order to maximize representation across all demographics.

To further encourage engagement and accessibility, the survey was made available in multiple languages. The online version was offered via SurveyMonkey in English and Spanish, while the paper version was available in Chinese (Traditional and Simple), French, Spanish, Russian, and Karen. The paper version was available for download on the TCWH website or by request through email or phone. A telephone survey option was also promoted, particularly through partnerships with 2-1-1 and the County Office For the Aging (COFA). These outreach efforts were further supported by targeted email communications, press releases, and social and print media, encouraging both organizations and individuals to participate and spread the word about the survey. Those age 18 or over and living in Tompkins County were eligible to participate in this survey.

Survey Data Results

- Survey Goals and Demographic Distribution of the Respondents:
- Target Response Goal: 1,200 - 1,500 Respondents
    - Achieved: 2,266 opened survey/answered #1; more than 1,800 completed all or a majority of survey
- Zip Code Representation: 66% of the responses are from 14850
- Age Distribution: Over 60% of the responses from younger populations (Under 65); 38% are from 65+
- Race & Ethnicity Representation: White: 83%, Black: 2%, Asian: 2%, Other: 6%
- Gender Balance: 71% women; 23% men; 3% non-binary
- Education: 24% attended some college or less, 27% have a Bachelor's degree and 46% have a graduate or professional degree.

Compared to County demographics, the survey responses were skewed toward older adults and women.

Following the completion of the Community Health Survey, a comprehensive and methodical data analysis process was undertaken to extract meaningful insights that would inform the CHA and ultimately shape the CHIP. Individual survey questions were analyzed, and cross-tabulation was used to explore intersections between multiple variables. A focus was placed on disaggregating the data by key demographic and socioeconomic variables, including age, race, geographic location, income

level, and other factors that influence health equity. This step allowed the analysis to surface patterns of health disparities across populations. By exploring these intersections, the analysis revealed deeper insights into the relationship between health outcomes, social drivers, and lived experiences.

The survey asked residents to identify the three most important factors that contribute to a healthy community, a recurring question across previous assessments to support trend analysis. Among the 2,017 respondents, affordable healthcare (57%), affordable, safe housing (49%), and a clean environment (36%) emerged as the top three priorities, closely mirroring the findings from the 2022 and 2019 Community Health Assessments. Other frequently selected factors included preventative health services (30%), safe neighborhoods (24%), and mental health supports (24%). These selections provide important context for interpreting community needs and expectations related to wellbeing, access, and environmental quality. *(Figure 11)*

Following the completion of the survey data analysis, clear, accessible visualizations and presentation materials were produced. To ensure a diversity of perspectives in interpreting the results the ADT and the Steering Committee members engaged in structured analysis discussions. In these sessions, participants broke into smaller groups, each focusing on specific domains of the SDOH framework. Within these groups, the survey findings were reviewed using a set of guiding questions:

- What patterns and unexpected results emerge from the data?
- Do the findings align with the original goals and guiding questions of the Community Status Assignment from the MAPP 2.0 process?
- Are the results presented in a clear and accessible manner for both stakeholders and the general public?
- Where do data gaps exist, and what additional qualitative or secondary data might be needed to strengthen the interpretation?
- How can the survey results be shared back with the community in a transparent and engaging way?

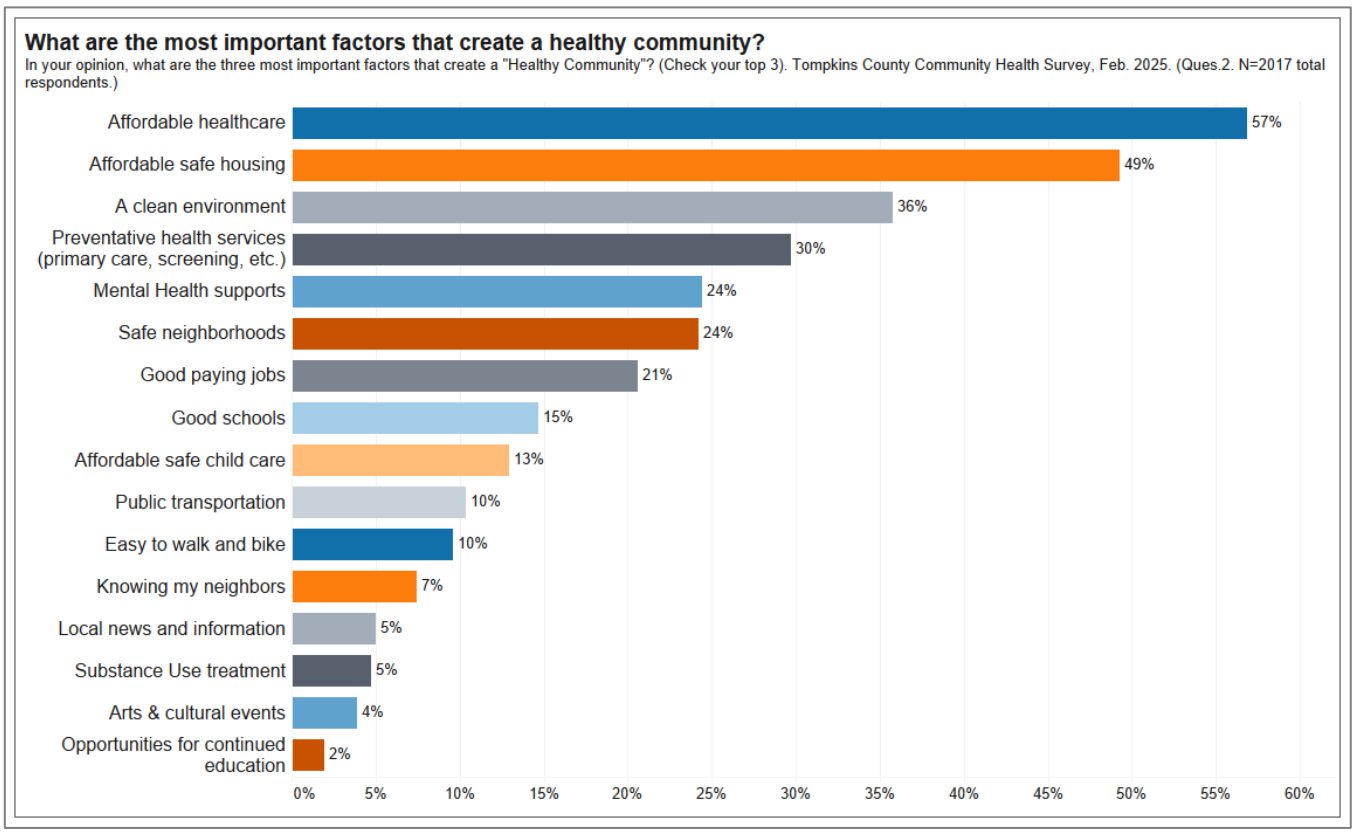

Figure 11 Factors that create a healthy community

COMMUNITY ENGAGEMENT

TCWH collaborated with a broad network of community partners, academic institutions, and advisory bodies to plan and conduct the 2025 Community Health Assessment (CHA). Guided by the MAPP 2.0 framework, the community engagement process was designed to center health equity, ensure diverse representation, and build long-term capacity for shared decision-making.

Key Collaborators and Structures

The Steering Committee served as the primary governance body overseeing the CHA/CHIP process. The committee was composed of 23 representatives from 11 organizations representing public health, healthcare, higher education, social services, community-based organizations, and advocacy groups. The Steering Committee worked collaboratively to establish the CHI charter and guiding values.

The Assessment Design Team (ADT), convened in Summer 2024, functioned as a cross-sectoral advisory group of 17 members responsible for reviewing assessment tools and supporting dissemination of the Community Health Survey. Members included representatives from the hospital, local agencies, non-profit organizations, academic institutions, and community stakeholders with experience in data analysis, communication, and engagement. The ADT met monthly to refine the Community Health Survey, advise on data collection strategies, and ensure alignment with the MAPP framework and community priorities.

In partnership with the Cornell University Master of Public Health (MPH) Program, TCWH engaged academic expertise in qualitative research design. Dr. Elizabeth Fox, Professor of Practice in the MPH Program, provided technical leadership in the design and implementation of qualitative data collection. This included the development of semi-structured interview tools, interviewer training, and integration of qualitative findings. Graduate students supported data coding, thematic synthesis, and community interpretation of findings.

Additionally, a team at Cornell MPH program, through a grant from the Cornell Center for Health Equity (CCHEq), provided ongoing consultation and served as a sounding board throughout the initial review and adoption of MAPP 2.0.

Community Engagement and Visioning

To establish a shared vision for health equity, TCWH launched a community visioning process in Spring 2024. Activities included an in-person event, co-hosted with the Human Services Coalition of Tompkins County (HSC), and a virtual session via Zoom. Ten community poster boards were also displayed across local organizations and public spaces, inviting residents to respond to two key prompts:

1. Who is in our community?
2. In five years, if our community achieved health equity, what would be different?

More than 250 community contributions were received through Post-it notes, drawings, and online comments. Responses were coded thematically, and the results were shared with the Steering Committee, which refined the feedback into a Community Vision Statement.

> *"We are a diverse and caring community rooted in belonging and mutual support. We envision a community where everyone, no matter their background, income, or ability, has access to inclusive healthcare, safe environments, and the resources needed to thrive physically, mentally, and socially."*

Sharing Findings and Incorporating Community Input

Preliminary findings and process updates were shared at multiple public convenings and through digital channels to ensure transparency and invite continued feedback.

PHASE I KICK-OFF EVENT (JUNE 7, 2024):

TCWH convened approximately 70 community partners and stakeholders to mark the completion of Phase I. The event introduced the vision statement, provided an overview of the MAPP 2.0 framework, and invited feedback on the direction of the three assessments: the Community Partner Assessment, Community Status Assessment, and Community Context Assessment. Participants also engaged in a Spectrum of Engagement activity to reflect on power-sharing and collaborative decision-making in Tompkins County.

ONGOING ENGAGEMENT THROUGH ADT AND STEERING COMMITTEE:

Feedback from the ADT and CCHEq meetings guided revisions to survey instruments, dissemination plans, secondary data analysis, and interview protocols. These groups served as iterative review bodies to ensure that community priorities were reflected in the assessment design and interpretation.

COMMUNITY PARTNER CONVENING (OCTOBER 9, 2025):

At the conclusion of Phase II, TCWH hosted a second partner convening to share preliminary CHA findings. This session focused on presenting key results from the Community Health Survey, secondary data analysis, and insights from qualitative data collected from the Maternal and Child Health Interviews as well as from the existing local data reports. Partners provided reflections on data, contextual factors, and emerging priorities, which are incorporated into the CHA narrative and inform the forthcoming CHIP planning process.

Through these efforts, TCWH ensured that the CHA was both rigorous and deeply grounded in community experience. Each phase intentionally built on the previous one, beginning with shared values and vision, moving through collaborative data collection, and culminating in the collective interpretation of findings that will guide community health improvement actions in Tompkins County.

RELEVANT HEALTH INDICATORS

Data Triangulation

The integration of secondary data with survey findings and the qualitative data was an important step in ensuring that the Community Health Assessment (CHA) presents a comprehensive, data-informed understanding of the community's health landscape. Data triangulation played a central role in this process, bringing together insights from all these three data components.

By weaving these data components together, the assessment was able to validate trends, identify gaps, and uncover patterns that might not be visible through any single component alone. This approach supported the development of well-defined claims rooted in key themes emerging across the data, ultimately providing a strong foundation for shaping targeted strategies and evidence-informed interventions in the Community Health Improvement Plan (CHIP).

Social Drivers of Health and Health Equity

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

The Healthy People 2030 website states the following:

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

The HP2030 framework includes five key areas of social drivers of health (https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health)

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and built environment
- Social and Community Context

These domains shape the conditions in which people live, work, and age, and they directly influence health-related disparities. NYS has also adopted these same core areas within its PA and statewide public health planning efforts, creating a shared language and structure that will be used throughout this report. *(Figure 12)*

Figure 12 Graphic for Social Drivers of Health

From the World Health Organization Constitution, "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

Health equity centers around the presence of dignity, respect, and community so that everyone has a fair and just opportunity to be healthy. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities. Advancing healthy equity requires that everyone has access to safe and secure housing, quality health care services, affordable and nutritious food, accessible transportation, social support networks, and protection against discrimination based on one's identity.

Source: NYS Prevention Agenda Plan, Reference #19

The Steering Committee reviewed the PA Domains and Priorities and provided recommendations about which areas should be investigated further during the CHA process and review of data. These recommendations were used to structure the CHA and to determine what data from secondary sources would be reviewed and highlighted in the narrative for this section of the CHA. The review of existing community reports and stakeholder input were also aligned with the Priorities. The section below describes thirteen chosen priorities from the NYS Prevention Agenda:

1. Economic Stability
    - Housing Stability and Affordability
    - Poverty
    - Nutrition Security
2. Social and Community Context
    - Suicide
    - Depression
    - Primary Prevention, Substance Misuse, and Overdose Prevention
    - Tobacco/ E-cigarette Use
3. Neighborhood and Built Environment
    - Injuries and Violence
4. Health Care Access and Quality
    - Access to and Use of Prenatal Care (Promote Infant and Maternal Health)
    - Preventive Services for Chronic Disease Prevention and Control
    - Oral Health Care
    - Preventive Services (Healthy Children)
5. Education Access and Quality
    - Health and Wellness Promoting Schools

Prevention Agenda Domain: Economic Stability

Economic Wellbeing

PREVENTION AGENDA PRIORITY: HOUSING STABILITY AND AFFORDABILITY

Access to safe, stable, and affordable housing continues to shape health and economic security in Tompkins County. Rising housing costs, limited availability, and increased demand for services have contributed to ongoing housing instability and homelessness. Local agencies and partners consistently identify housing as one of the most pressing social drivers of health in the region (Tompkins County Planning and Development, 2022; Horn Research, 2022).

Housing affordability remains a significant challenge. The renter affordability rate (households that spend 50 percent or more of their income on rent) in Tompkins County is 33%, compared with 26% across New York State and 24% nationally. *(Figure 13)* The rate of severe housing problems, which is defined by overcrowding, high housing costs, or lack of kitchen or plumbing facilities is 21%, slightly lower than the state rate of 23%, but clearly higher than the national rate of 17% (County Health Rankings, 2017-2021). *(Figure 14)* About 32% of households spend half or more of their income on housing, and the rental vacancy rate remains low at 3.2%. Waitlists for Section 8 vouchers or public housing range from two to two-and-a-half years, illustrating the ongoing demand for affordable units (Horn Research, 2022). Consistent with these findings, results from the Community Health Survey highlight that 49% of respondents identified affordable, safe housing as one of the most important factors contributing to a healthy community (Community Health Survey, 2025). *(Figure 11)*

Homelessness trends have fluctuated over the past several years but remain higher than pre-pandemic levels. The Point-in-Time count identified 91 individuals experiencing homelessness in 2018, 171 in 2019, and 133 in 2020, before rising sharply to 273 in 2023 and decreasing to 210 in 2024. In 2025, the PIT count recorded 155 individuals staying in shelter, transitional housing, or outdoors. Data from the Homeless Management Information System recorded 641 individuals accessing homelessness services in 2023 and 698 unduplicated individuals in 2025, with annual totals ranging from 528 to 720 between 2018 and 2023 (HUD, 2018-2024).

Permanent supportive housing capacity has expanded, yet demand continues to outpace availability. The number of supportive housing beds increased from 71 in 2012 to 175 in 2023, before a decline to 153 in 2024 (Department of Housing and Urban Development (HUD), 2012-2024). *(Figure 15)*

In 2020, 12.6 per 10,000 residents were homeless, one of the highest rates among comparable Continuums of Care (CoC), and 54.5 per 10,000 residents accessed emergency or transitional housing within the same year (HUD, 2012-2024; Horn Research, 2022).

Disparities persist across racial and demographic lines. In 2024, 48% of shelter residents and 22% of unsheltered individuals identified as Black, Indigenous, or People of Color (BIPOC), though these groups make up only 12.4% of the general homeless CoC population. Among those in shelters, 38% reported a mental health disorder, 26.8% reported substance use disorder, and 14.8% had a chronic health condition. *(Figure 15)* Forty percent identified as survivors of domestic violence, and 41% of those were actively fleeing abuse when entering shelter (HUD, 2024).

Youth and young adults represent a growing share of the unhoused population. Eleven percent of shelter guests are between 18 and 25 years old, and local schools report that student and family homelessness has tripled since 2021. Among homeless youth, 25% identify as LGBTQ+, 29% are parents or pregnant, and only 36% are enrolled in school or employed. Stakeholders note that there are no developmentally appropriate shelters for young adults in the County (Tompkins County Youth Services, 2025).

Individuals returning to the community after incarceration face significant housing barriers, including limited access to permanent housing, long waits for subsidized units, and landlord discrimination. To curb these challenges locally, the Sunflower Houses Program was established as a collaboration between Ultimate Reentry Opportunity (URO), Ithaca Neighborhood Housing Services (INHS), and Opportunities, Alternatives and Resources (OAR). Sunflower Houses provides transitional, low-barrier, affordable housing paired with wraparound services to support successful reentry. Program data shows that 0% of participants had permanent housing at entry, underscoring the severity of housing instability among people leaving incarceration. Nationally, formerly incarcerated individuals are 10 times more likely to experience homelessness, and those with multiple incarcerations face thirteen times the risk (Sunflower Houses: Qualitative Assessment Report, 2025). By addressing housing access alongside supportive services, this model strengthens stability during reentry and improves pathways to long-term community reintegration.

Together, these data reveal how affordability, availability, and systemic barriers intersect to perpetuate housing insecurity. High rent burdens, limited affordable housing stock, and long waitlists leave many residents at risk of displacement. Community members described the strain vividly: “There is not enough affordable housing here, yet luxury apartments sit empty,” and “I’m chronically homeless because there’s no place for people to go.” Others noted the frustration of complex application systems. “I think [getting housing] should be an easier process.… The waiting process is forever. They’ll say they will get you a place in 10 months. You forget about it and move on. It definitely should be easier.” (Horn Research, 2022; Sunflower Houses: Qualitative Assessment Report, 2025).

Stakeholders have identified additional barriers, including community resistance to affordable housing development, transportation challenges, and fragmented access to services. These obstacles can make it difficult for individuals to find or maintain housing, particularly for those with disabilities, criminal justice involvement, or limited income.

Tompkins County agencies and partners continue to coordinate efforts to expand affordable housing and improve support services. The Tompkins County Continuum of Care plays an important role in this work. The Tompkins County Continuum of Care (CoC NY-510) is a collaborative network led by the Human Services Coalition (HSC) that coordinates public, private, and non-profit agencies to prevent and end homelessness in the area, aiming to make it "rare, brief, and one-time" through strategies like Coordinated Entry, Housing First, and community-wide planning, connecting vulnerable individuals to housing and supportive services. Local initiatives focus on increasing the availability of permanent supportive housing, enhancing case management for individuals at risk of homelessness, and reducing barriers within public assistance systems. Community programs are also strengthening coordination between mental health, substance use, and housing services to better meet the needs of residents with complex circumstances (Local Services Plan, 2024; Horn Research, 2022).

While progress has been made through expanded supportive housing such as Asteri Apartments and Amici House, and improved service coordination, the persistent gap between housing costs and income levels underscores the need for sustained local investment and cross-sector collaboration to ensure that all residents have access to safe, stable, and affordable housing.

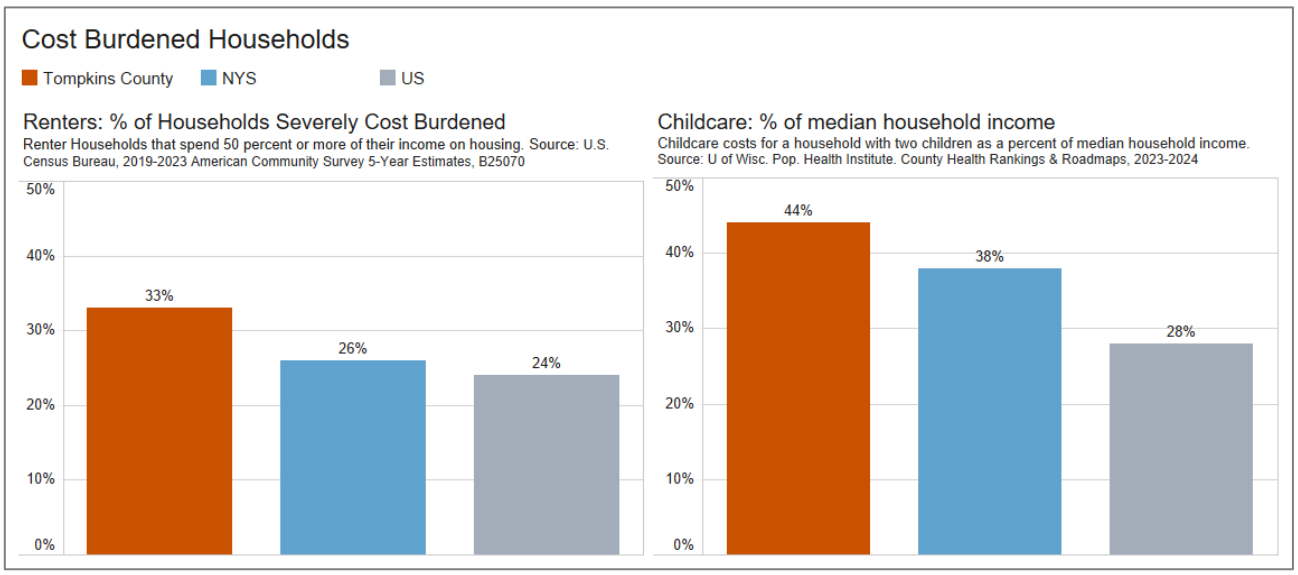

Figure 13 Cost burdened households

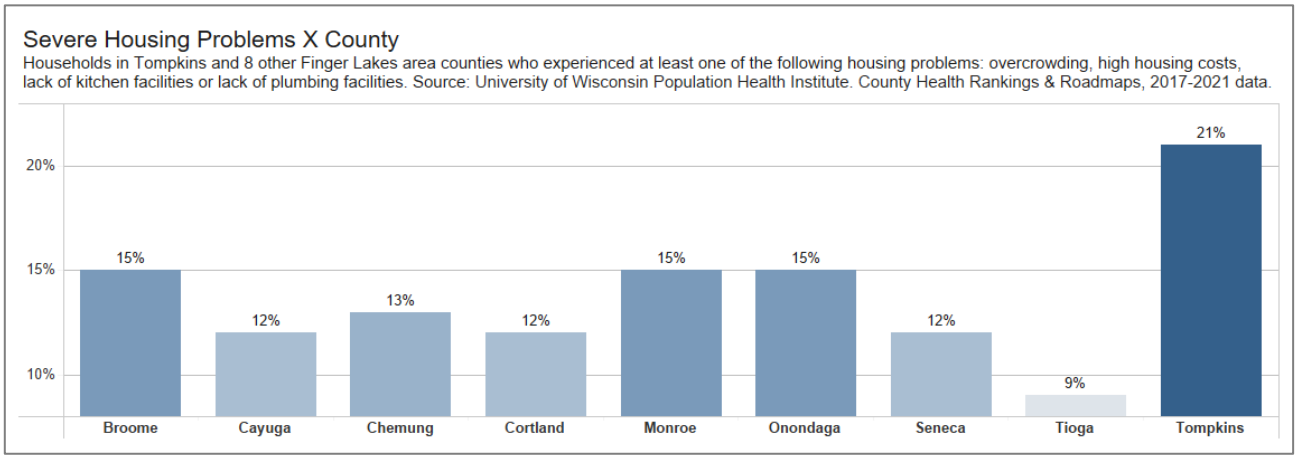

Figure 14 Severe housing problems X county

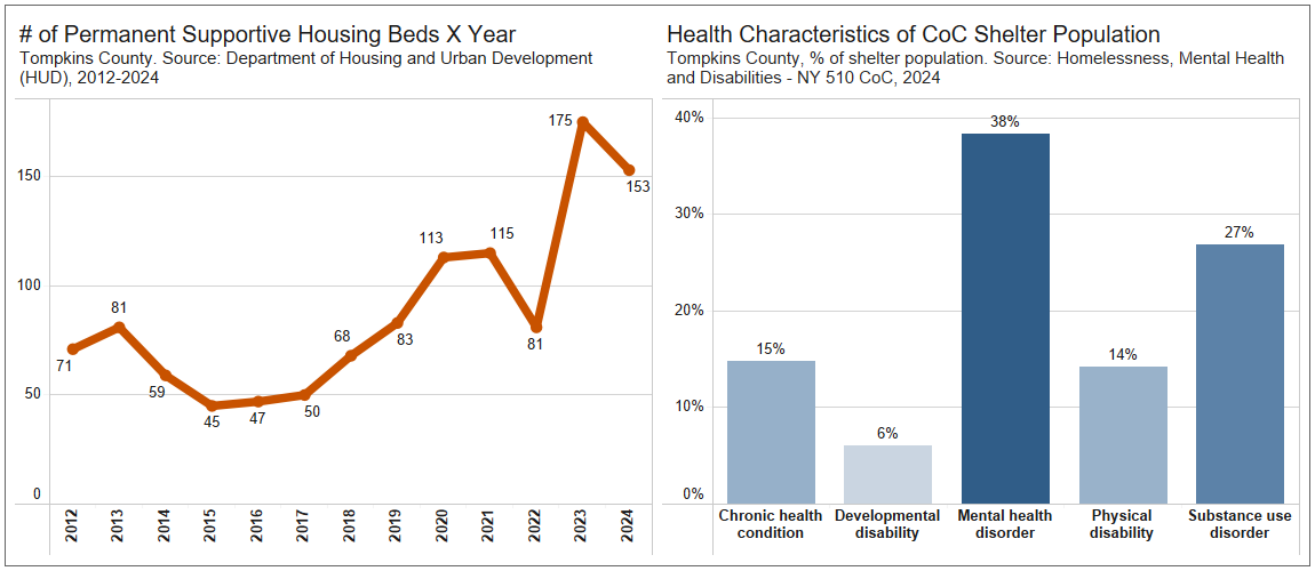

Figure 15 Permanent supporting housing beds & health characteristics of the shelter population

PREVENTION AGENDA PRIORITY: POVERTY

Economic stability remains a key driver of community health in Tompkins County. While the local poverty rate has declined over the past decade, many residents continue to face financial hardship due to the high cost of living, childcare expenses, and limited access to affordable housing. These challenges affect families' ability to meet basic needs and maintain overall well-being (U.S. Census Bureau, 2013–2023).

Trend data shows gradual improvement where the County's poverty rate declined from 20.3% in 2013 to 15.9% in 2023. *(Figure 16)* However, the County does not meet the HP2030 target of 8% and remains above both the statewide rate (14%) and national average (12%) (U.S. Census Bureau, 2019-2023). Communities facing structural racism and social injustice are particularly affected. For County residents who identify as Black or African American alone, the poverty rate is 37.2%. White alone is 13.9%. The City of Ithaca experiences the highest concentration of poverty, where nearly one in three residents live below the poverty line. Rates are lower in surrounding towns such as Danby, Ulysses, and Caroline, where fewer than one in ten residents experience poverty (U.S. Census Bureau, 2019-2023). In a college town, the student population that works part time or not at all can skew the poverty rate for non-family households upward. *(Figure 17)*

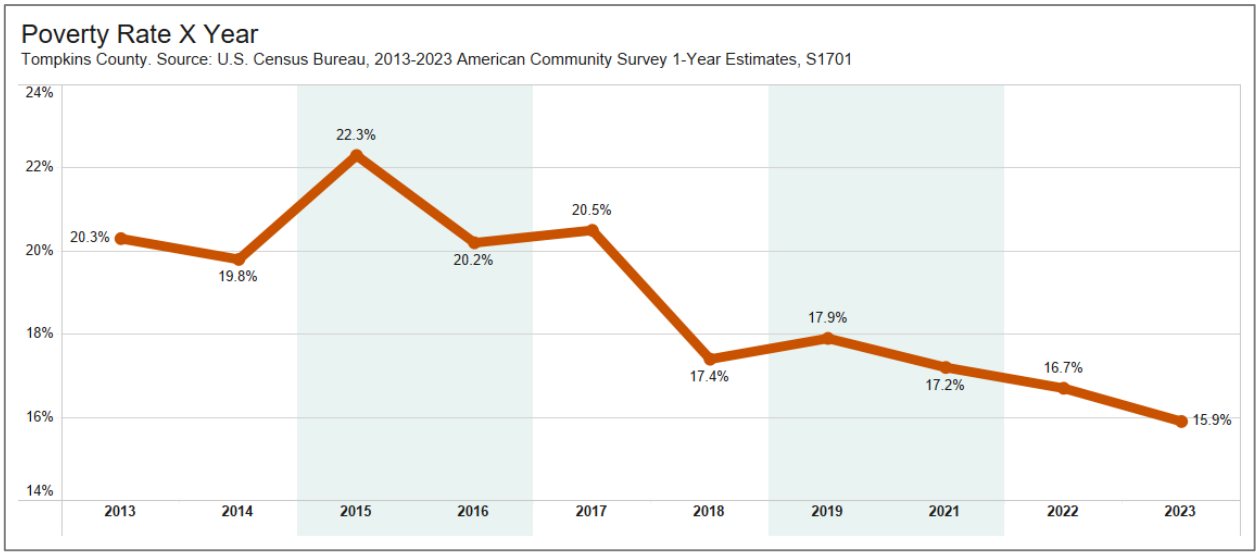

Figure 16 Poverty rate X year

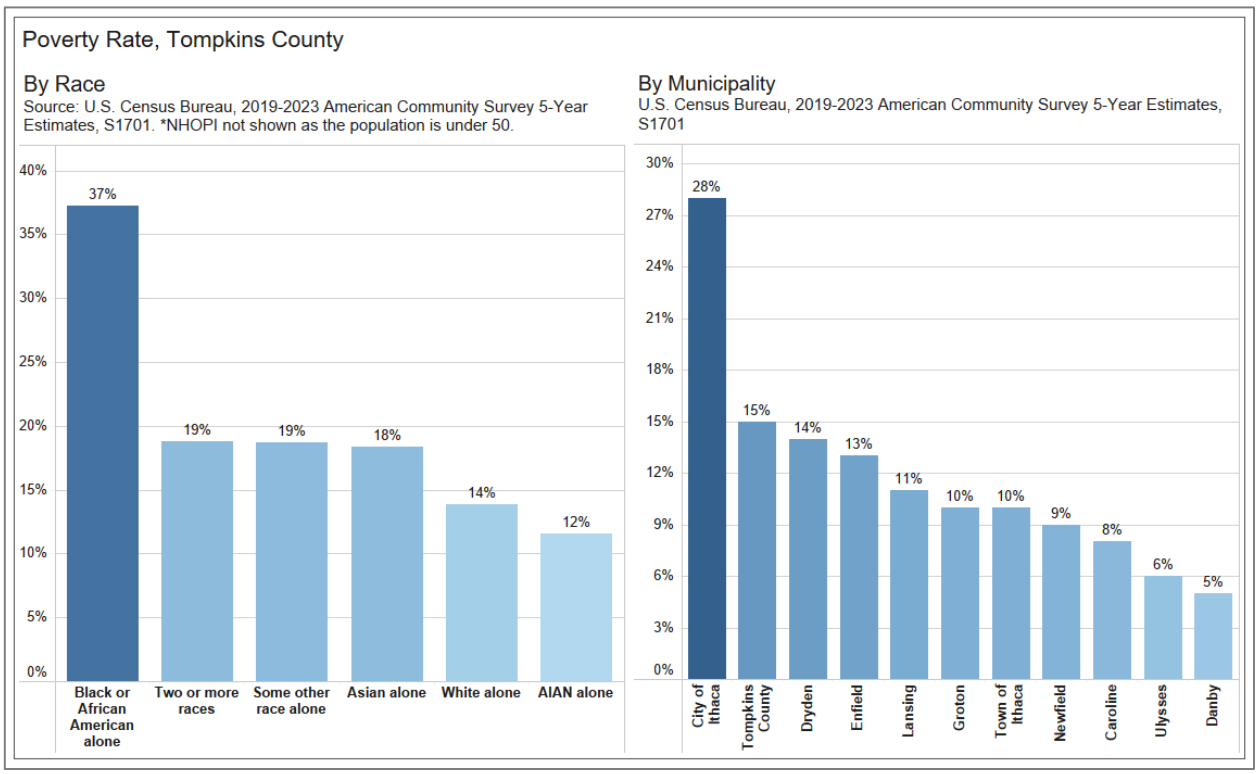

Figure 17 Poverty rate X race & rate X municipality

Children remain especially vulnerable. About 13% of children in Tompkins County live in poverty (roughly 1 in 8 children). This is lower than the 19% of children statewide, but still reflective of persistent financial hardships faced by local families (County Health Rankings, 2025). Among older adults aged 65+, 7.9% live in poverty, lower than the state rate of 12.7%, reflecting some degree of stability among seniors (U.S. Census Bureau, data as of March 2025).

Other indicators illustrate broader financial pressure. Child-care costs for a household with two children account for 44% of median household income, compared with 38% statewide and 28% nationally. Median household income in Tompkins County is $68,200, below both the state ($82,100) and national ($77,700) figures. The income-inequality ratio (5.6) is slightly lower than the state (5.8) but higher than the national (4.9) average (County Health Rankings, 2019-2023).

The 2025 Community Health Survey question asked about difficulty paying for basic household needs in the past year and a substantial portion of respondents reported challenges *(Figure 18)*. The most commonly cited financial stressors were medical expenses (20%), utilities (18%), rent or mortgage (18%), and food (16%). Other areas of financial strain included transportation (11%) and childcare (6%).

Further analysis through cross-tabulation showed younger adults and individuals with lower incomes were disproportionately affected by these financial difficulties. These populations experienced higher rates of hardship across nearly every category particularly for housing, medical expenses, and

basic utilities. The incidence of financial strain decreased with age and rising income based on the experience of the survey respondents.

Stress and anxiety about meeting basic needs were most common among younger adults, decreasing as age increased. The highest levels of stress were reported by individuals unable to work due to disability or other reasons and those who were unemployed, while retired individuals and those employed full-time reported the lowest levels. Stress and anxiety also declined consistently as income increased: over half of respondents earning less than $15,000 reported frequent stress or anxiety about meeting basic needs. However, some degree of financial stress remained prevalent across income levels, with about one in four respondents indicating they “sometimes” experienced such stress. *(Figure 19, Figure 20)* As a resource-rich community, respondents who reported difficulty paying for basic needs were asked if they accessed resources that addressed at least some of their needs. Four-in-ten (40%) indicated that they had and found some benefit, while 22% reported no needs and nearly one in three either did not know about available resources or did not engage with them despite awareness, highlighting both the value of existing supports and gaps in awareness or effectiveness (Community Health Survey, 2025). *(Figure 21)*

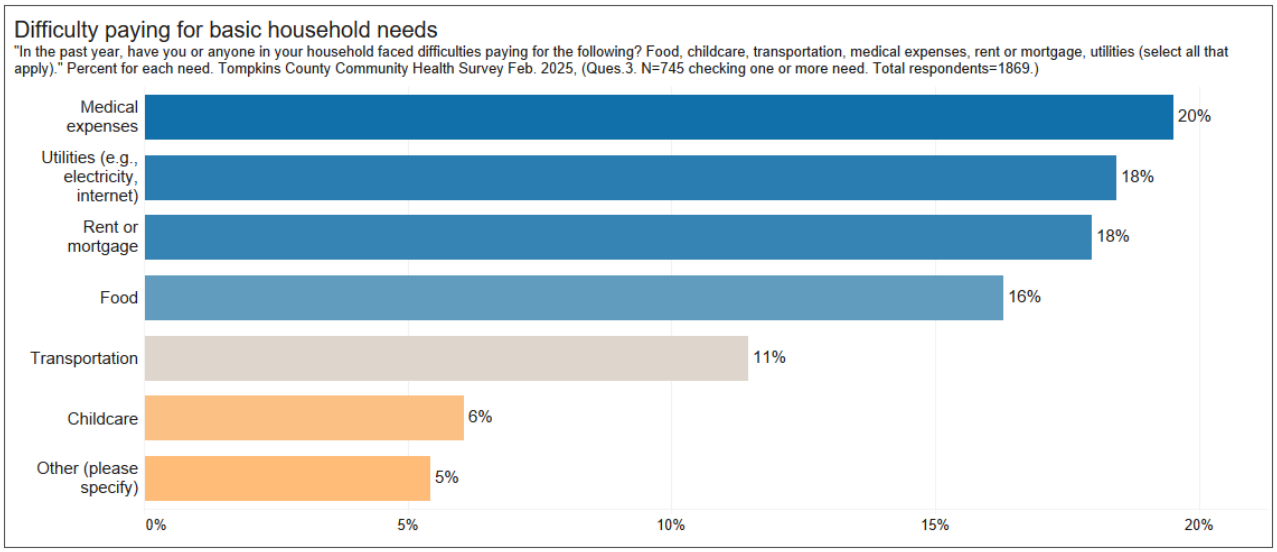

Figure 18 Difficulty paying for basic household needs

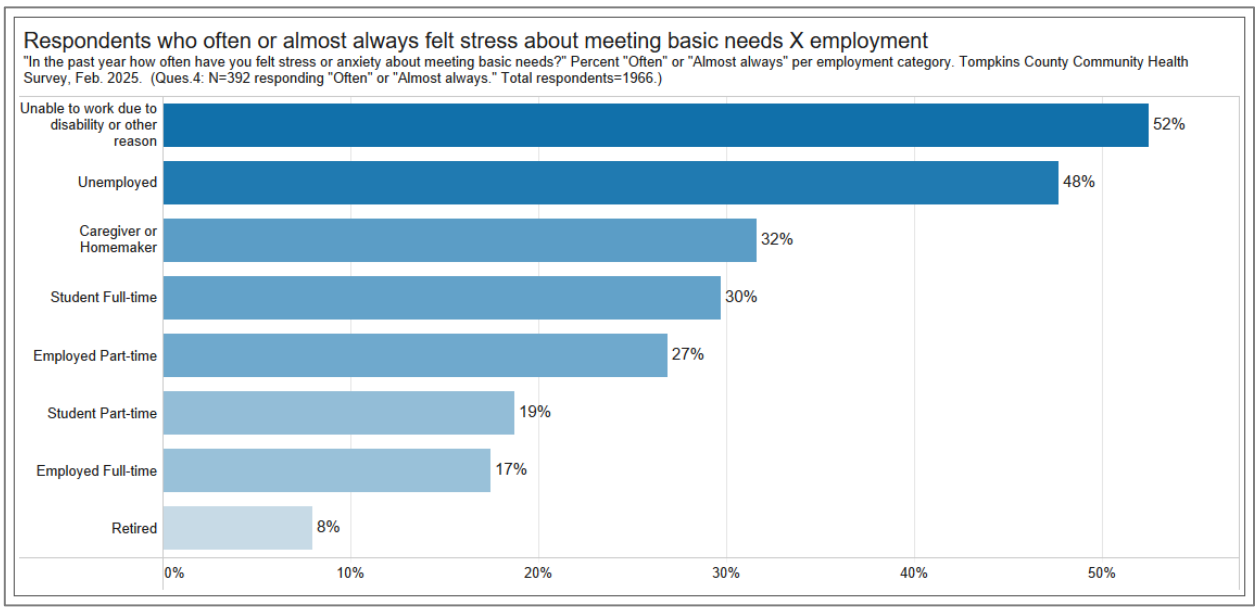

Figure 19 Stress about meeting basic needs X employment status

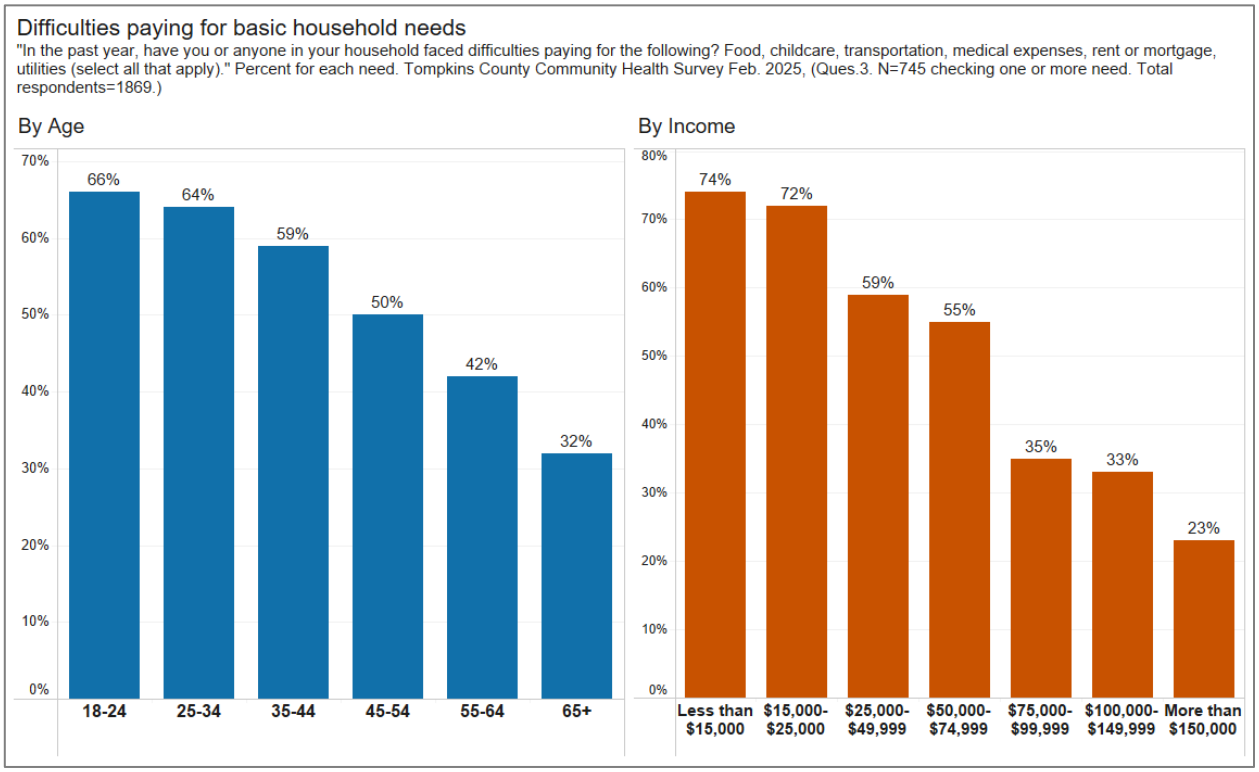

Figure 20 Difficulties affording basic needs X age and X income

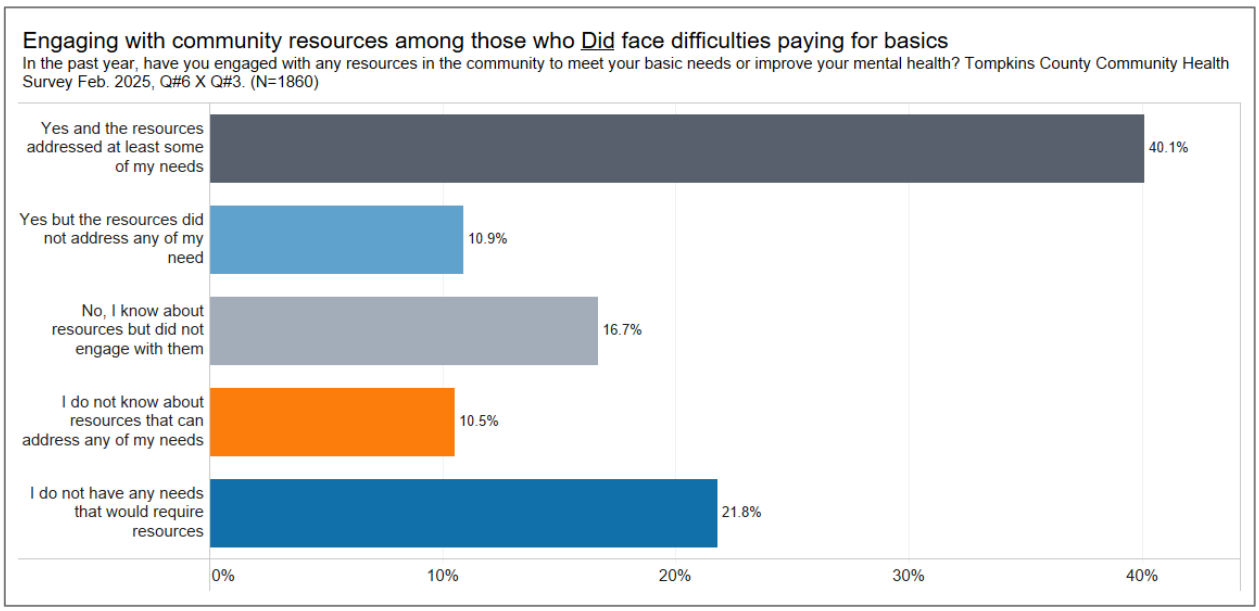

Figure 21 Engaging with community resources

While economic indicators show gradual progress, they mask the day-to-day difficulties faced by working families. Local residents often describe the "in-between" position of earning too much to qualify for public assistance but not enough to afford childcare, rent, or food. As one parent explained, "I think it's just those in between areas where you could have a household that's making like $50k a year…[being denied] WIC or food stamps because they're making that much money, but still, they're struggling, bills are popping up, but they don't get qualified." Others noted that childcare costs in Ithaca are a major concern, with one resident saying, "Colleagues that I've spoken to…[had difficulty] with childcare just due to the cost of it in Ithaca. I'm fortunate where my husband is on paternity leave right now, so he's taking care of him [the baby]. But I know that's a big, big concern and a big issue." These stories reflect how structural barriers, not just individual income, shape financial insecurity (Maternal and Child Health Report, 2025).

People with low-wage jobs also described frustration with benefit eligibility thresholds. One participant shared, "...you are cut off as soon as you get a job… I make fifteen dollars an hour and get no help. It's backwards." This sense of instability highlights the tension between workforce participation and access to essential supports (Sunflower Houses: Qualitative Assessment Report, 2025).

Although Tompkins County's poverty rate has improved since its 2015 peak, economic vulnerability remains widespread. Several ongoing initiatives aim to reduce economic hardship and strengthen financial stability for residents. Local organizations are expanding housing supports, including rental assistance, security deposits, and programs that help residents maintain stable housing. Food access efforts continue to grow through community cupboards, school-based meal supports, and regional partnerships with the Food Bank of the Southern Tier. The rollout of New York's 1115 Medicaid Waiver brings additional opportunities to address health-related social needs by supporting services such as housing navigation, care management, and nutrition interventions for eligible residents.

Community education and workforce programs, including initiatives through Tompkins Cortland Community College and state tuition-assistance pathways for first-time college students, work to increase earning potential and economic mobility. Such efforts are in progress across the County to alleviate poverty by addressing both immediate needs and long-term pathways to stability.

PREVENTION AGENDA PRIORITY: NUTRITION SECURITY

Access to nutritious and affordable food is foundational to health and well-being. In Tompkins County, food insecurity has remained a persistent concern despite a strong network of community food resources. Rising costs of living, income gaps, and uneven access to assistance programs have contributed to challenges for households across income levels, particularly among families with children, older adults, and communities of color (Feeding America, 2019-2023).

Findings from the Community Health Survey further reflect these challenges. Sixteen percent of respondents reported experiencing difficulty affording food in the past year, highlighting the ongoing strain of meeting basic nutritional needs, especially among residents with lower incomes. *(Figure 18)*

Between 2019 and 2023, the share of residents experiencing food insecurity in Tompkins County ranged from 9% to 13%. The statewide average was 11% to 15% during the same period (Feeding America, 2019-2023). In 2023, 13% of County residents, approximately one in eight, reported lacking reliable access to sufficient food. Disparities by race also persist with 33% of Black residents and 28% of Latino residents experiencing food insecurity, compared with 12% of White non-Hispanic residents (Feeding America, 2019-2023).

Child food insecurity also increased in recent years, rising from 8% in 2021 to 14% in 2023 highlighting the continued impact of economic recovery on families with children (Feeding America, 2019-2023). *(Figure 22)*

Demand for emergency food assistance has grown substantially. The Food Bank of the Southern Tier recorded 98,725 individual pantry requests in 2019, 195,669 in 2023, and 235,465 in 2024 which was a 20% increase in just one year and more than double pre-pandemic levels (Food Bank of the Southern Tier, 2024). These requests represent both single and repeat visits by households facing recurring food shortages. *(Figure 23)*

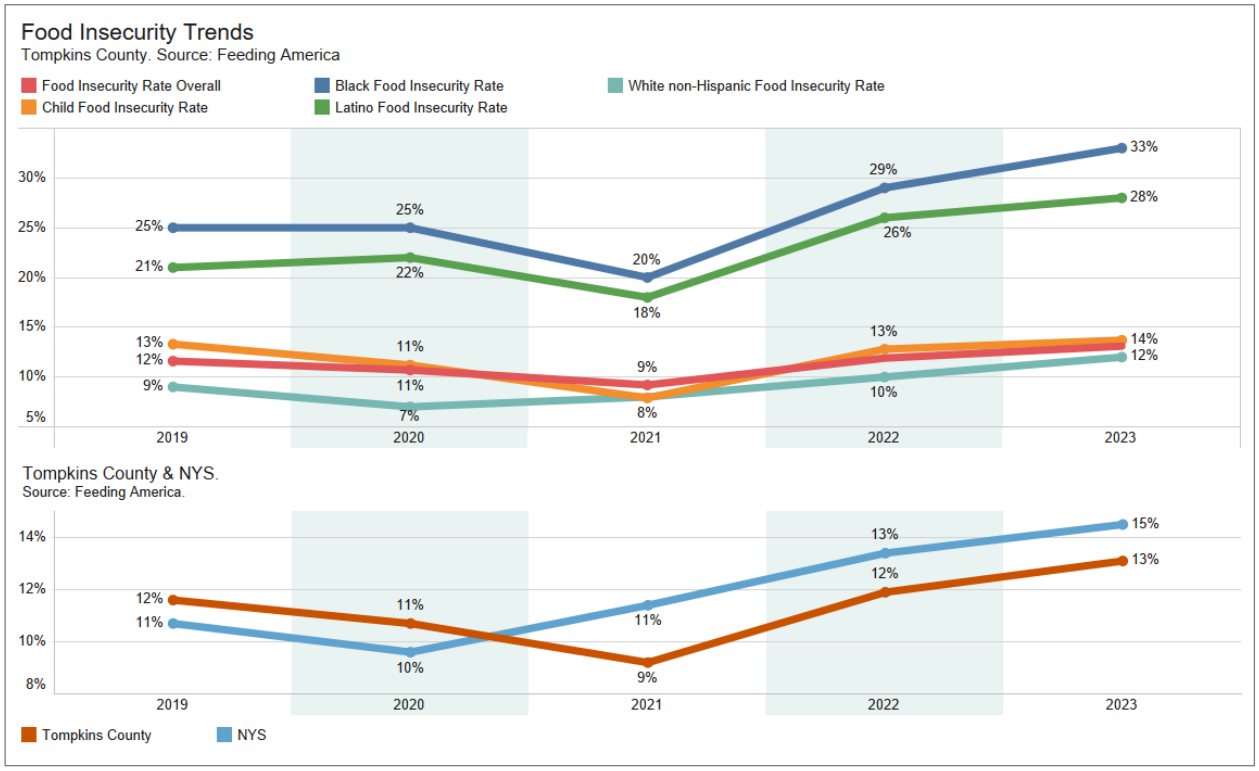

Figure 22 Food insecurity trends

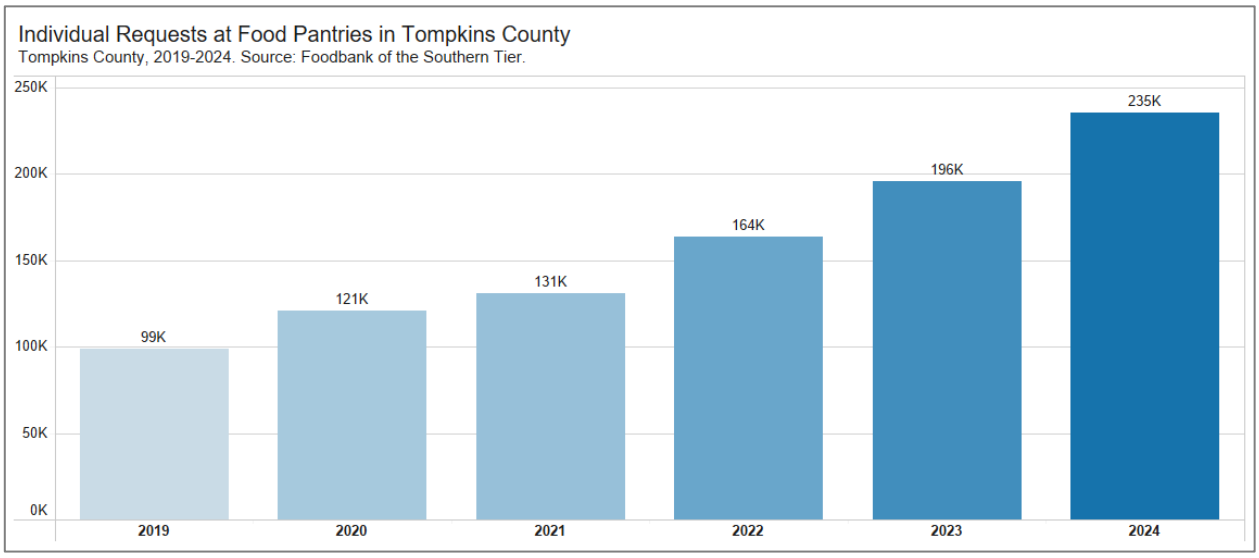

Figure 23 Trend of requests at food pantries

Geographic access also plays a role. About 5% of low-income residents in Tompkins County live far from a grocery store offering fresh produce (County Health Rankings, 2019). Participation in federal nutrition programs remains limited with only 50% of eligible residents receiving Supplemental Nutrition Assistance Program (SNAP) benefits in 2023 (NYS Office of Temporary and Disability Assistance, 2024). Forty-five percent of eligible families were enrolled in the Women, Infants, and Children (WIC) program during 2020-2021. Among children aged one to four, only 31% of eligible children were covered (Hunger Solutions, 2023).

Older adults also report difficulty accessing food. In 2023, 12% of residents aged 60 and older indicated that obtaining enough food was a minor, moderate, or major problem (Tompkins County Office for the Aging, 2023).

These findings illustrate that food insecurity is a persistent challenge in Tompkins. Many working families earn too much to qualify for public assistance but too little to reliably afford groceries. Community members frequently describe the strain of balancing food costs with other essential expenses such as rent and utilities. One resident shared, “Food is outrageous… being able to feed your children lifts the burden off your shoulders when you know your Wi-Fi is gonna get cut off.”(Maternal and Child Health Report, 2025)

Rural residents, people with disabilities, and communities of color face additional barriers related to transportation, cultural food preferences, and limited access to nearby grocery stores. Stakeholders also note stigma and confusion around benefit eligibility, which can discourage participation in SNAP or WIC. The combination of high food prices, limited program participation, and inconsistent access to healthy options underscores the need for more equitable and coordinated local food systems.

Tompkins County benefits from a robust network of food pantries and mutual aid efforts that help reduce food insecurity. Initiatives such as Tompkins Food Future, FoodNet Meals on Wheels, the Food Bank of the Southern Tier, and Daily Food Pantries & Community Meals have expanded local coordination and outreach, emphasizing sustainability, cultural inclusion, and community-driven solutions (https://ccetompkins.org/food/food-assistance-programs). Efforts are also underway to improve enrollment in federal nutrition programs, enhance transportation access, and increase the availability of affordable, healthy food options countywide (Tompkins Food Future, 2022). Transportation access is further supported through the County funded One Call One Click Transportation Center, operated by 211 through HSC, which helps residents arrange rides to grocery stores, medical appointments, and other essential destinations by coordinating with rideshare and local transportation providers. Find additional information about these resources in the Community Assets & Resources section.

Prevention Agenda Domain: Social and Community Context

Mental Wellbeing and Substance Use

PREVENTION AGENDA PRIORITY: SUICIDE

Supporting mental wellbeing and reducing suicide remain shared priorities in Tompkins County. Mental health challenges affect residents across age groups, often intersecting with housing instability, substance use, and barriers to care. Recent investments in crisis response and behavioral health systems have expanded immediate support options, yet access to timely and affordable mental health services continues to be a concern (Local Services Plan, 2024-2028).

The age-adjusted suicide mortality rate in Tompkins County has fluctuated over time, ranging from 9 per 100,000 in 2014-2016, 13.6 in 2016-2018 to 10.9 per 100,000 in 2020-2022. This rate fails to meet the NYS Prevention Agenda 2030 objective of 6.7 per 100,000 and is slightly higher than the statewide average of 8 per 100,000 (Vital Records, as of March 2025). *(Figure 24)*

Emergency department (ED) visit data provide additional insight into self-harm behaviors. *(Figure 25)* In 2022, self-harm ED visit rates were highest among individuals aged 10-19 years (357.9 per 100,000) and 25-34 years (189.3 per 100,000). Rates per 100,000 were lower among older adults, ranging from 37.2 among those aged 45-54 years to 29 among those aged 65-74 years (SPARCS, 2022).

By race, Black residents experienced a rate of 176.4 per 100,000, followed by 116.8 among White residents, and 15.3 among Asian and Pacific Islander residents (SPARCS, 2022).

Mechanisms of self-harm also vary. In 2021, half (49.5%) of self-harm ED visits involved overdose or drug poisoning, 41% involved cutting or piercing, 5.7% were attributed to other mechanisms, and 3.8% to non-drug poisoning.

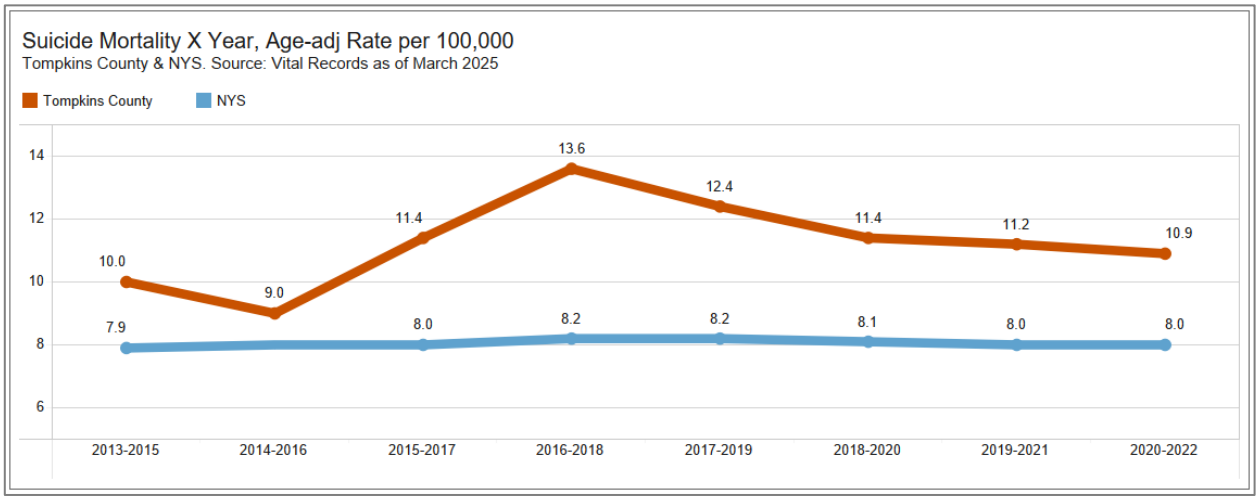

Figure 24 Suicide mortality X year

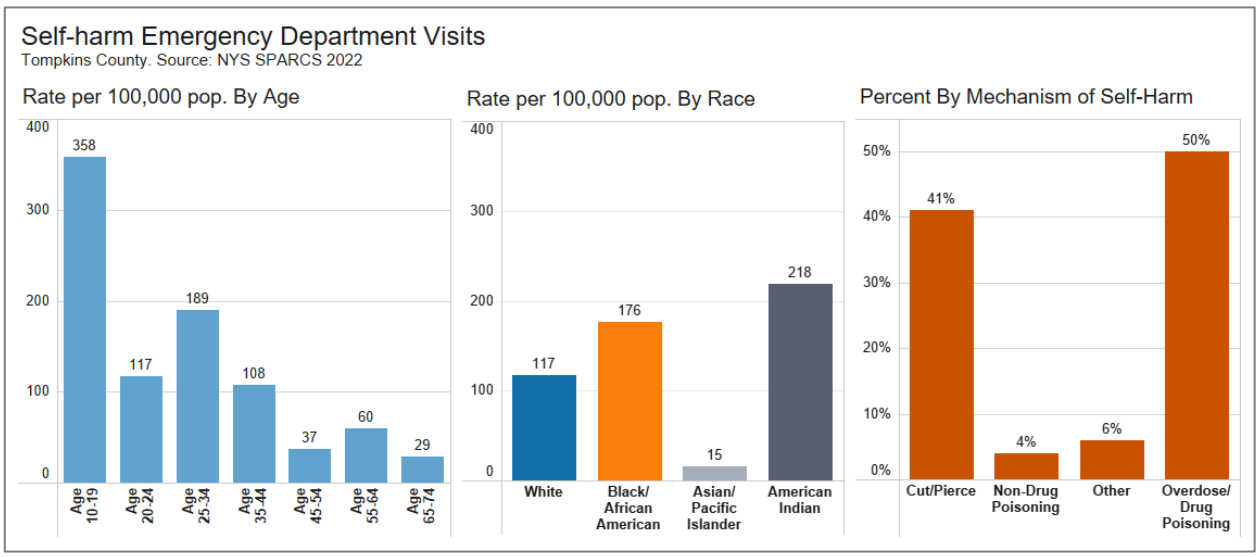

Figure 25 Emergency department visits due to self-harm

Local data also suggests that mental health needs are growing, particularly among young adults and those facing social and economic stressors. Community feedback underscores ongoing access challenges. One resident explained, “We don’t have enough therapists in this community for the need and… who is able to take insurance versus not... that limits the type of care provided.” (Maternal and Child Health Report, 2025). These barriers could be compounded by workforce shortages across the behavioral health system and long wait times for therapy.

Findings from the 2025 Community Health Survey reinforce these patterns where 8% of respondents reported experiencing thoughts of self-harm or suicide in the past year. And when analyzed by age, younger adults reported markedly higher rates of suicidal ideation compared with middle-aged and older adults. *(Figure 26)* Along with that, the respondents also reported access to mental health services was limited primarily by provider availability (26%) and lack of in-network coverage (20%). Cost (16%) and difficulty making appointments (11%) also emerged as barriers. *(Figure 27)* Together, these challenges underscore the need for timely, affordable, and coordinated mental health services.

The combination of self-harm visits among youth and adults, elevated suicide rates, and limited provider capacity highlights an urgent need for preventive and early intervention strategies. Community members and service providers also emphasize the importance of integrating mental health with primary care and social supports, particularly in rural areas.

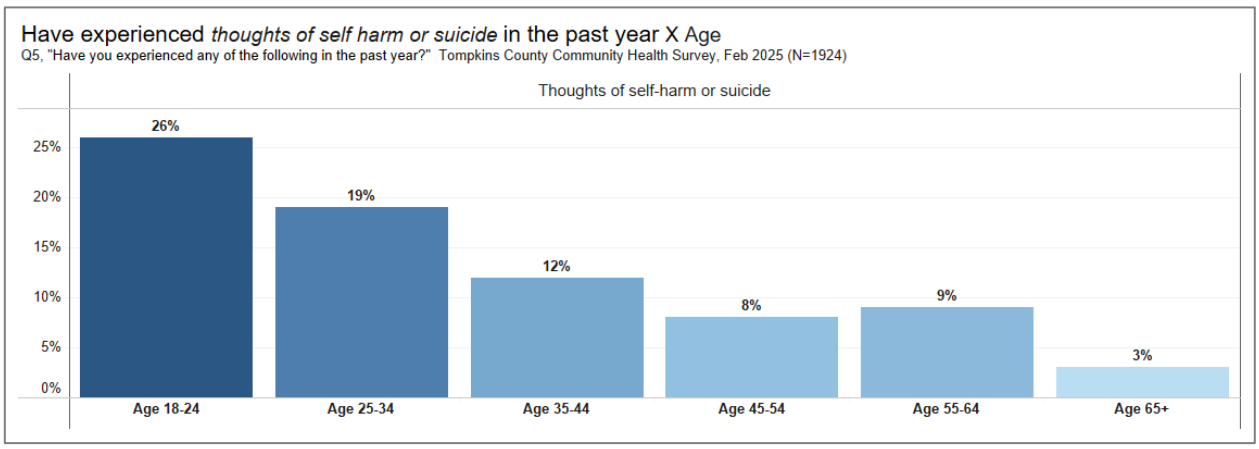

Figure 26 Experienced thoughts of self-harm or suicide

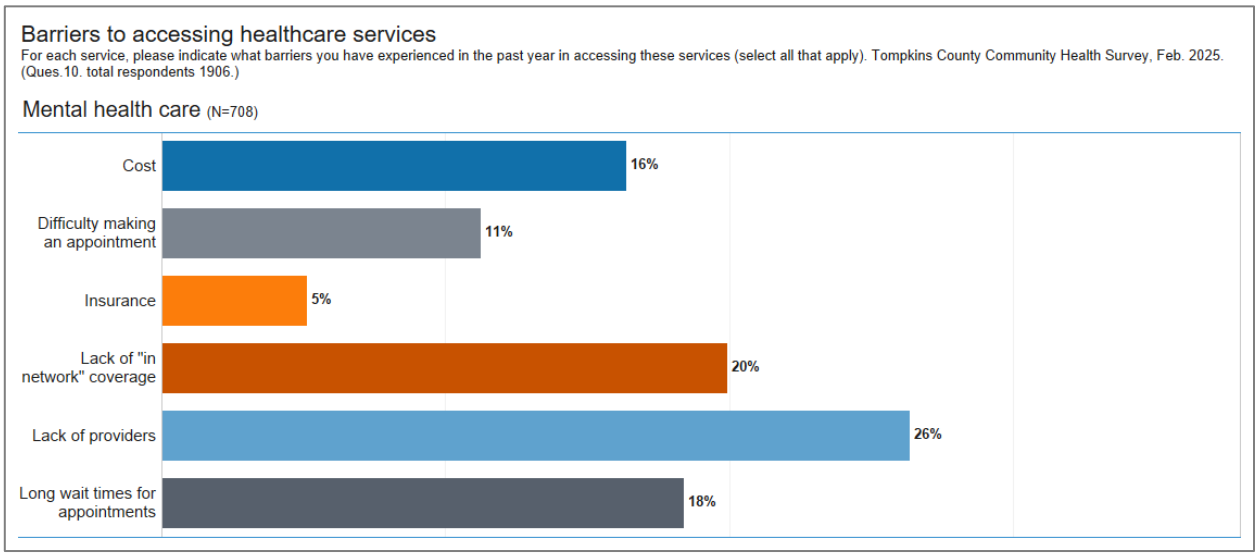

Figure 27 Barriers to accessing mental health care services

Tompkins County continues to strengthen its behavioral health infrastructure through coordinated systems improvements. The Local Services Plan (LSP) reports that the launch of the 988 Suicide and Crisis Lifeline nationally and the Crisis Services for Individuals with Intellectual and Developmental Disabilities (CSIDD) which is a recognized evidence-based model implemented in various states like New York, in 2022 expanded access to immediate crisis response and referral pathways. Concurrent workforce development initiatives are underway to increase the number of licensed behavioral health professionals and enhance access to care across income and insurance levels (Local Services Plan, 2024-2028).

Partnerships among healthcare providers and community-based organizations such as the Tompkins County Suicide Prevention Coalition have advanced suicide prevention efforts through initiatives such as the Zero Suicide Prevention Committee, which includes training staff for early intervention, risk screening, and mandating continuous quality improvement. Sustained investment in workforce capacity, trauma-informed care, and community-based prevention remains essential to improving mental wellbeing and reducing suicide throughout Tompkins County.

PREVENTION AGENDA PRIORITY: DEPRESSION

Mental wellbeing continues to be a priority in Tompkins County, where community partners and health providers emphasize the growing importance of addressing depression across the lifespan. Rising rates of reported depressive symptoms among adults, youth, and older adults highlight the need for comprehensive, accessible, and trauma-informed mental health services.

The percentage of adults reporting a depressive disorder increased from 15.3% in 2016 to 23.0% in 2021, reflecting a clear upward trend (BRFSS Health Indicators by County and Region). In addition, 12% of adults reported experiencing poor mental health for 14 or more of the past 30 days which is slightly lower than the statewide rate of 13% and on par with the national rate of 15% (County Health Rankings, 2024). *(Figure 28)*

Among youth, emotional distress also remains notable. In the 2023 CLYDE Youth Survey, 35.4% of students in grades 7-12 reported feeling depressed most days, with prevalence rising by grade level, from 32.4% in grade 7 to 39.4% in grade 12. Nearly 44% of students expressed feelings of low self-worth ("I am no good at all"), and 72% reported using substances to "feel better," indicating a strong link between emotional distress and coping behaviors (CLYDE Youth Survey, 2023). *(Figure 29)*

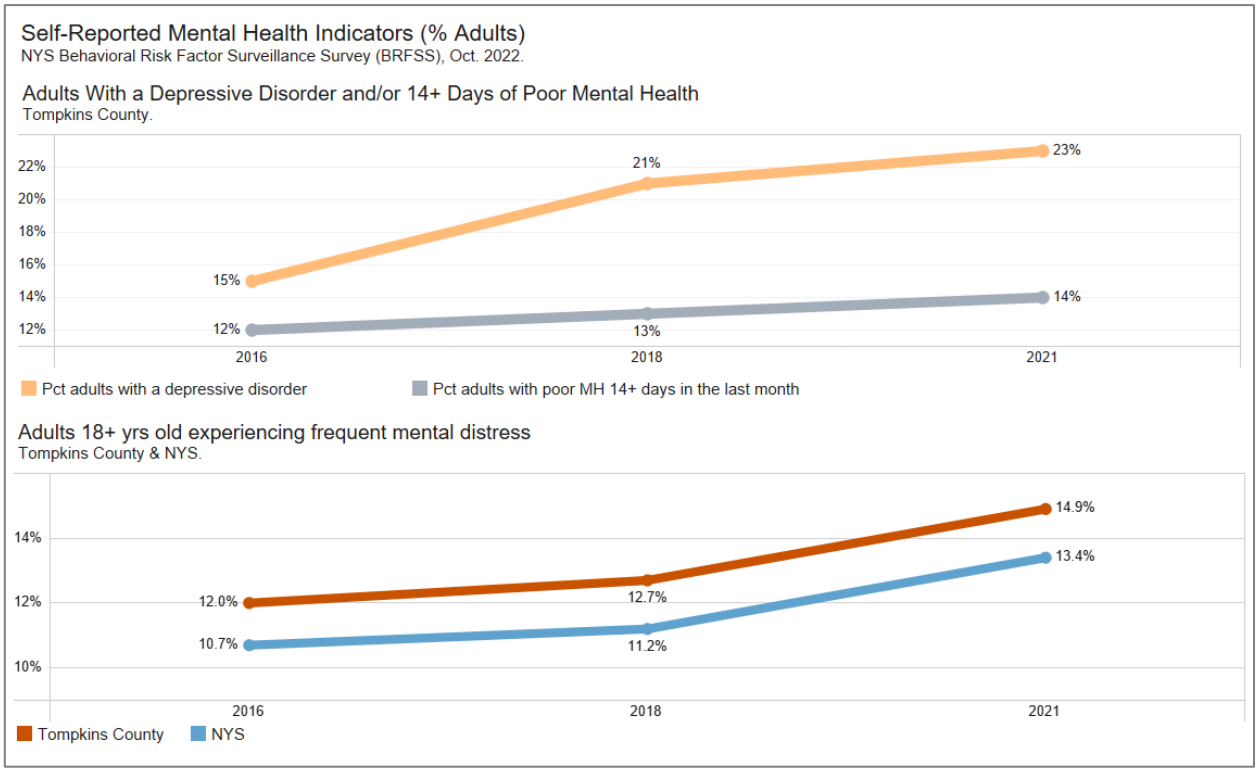

Figure 28 Mental health concerns self-reported by adults

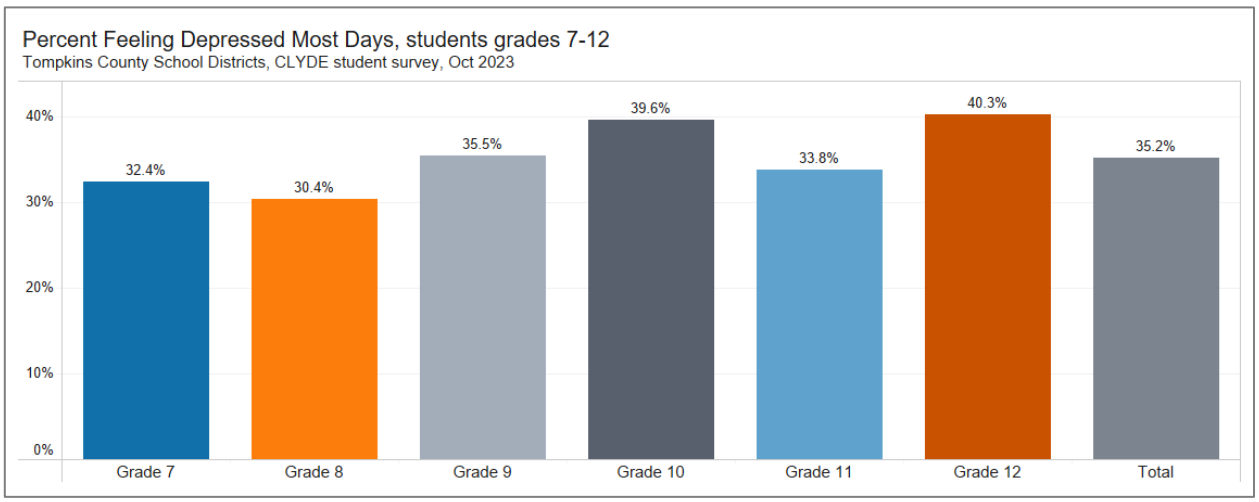

Figure 29 Students grades 7-12 reported feeling depressed

Older adults also experience notable emotional challenges. In 2023, 37% of residents aged 60 years and older reported feeling lonely or isolated to some degree, whether as a minor, moderate, or major concern (Community Assessment Survey for Older Adults, COFA, 2023).

Findings from the Community Health Survey indicate that 39% of respondents experienced feelings of loneliness or isolation in the past year, and 32% reported having a limited social support network (e.g., friends or family). Age-related patterns show that these challenges are most prevalent among younger adults, particularly those aged 18-34, and decrease steadily with age. Findings also show that 12% of respondents reported using drugs, THC products, alcohol, tobacco, or nicotine products more than they would like in the past year. When cross-tabulated with age, substance use beyond desired levels was most common among younger adults, particularly those aged 25-34, and declined consistently with age. This pattern again suggests that younger populations may face higher stress or coping-related substance use behaviors (Community Health Survey, 2025). *(Figure 30)*

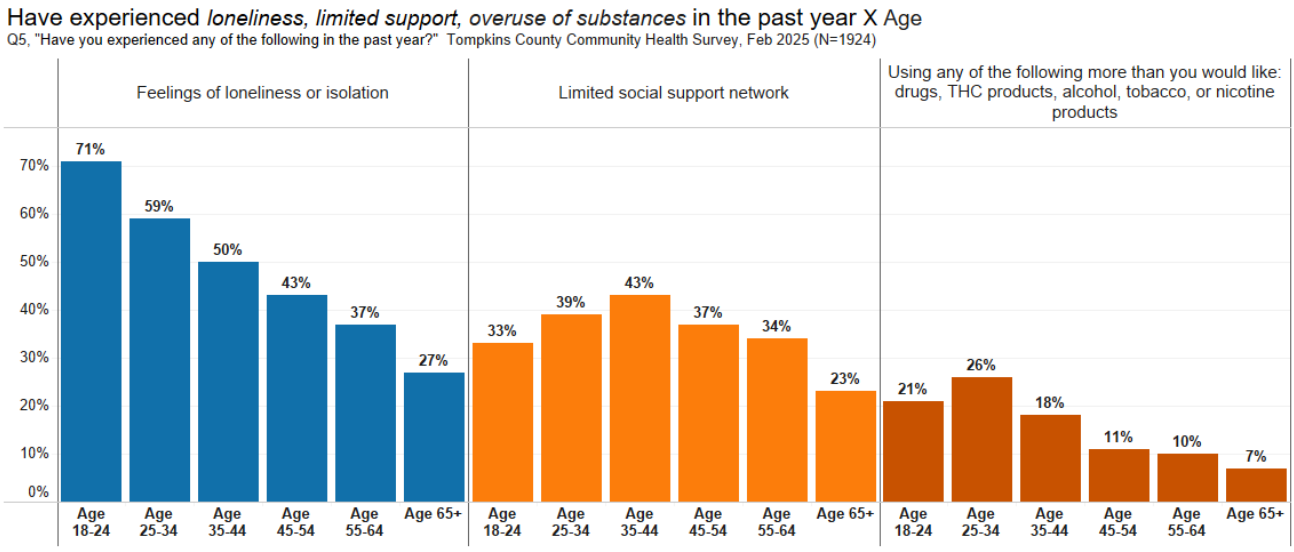

Figure 30 Experienced loneliness, isolation, or limited social support network, or overusing substances

Multiple community assessments underscore ongoing barriers to accessing mental health care. Persistent workforce shortages have reduced the availability of mental hygiene and behavioral health services, limiting options for timely treatment (Local Services Plan, 2024-2028). Residents frequently cite long waitlists, stigma, and limited access to trauma-informed care, particularly for those seeking support for substance use or co-occurring disorders (Sunflower Houses: Qualitative Assessment Report, 2025).

A local youth assessment similarly found that individuals on Medicaid face longer wait times and fewer provider choices, with many reporting difficulties finding therapists who accept insurance (Youth Mental Health in Tompkins County - CCE Tompkins in partnership with Village at Ithaca, 2025). These findings suggest that even as awareness and demand increase, structural and financial barriers continue to prevent many residents from receiving consistent, high-quality care.

To address these challenges, Tompkins County is advancing efforts to expand behavioral health services and workforce. In November 2024, TCWH opened up a new clinic space to current mental health clients at 55 Brown Rd., and began adding in new clients to this location in the spring of 2025. This additional clinic offers brand new construction, accessible first floor offices with plenty of free, open parking. Clinicians from both the Adult and Children/Youth teams are able to meet with clients at this location, increasing our capacity to serve by 30%.

> "Almost half of all adults in the United States will experience a mental health illness at some point in their life, half of those by age 14. And yet, about 42% of people in this country never get access to the care that they need. This clinic was built with those statistics in mind: we wanted to make sure that people in our community have access to the care that they need and deserve."
>
> *— Harmony Ayers-Friedlander, Deputy Commissioner of Mental Health, Tompkins County Whole Health*

A workforce diversity survey is conducted annually as an objective of the Local Services Plan and a requirement of the Local Government Unit (County Mental Health Services).

A co-response system with specially trained law enforcement and licensed mental health clinicians through Crisis Alternative Response and Engagement (CARE) Teams was instituted in Tompkins County starting in 2023. There are currently two teams, one with the Sheriff's Department and one with City of Ithaca Police. The goals of the teams include de-escalation, linking people to services, and providing in-person follow-up within 24-48 hours - an approach designed to divert people from the criminal justice system and unnecessary hospitalization.

PREVENTION AGENDA PRIORITY: PRIMARY PREVENTION, SUBSTANCE MISUSE, AND OVERDOSE PREVENTION

Reducing substance misuse and preventing overdose remain top priorities for Tompkins County. Over the past decade, the County has strengthened prevention, harm reduction, and treatment systems to respond to evolving substance use patterns. Progress in reducing prescribing rates and expanding access to naloxone reflects the County's commitment to a comprehensive and health-centered approach. However, fluctuations in overdose mortality and treatment demand demonstrate that continued investment and coordination are necessary to sustain this progress.

Overdose mortality data show that Tompkins County remains below statewide averages but does not meet the Prevention Agenda goals. The crude rate of overdose deaths involving any drugs was 26.1 per 100,000 population in 2023, below the state rate of 32.3 yet above the NYS 2030 objective of 22.6. Deaths specifically involving opioids were 23.2 per 100,000 population, not meeting the 2030 target of 14.3 (Vital Statistics, 2025). *(Figure 31)*

Quarterly surveillance data reveal continued variation in overdose outcomes in Tompkins County. Between 2021 and 2024, opioid-related overdose deaths ranged from a crude rate of 11.3 per 100,000 person-years in the first quarter of 2021 to 23.2 in the Q1 of 2023, then declining to 3.9 by Q4 of 2024. Throughout this period, rates remained below statewide levels and ultimately met the NYS 2030 objective of 14.3 per 100,000. Outpatient emergency department visits for opioid-related overdoses followed a similar downward trajectory, declining from a peak rate of 104 per 100,000 in 2022 to 42.5 by the last quarter of 2024, meeting the Prevention Agenda target rate of 53.3 and reflecting sustained improvement in prevention and early response (SPARCS, 2025). *(Figure 32)*

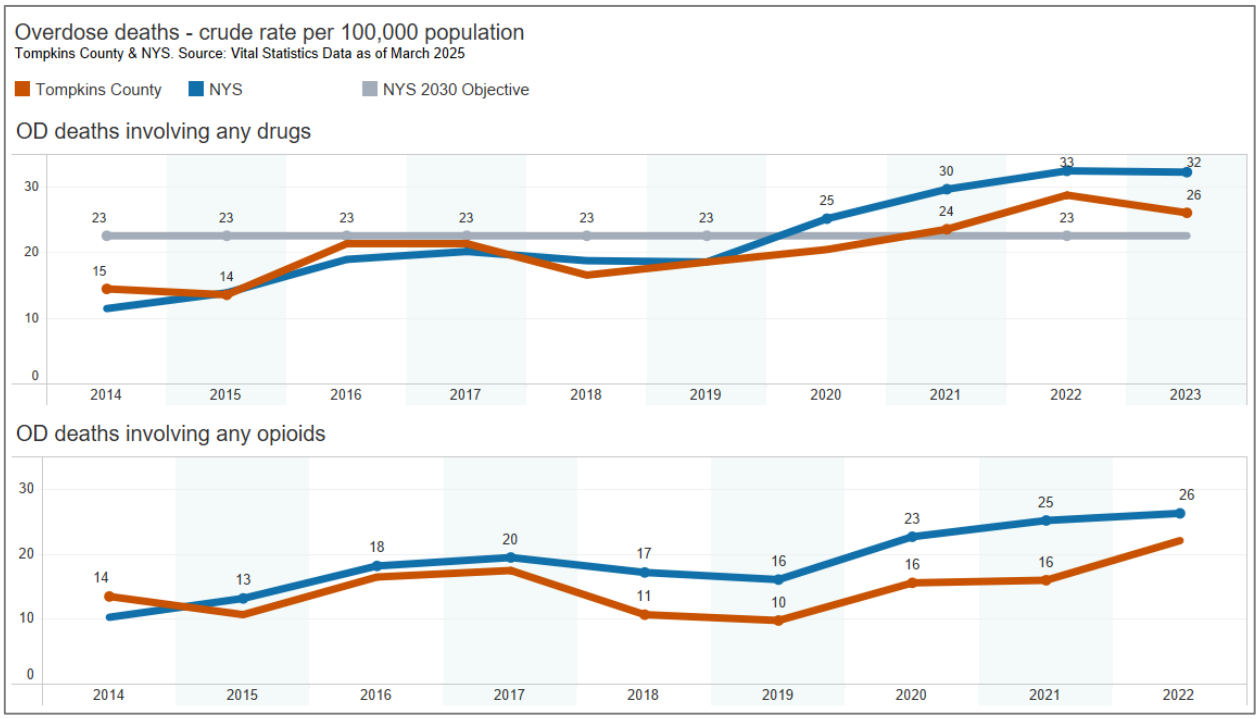

Figure 31 Trend in overdose death by any drug & by any opioid

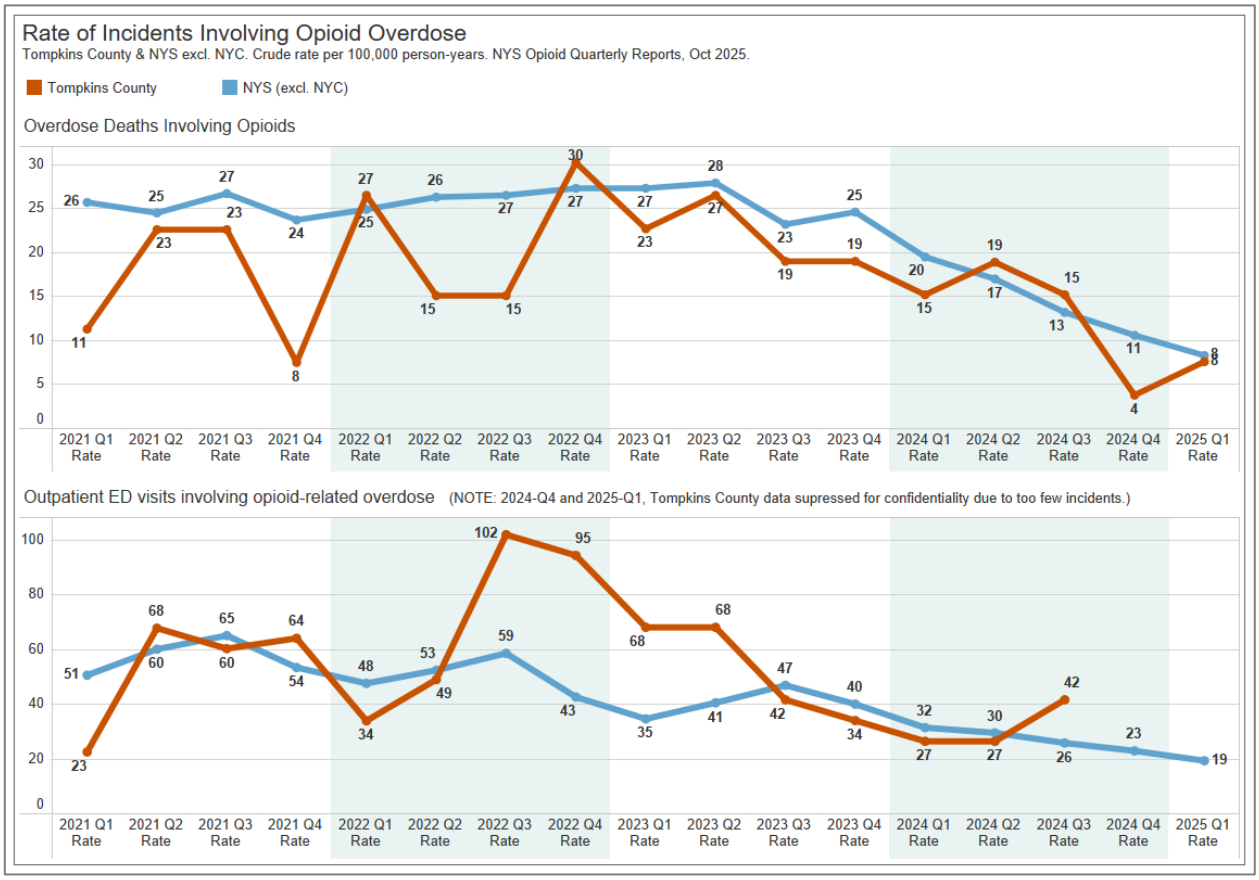

Figure 32 Trend in opioid OD mortality or emergency visits

Opioid prescribing has declined steadily in Tompkins County. The crude prescription rate decreased from 517.5 per 1,000 population in 2012 to 327.3 in 2023, consistent with statewide trends (NYS PMP, 2024). (Figure) Among opioid-naïve patients, the rate of initial prescriptions was 81 per 1,000 population in 2023, approaching the NYS 2030 objective of 77.9. (Figure) The proportion of opioid-naïve patients receiving prescriptions longer than seven days declined from 34.6% in 2016 to 18.1% in 2023, again moving closer to the state target of 13.6% (NYS PMP, 2024). *(Figure 33)*

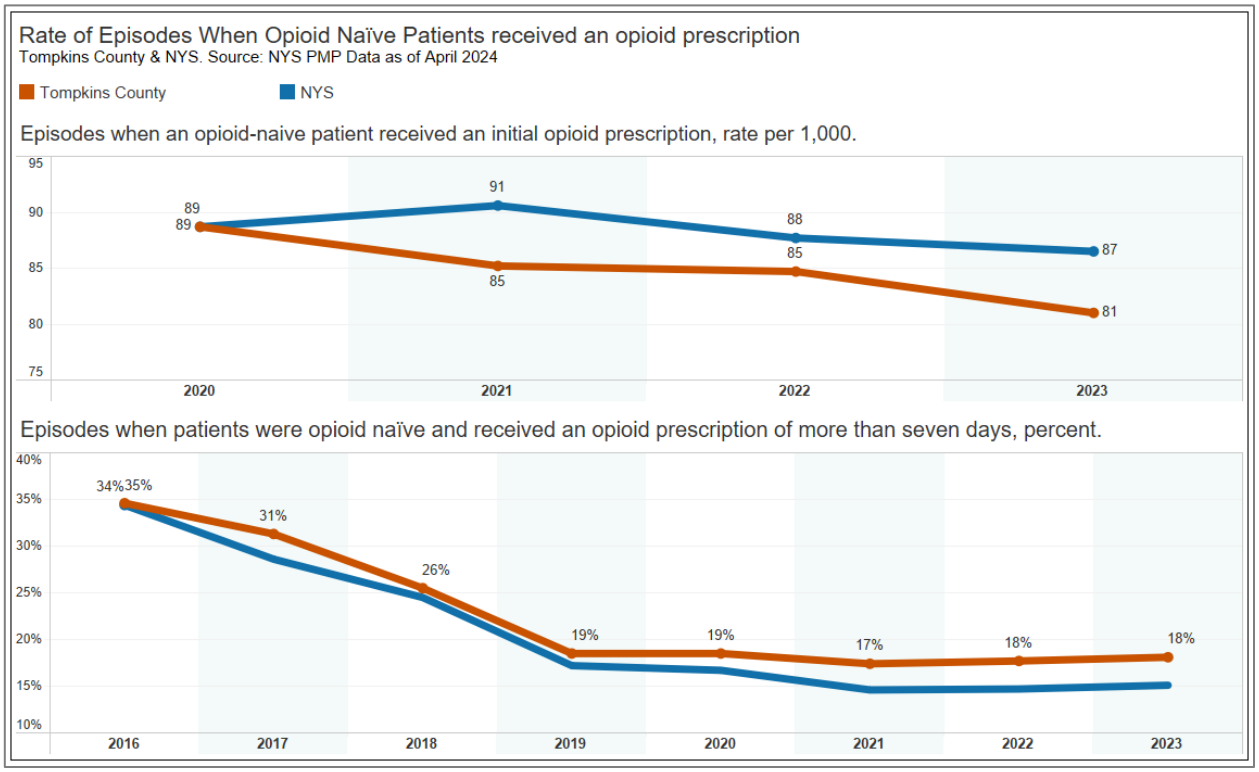

Figure 33 Rate of opioid prescribing

To address these challenges, treatment engagement has expanded considerably. Enrollment in OASAS-certified treatment programs for individuals reporting opioids as their primary substance increased from 222.5 per 100,000 in 2010 to 773.4 in 2023, exceeding the NYS 2030 objective of 511.7 (OASAS, 2024). *(Figure 34)* Naloxone administration by EMS peaked at 8 per 1,000 unique 911 dispatches in 2021-2022 before decreasing to 4.7 in 2023 (NYS EMS, 2024).*(Figure 35)* At the community level, naloxone kit distribution grew sharply from 1,284 kits in 2020 to 6,264 in 2023 reflecting strong community engagement and commitment to prevention (NYS Community Opioid Overdose Prevention Program, 2025). *(Figure 36)* Benzodiazepine prescribing also declined from 256.7 per 1,000 in 2012 to 236.8 in 2023, mirroring state patterns (NYS PMP, 2024). *(Figure 37)*

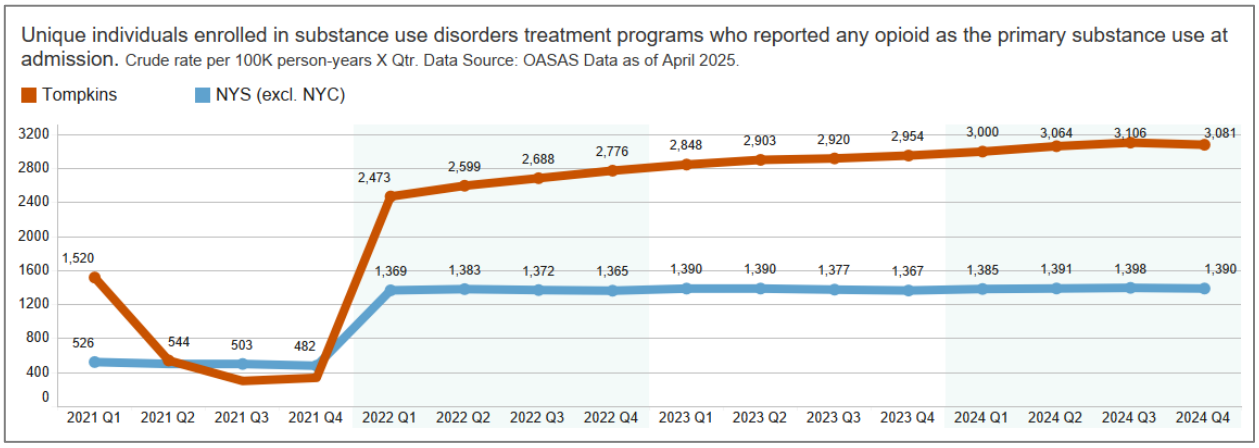

Figure 34 Trend for enrollment in OASAS treatment programs

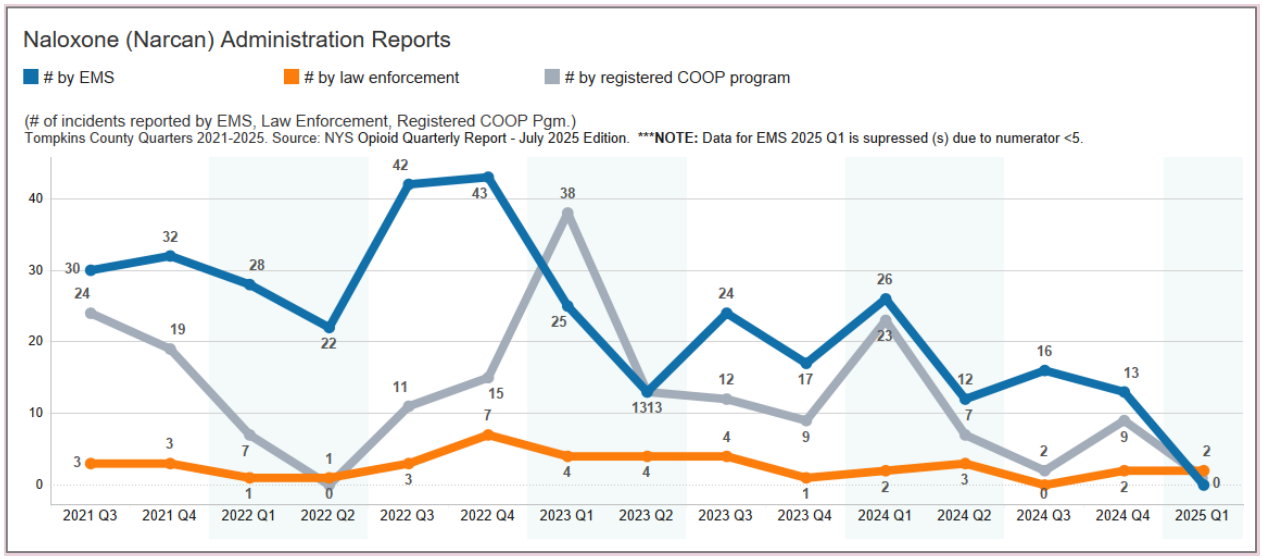

Figure 35 Naloxone administration by varied providers

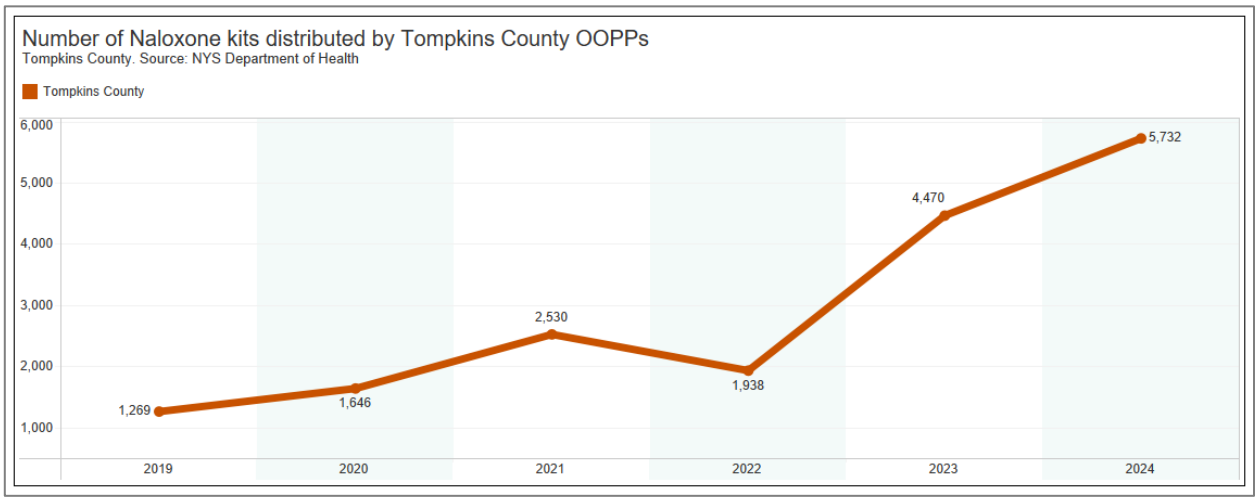

Figure 36 Trend for community distribution of naloxone kits

Figure 37 Trends for opioid prescribing

Tompkins County has also strengthened its emergency response capacity to reduce delays in life-saving care, particularly in rural parts of the county. The Department of Emergency Response initiated a Rapid Medical Response Program (RMR) that provides prehospital medical services across all municipalities that respond to both urban and geographically remote areas. Efforts to improve dispatch efficiency, expand first-responder coverage, and enhance coordination among agencies aim to shorten response times for overdose events and other medical emergencies, supporting the broader system of harm reduction and acute care (Tompkins County Department of Emergency Response, 2024).

A Tompkins County Narcan Partnership coalition was convened in 2024 and now meets quarterly in partnership with the Rural Health Institute. This coalition includes prevention partners who work across Cortland and Tompkins counties to ensure continuity of Narcan distribution, training, and education.

These data illustrate meaningful progress in prescribing practices, harm reduction, and treatment engagement. Stakeholders have also noted that while local prevention infrastructure has grown, maintaining trained personnel, treatment access, and sustainable funding remains an ongoing challenge.

At the national level, changes announced by SAMHSA in September 2025 regarding its strategic priorities raise concerns about the future of harm reduction and voluntary, health-led crisis response. Local progress in naloxone distribution, medication-assisted treatment, and community-

based prevention may be affected if federal support shifts away from harm reduction strategies toward more abstinence-based or coercive approaches, underscoring the importance of sustaining local investment and cross-sector collaboration (SAMHSA Strategic Priorities, 2025).

Sustained local investment and cross-sector coordination will be essential to reduce overdose mortality, expand treatment access, and achieve alignment with NYS Prevention Agenda 2030 goals ensuring that progress in substance misuse prevention continues to translate into improved health and safety for all Tompkins County residents.

PREVENTION AGENDA PRIORITY: TOBACCO/ E-CIGARETTE USE

Patterns of tobacco and nicotine use have shifted notably in recent years, reflecting both the success of longstanding tobacco control measures and the growing influence of vaping among youth. While traditional cigarette smoking has declined across age groups, new products, particularly flavored e-cigarettes, continue to attract younger users. These changes highlight evolving public health challenges around nicotine dependence, risk perception, and marketing exposure.

Adult cigarette smoking in Tompkins County has declined steadily, dropping from 16.1% in 2016 to 8.9% in 2021. The County rate remains below the statewide average of 12% and continues to move toward the New York State Prevention Agenda 2030 objective of 7.9% (NYS BRFSS, 2022). *(Figure 38)*

Among youth, vaping remains less common locally than statewide but follows similar age-related trends. In 2023, 2% of Tompkins County students in grades 7-8 and 9% of students in grades 9-12 reported using nicotine vapes in the past 30 days (CLYDE Youth Survey, 2023.) Lifetime nicotine vape use in Tompkins County increased by grade, from 3% in grade 7 to 22% in grade 12, while lifetime marijuana vape use rose from 1% to 25% (CLYDE Youth Survey, 2023). *(Figure 39)* Statewide, 13.2% of students used nicotine vapes, and use peaked among 12th graders (22.1%) (NYS Youth Tobacco Survey, 2022).

Youth perception of risk also influences behavior. In 2023, 25.6% of students in grades 7-12 reported perceiving “no risk” or “slight risk” from nicotine vaping, compared with 18.8% for cigarettes (CLYDE Youth Survey, 2023). *(Figure 41)* This pattern suggests that e-cigarettes are often viewed as safer alternatives, even as nicotine exposure remains a concern for adolescent brain development and addiction risk.

Declining adult smoking rates represent a major public health achievement, but the continued normalization of vaping among youth underscores a shifting landscape of nicotine use. Qualitative insights illustrate this transition: “Our middle schoolers, our 7th and 8th graders… they’re the ones that are more likely to say that they’re using for curiosity and social pressure. But once you get into high school, they’re using it for coping.” (Key Informant Interview, 2025). These insights highlight how motivations for vaping evolve, from experimentation to self-regulation of stress, emphasizing the importance of early, developmentally appropriate prevention.

To address these challenges, Tompkins County partners are focusing on youth education and cessation supports to address emerging nicotine use trends. To reduce nicotine use among youth, the Youth Development Program at TST BOCES provides multiple school-based supports, including Teen Intervene, an evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) model for students experiencing mild to moderate substance use. The BOCES program also supports peer-supported cessation groups for students seeking to reduce or end nicotine use and tobacco and nicotine prevention lessons for students in grades K through 5. Local CLYDE data reinforces positive social norms by highlighting that the vast majority of students in Tompkins County have not vaped nicotine in their lifetime (84%) and are not currently using nicotine vapes (no 30-day use, 91%). These combined efforts are helping to strengthen early prevention and support healthier environments for the youth across the County.

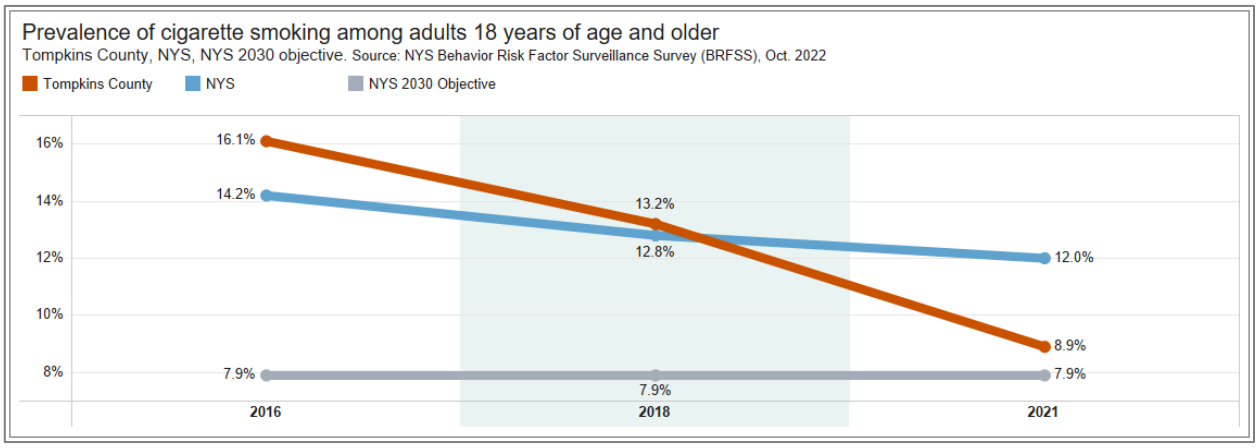

Figure 38 Adult cigarette smoking

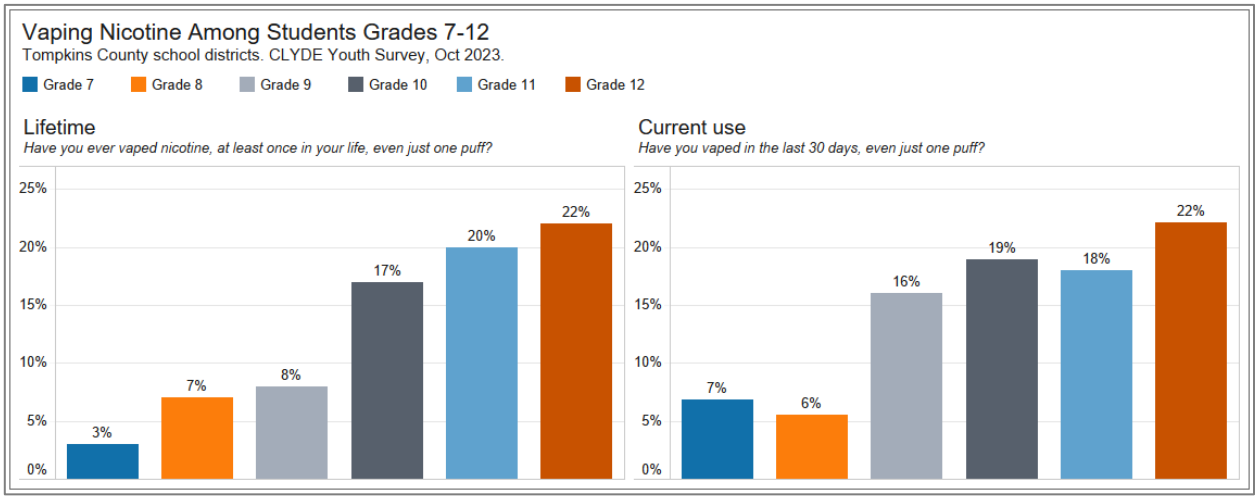

Figure 39 Youth nicotine vaping

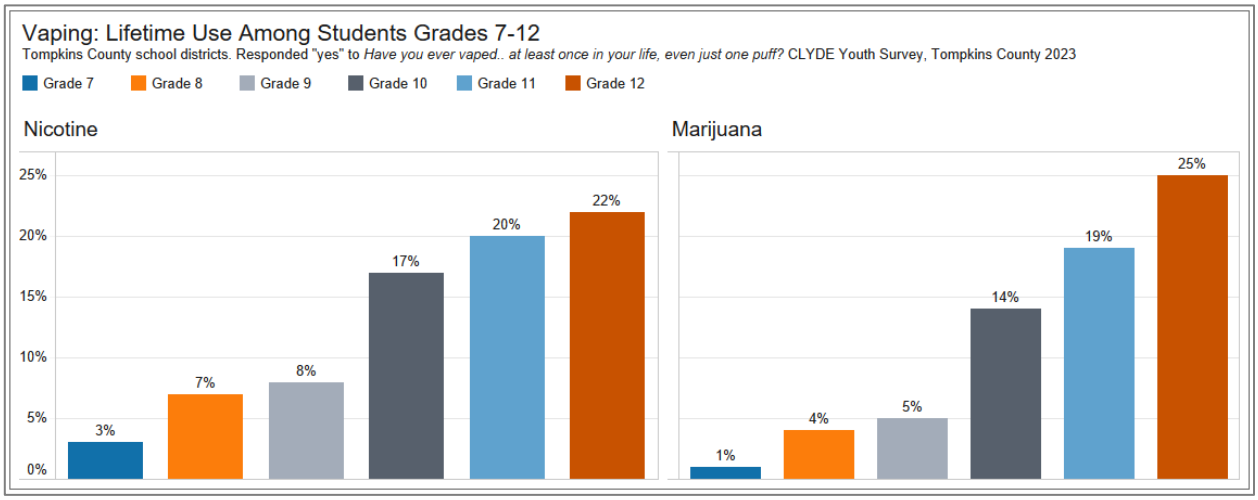

Figure 40 Youth any vaping

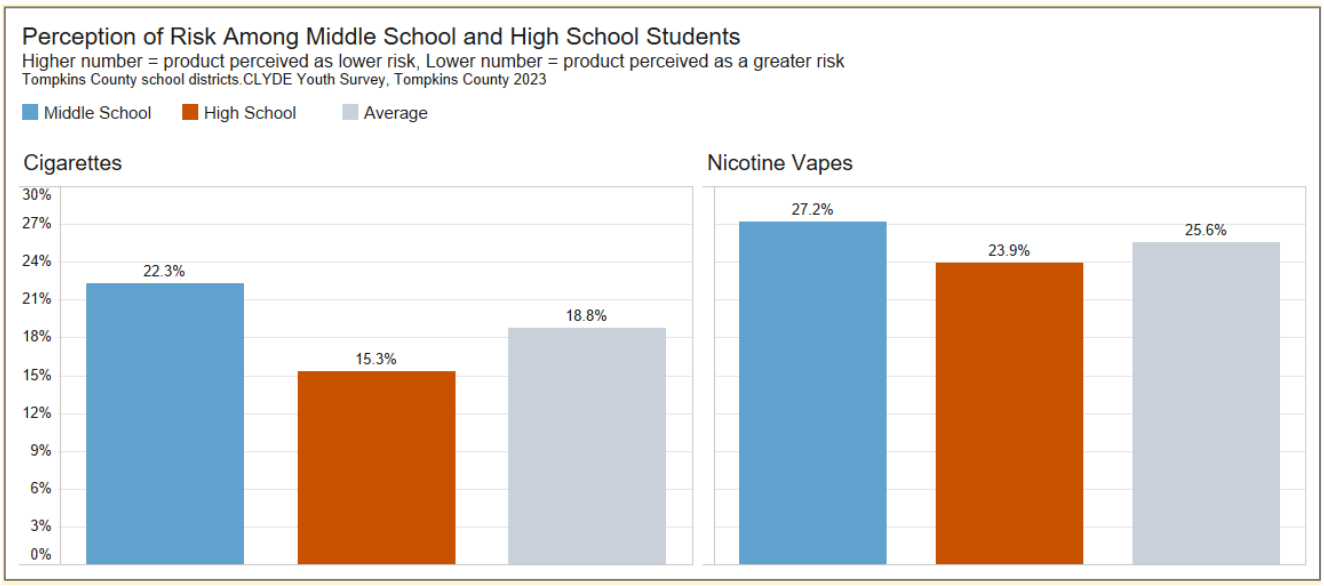

Figure 41 Students' perception of risk

Prevention Agenda Domain: Neighborhood and Built Environment

Safe and Healthy Communities

PREVENTION AGENDA PRIORITY: INJURIES AND VIOLENCE

Injuries and violence are critical components of community safety and wellbeing. They encompass preventable causes of morbidity and mortality, from unintentional injuries and falls to violence-related emergencies. Monitoring these indicators helps identify both structural and behavioral drivers of safety and informs multi-sector prevention strategies in Tompkins County.

Crime and injury indicators have remained relatively stable in recent years, though some measures remain slightly above state averages. Between 2017 and 2021, the index crime rate ranged from 1,823 to 2,094 per 100,000 population, compared with 1,731 to 1,830 statewide, while the property crime rate ranged from 1,694 to 1,928 per 100,000, exceeding the state average of 1,347 to 1,474 (NYS Division of Criminal Justice Services, 2017-2021). *(Figure 42)*

Domestic violence rates fluctuated between 254.9 and 336.7 per 100,000 population from 2019 to 2023, with the most recent rate of 282.8 slightly above the state average of 269.8 (NYS Division of Criminal Justice Services, 2019-2023). *(Figure 42)*

Assault-related emergency department visits, including those related to abuse, have increased sharply, from 37 ED visits reported in 2020 to 135 in 2024. In 2024, 59.8% of patients identified as White or Caucasian, 9.5% as Black or African American, and 23.7% were reported as unknown (Cayuga Health Partners, 2020-2024). *(Figure 43)*

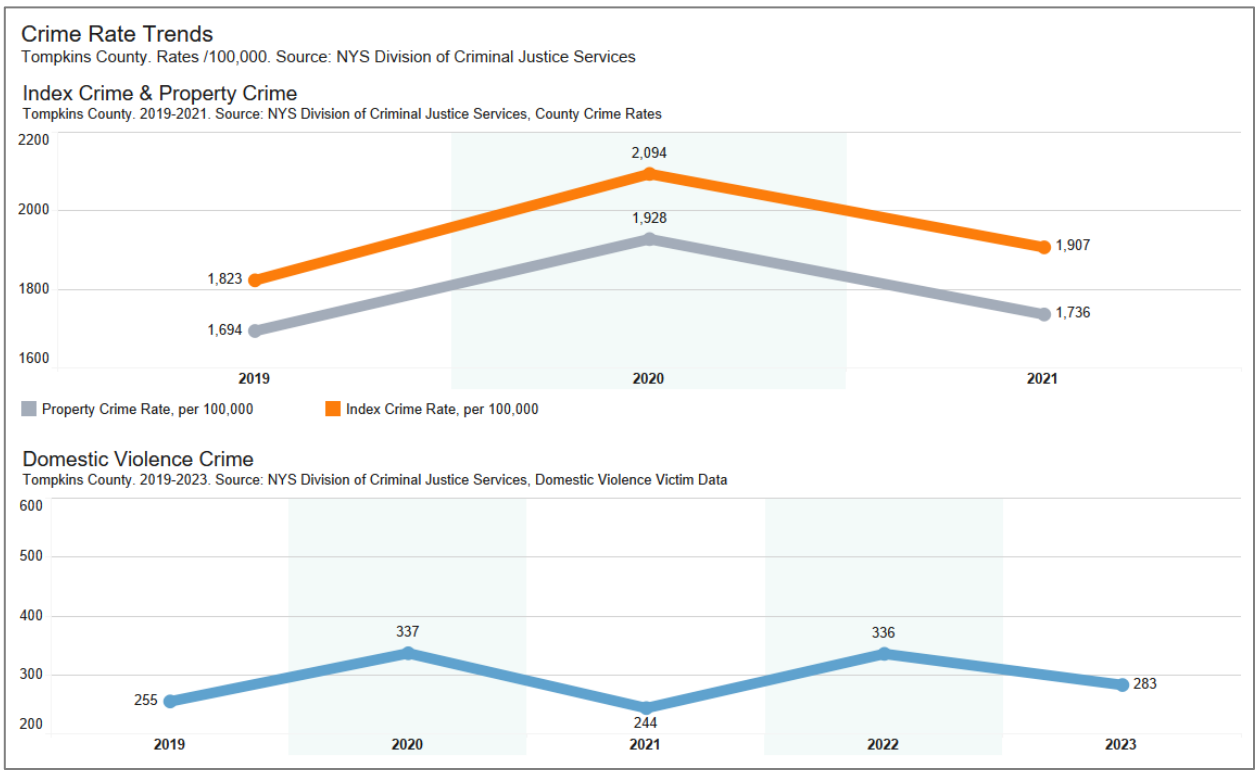

Figure 42 Crime rate trends

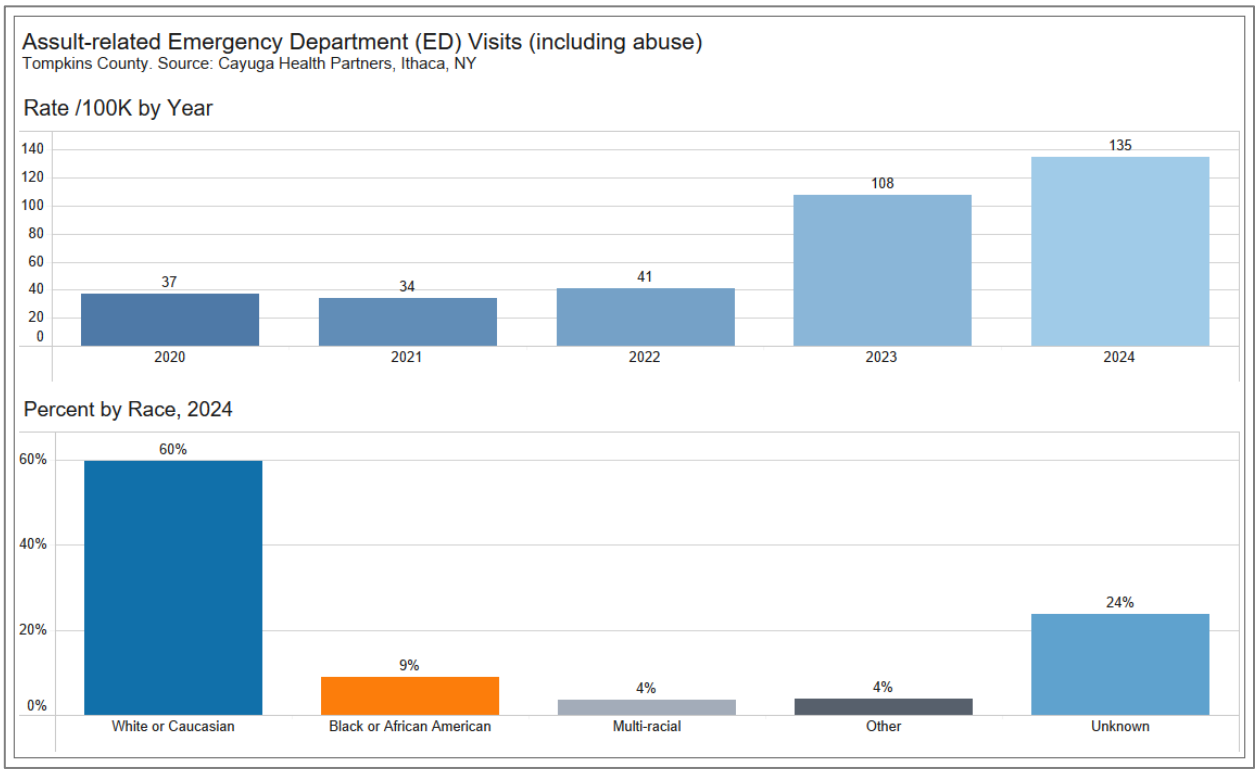

Figure 43 Assault-related ED visits

Unintentional injuries remain one of the leading causes of preventable harm, though Tompkins County's mortality rate has stayed below the statewide average (Vital Statistics, Data as of August 2024). From 2013 to 2022, unintentional injury mortality ranged from 28 to 51.6 per 100,000

population, compared with 34.9 to 58.2 statewide. *(Figure 44)* Racial disparities persist where mortality rates were 132.4 per 100,000 among Black residents, two-and-a-half times the rate of 51.2 among White residents and almost 7X the 18.5 rate among Asian/Pacific Islander residents (unstable) (NYS CHIRS; NYS County Health Indicators by Race and Ethnicity, 2020-2022). *(Figure 45)*

Motor vehicle injury mortality has remained relatively steady between 5.2 and 8.3 per 100,000 population (2014-2021), similar to statewide rates of 6.9 to 8.5 per 100,000. By race, mortality rates were 8.6 among White residents, 10.9 among Black residents (unstable), and 11.8 among Asian/Pacific Islander residents (unstable) (NYS CHIRS; NYS CHIRE).

Falls among older adults continue to be a monitored Prevention Agenda indicator. In 2022, the falls hospitalization rate was 34.8 per 100,000 population, lower than the state rate of 51.0, excluding New York City (SPARCS, 2024). *(Figure 46)*

Although Tompkins County performs better than the state average in certain indicators, such as unintentional injury and falls hospitalization, persistent disparities in violence, property crime, and injury mortality reveal deeper social and racial inequities.

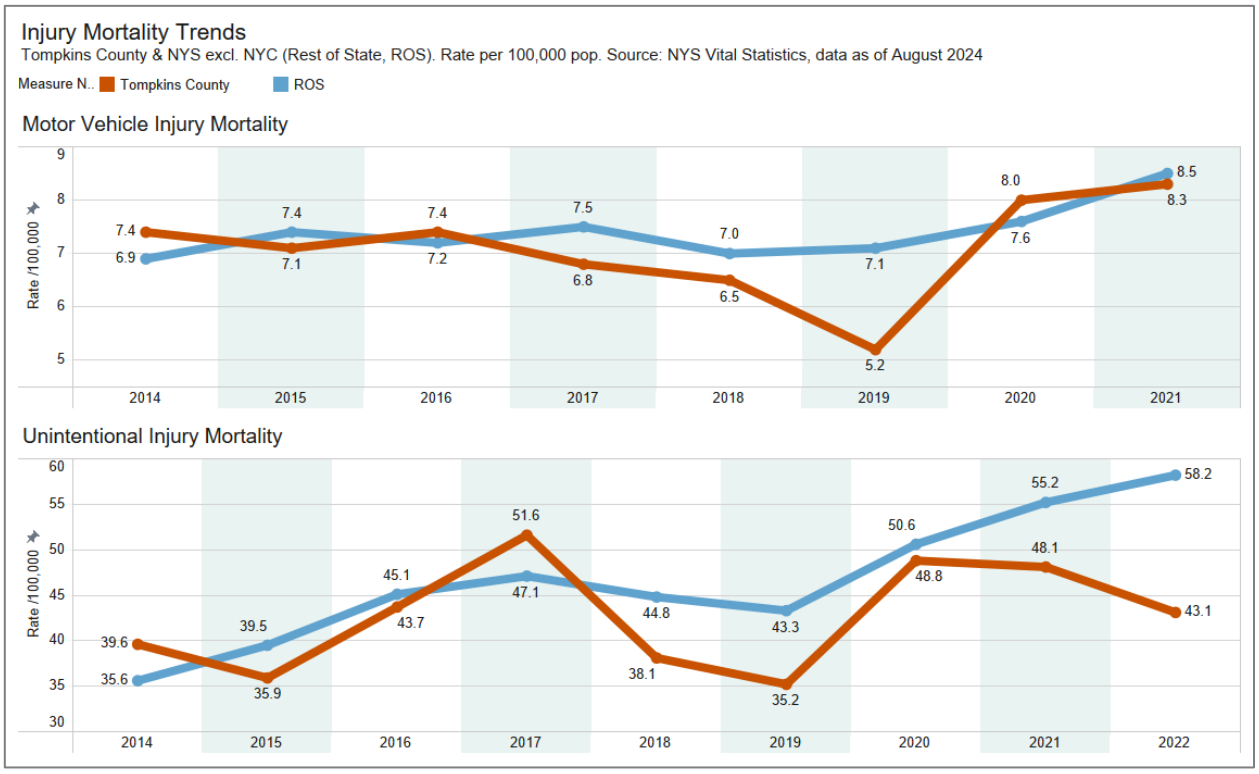

Figure 44 Injury mortality trends

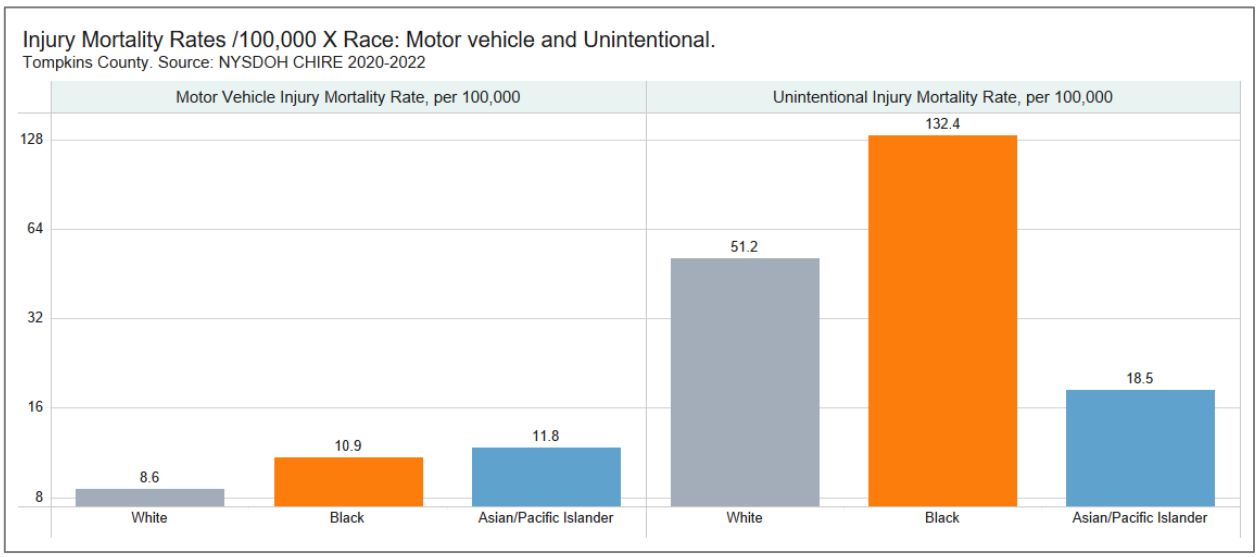

Figure 45 Injury mortality X race

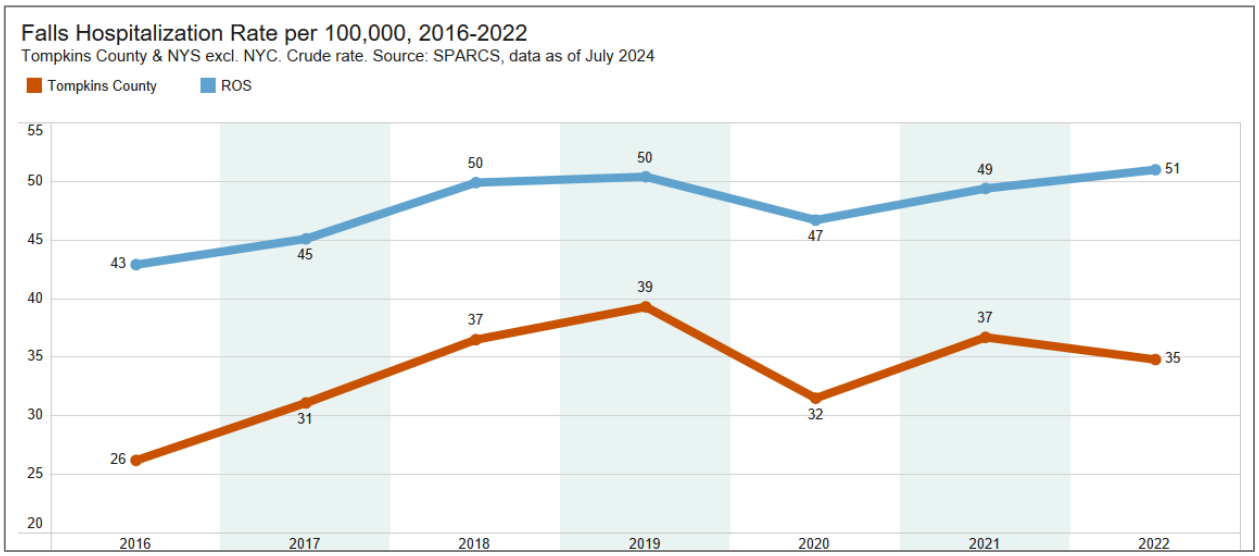

Figure 46 Trend for hospitalization due to falls

The 2025 Community Health Survey asked a question to rate the safety of their neighborhoods. The vast majority of respondents across all municipalities in Tompkins County reported feeling safe. These responses suggest a high overall sense of community security, though slight variations were observed by location. Municipalities such as Newfield (99%), Caroline (98%), Ulysses (98%), and Lansing (97%) reported the highest perceptions of neighborhood safety. Other areas like Danby, Dryden, and the City of Ithaca also had high safety ratings, with 96% of respondents describing their neighborhoods as safe. However, Groton had some perceived neighborhood insecurity with 11% of respondents rating their neighborhood as “not safe” or “not sure.” These figures highlight that safety concerns, while limited, still exist for some residents. *(Figure 47)*

Tompkins County’s ongoing safety initiatives reflect a collaborative approach. Tompkins County continues to advance equitable and community-centered safety initiatives. The Community Justice Center (CJC), established through the Reimagining Public Safety Initiative, tracks and reports public

safety data through an interactive dashboard to enhance transparency and accountability. The Crisis Alternative Response and Engagement (CARE) Team, launched in 2023, pairs mental health professionals with law enforcement to respond to behavioral health and substance use-related 911 calls, diverting individuals from the criminal justice system to care and support. The County Office for the Aging (COFA) also plays a key role in safety for older adults through evidence-based falls prevention programs and its Personal Emergency Response System (PERS), which offers rapid assistance for individuals living alone or at elevated risk.

These programs, alongside the Healthy Neighborhoods Program (HNP), which provides home safety assessments to reduce fall and environmental hazards, reflect Tompkins County's commitment to collaborative, data-informed, and health-led approaches to public safety that prioritize trust, prevention, and the wellbeing of communities fighting racism and social injustice (Tompkins County / Ithaca Community Justice Center, Tompkins County Sheriff's Office, TCWH).

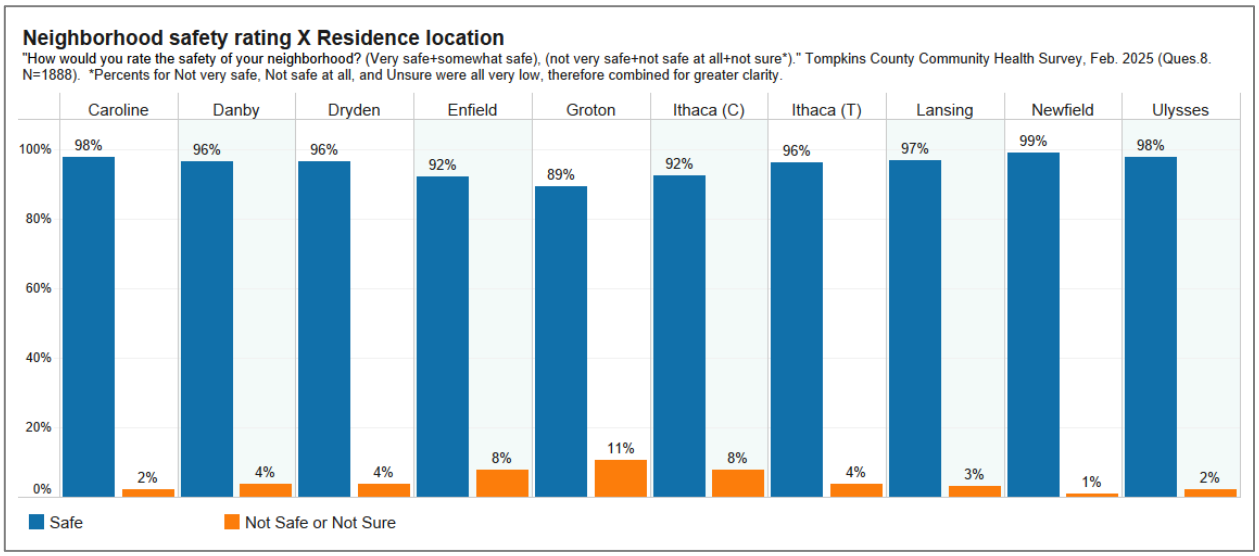

Figure 47 Residents' perception of neighborhood safety

Prevention Agenda Domain: Health Care Access and Quality

Health Insurance Coverage and Access to Care

PREVENTION AGENDA PRIORITY: ACCESS TO AND USE OF PRENATAL CARE (PROMOTE INFANT AND MATERNAL HEALTH)

Prenatal care is one of the most essential preventive health services, providing early risk assessment, health promotion, and therapeutic support to improve maternal and infant outcomes. The World Health Organization (WHO) recommends that birthing people have at least eight prenatal contacts, beginning within the first 12 weeks of pregnancy, to enable timely detection of complications and promote positive pregnancy experiences. Early and consistent prenatal care is associated with lower rates of preterm birth, low birth weight, stillbirth, and maternal and infant mortality (NYS Prevention Agenda Plan (version 2), 2025).

Increasing access to care is critical to reducing inequities in maternal health outcomes. In Tompkins County, birthing people from communities facing structural racism and social injustice, particularly Black, Hispanic/Latino, and low-income families, are more likely to experience delayed or inadequate prenatal care and poorer birth outcomes. Barriers such as limited provider availability, cost, transportation, and lack of culturally responsive care exacerbate these disparities.

In 2024, 76% of birthing people in Tompkins County received prenatal care during the first trimester which was below the NYS 2030 target of 83%. *(Figure 48)* Early prenatal care varied by insurance type. Among all birthing people covered by Medicaid, 68% received early prenatal care, compared with 82% of those with private insurance (Statewide Perinatal Data System-SPDS, 2024). Racial inequities persist, with only 65% of Black/African American birthing parents receiving early prenatal care compared to 78% of White residents (SPDS, 2024). *(Figure 49)* Late or no prenatal care occurred among 3.2% of births, a rate slightly better than the statewide figure of 4.3% (Vital Statistics, 2019-2021).

These inequities are reflected in birth outcomes. While the County's overall preterm birth rate of 8% meets the HP2030 objective of 9.4%, rates among Black birthing people remain higher at 13% compared with 8% among White residents. Similarly, low birth weight affected 14% of non-Hispanic Black births compared with 6% of non-Hispanic White births (County Health Rankings, 2017-2023; SPDS, 2022-2024). *(Figure 50)*

Community input resonates with these findings. One birthing parent shared, "I'm booking as early as I'm allowed to, and I still can't see a midwife for a checkup right when I'm required to." Another reflected, "If you aren't looking for diseases that may impact Black people, it's [diseases] not even on your radar." Parents also cited challenges such as limited specialist availability, poor continuity of care at the County's sole OB-GYN office, and difficulties navigating insurance and billing systems. These barriers often led to delayed care and heightened stress during pregnancy and postpartum. As one parent described, "I felt completely alone during that time [postpartum]… I had never needed so much support before" (Maternal and Child Health Report, 2025).

TCWH continues to address these gaps through coordinated, equity-centered initiatives. MOMS Plus+, a County-funded program, provides home visits by nurses to support pregnant and postpartum families with education, care coordination, and emotional support. Healthy Infants Partnership (HiP), a state-funded initiative, connects families with community health workers who offer breastfeeding support, referrals, and navigation assistance. The federally funded Women, Infants, and Children (WIC) Program further supports maternal and child health by improving access to nutritious foods, nutrition education, breastfeeding support, and referrals to health and social services for eligible families. Community Baby Showers, hosted by local partners, provide essential supplies and connect families to services that promote health, stability, and social connection. Together, these programs strengthen maternal and infant health by reducing access barriers and fostering trust between families and care providers (Maternal and Child Health Report, 2025).

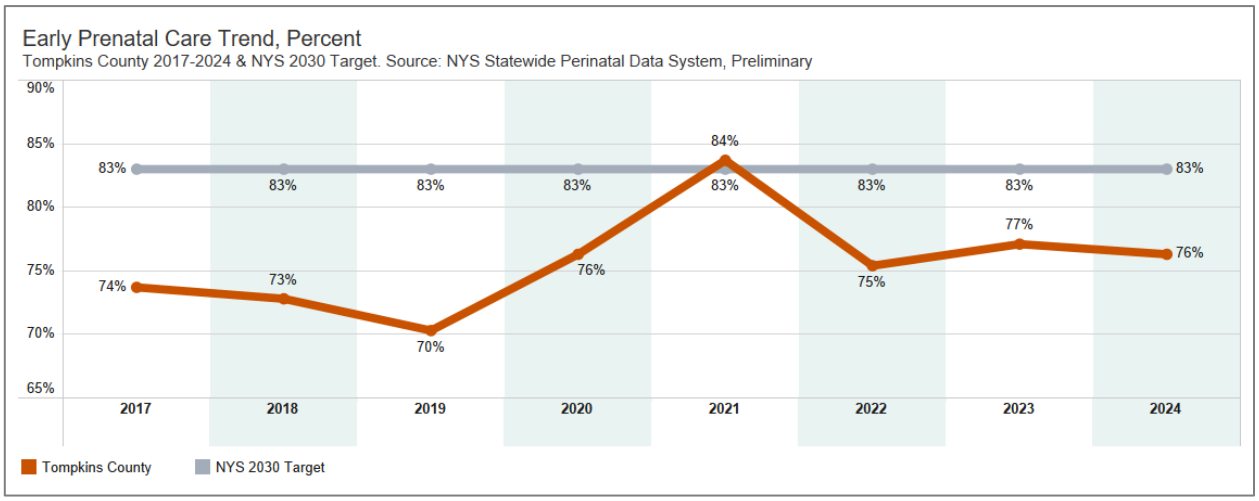

Figure 48 Early prenatal care

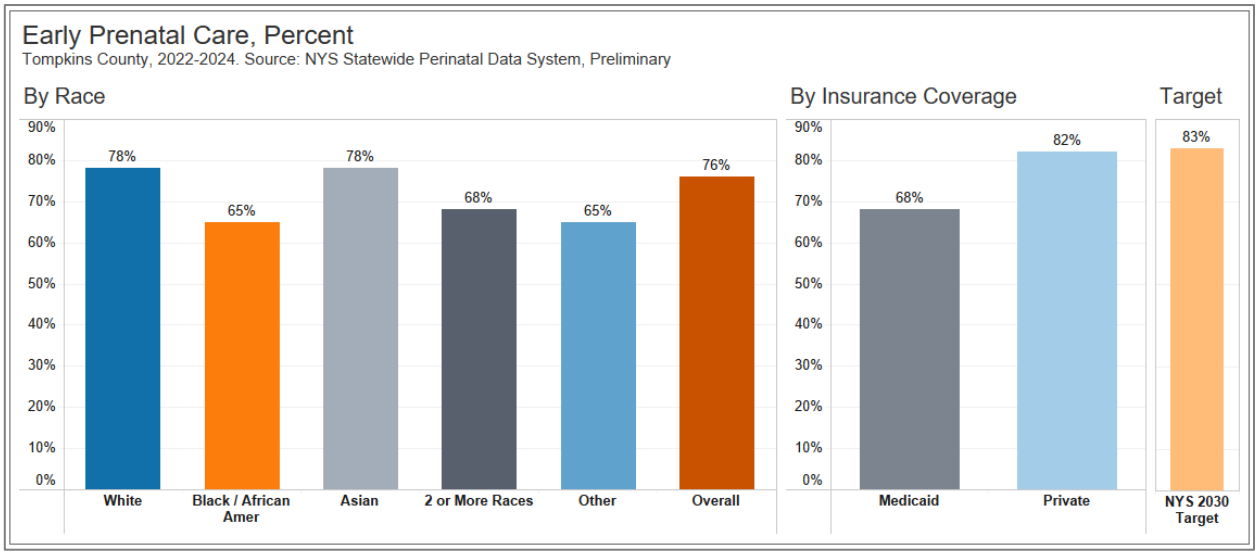

Figure 49 Early prenatal care X race and X insurance

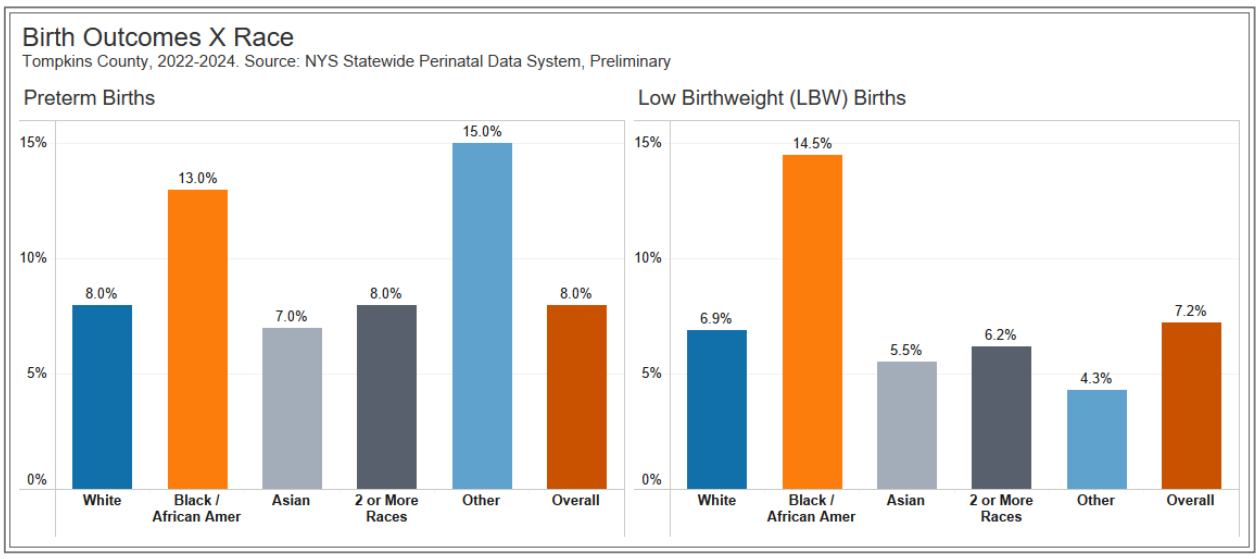

Figure 50 Birth outcomes X race

PREVENTION AGENDA PRIORITY: PREVENTIVE SERVICES FOR CHRONIC DISEASE PREVENTION AND CONTROL

Cancer, heart diseases, diabetes, and related chronic conditions remain major contributors to illness and premature mortality in Tompkins County. Over the ten-year span from 2013 to 2022, cancer and heart disease have evenly shared the #1 cause of death in Tompkins County. However, while cancer was the leading cause for 2019, 2020, and 2021, the rate of cancer deaths per 100,000 has decreased from 126.8 in 2019 to 122.7 in 2022. Heart disease, cancer, unintentional injury, Chronic Lower Respiratory Diseases (CLRD), COVID, diabetes, and cerebrovascular diseases are the top seven for 2022, the most recent data available (Vital Statistics, Data as of August 2024).

Cancer

Increasing screening rates is well recognized as a preventive measure for reducing cancer mortality. Among Tompkins adults aged 50-75, 78% were screened for colorectal cancer based on 2018 BRFSS exceeding both the HP2030 target of 72.8% and the ROS average of 73.7%.

The comparison is flipped for cervical cancer screening where only 68% of Tompkins women aged 21-65 are screened, compared to 84.7% for the ROS and below the HP2030 target of 79.2% (NYS BRFSS, 2018-2022).

The most recent rates for breast cancer screening of Tompkins women aged 50-74 is 83.5%, above the ROS rate of 78.2% (BRFSS, 2022). New York State also reports improvement in the rate of mammograms among women aged 50-74 who are enrolled in the Medicaid program, increasing from 56% in earlier reporting periods (2016 data reported in the 2019 CHA). Among older women, 48% of female Medicare enrollees aged 65-74 receiving annual mammography screenings but lowest

among Black women with a rate of 29% and highest among Asian women with 53% (County Health Rankings, 2022). *(Figure 51)*

The female breast cancer incidence rate stands at 113 per 100,000 which is below the state average of 145. However, the late-stage female breast cancer incidence rate of 44.9 per 100,000 is categorized as high concern within the state's quartile distribution (NYS CHIRS, 2021). *(Figure 52)*

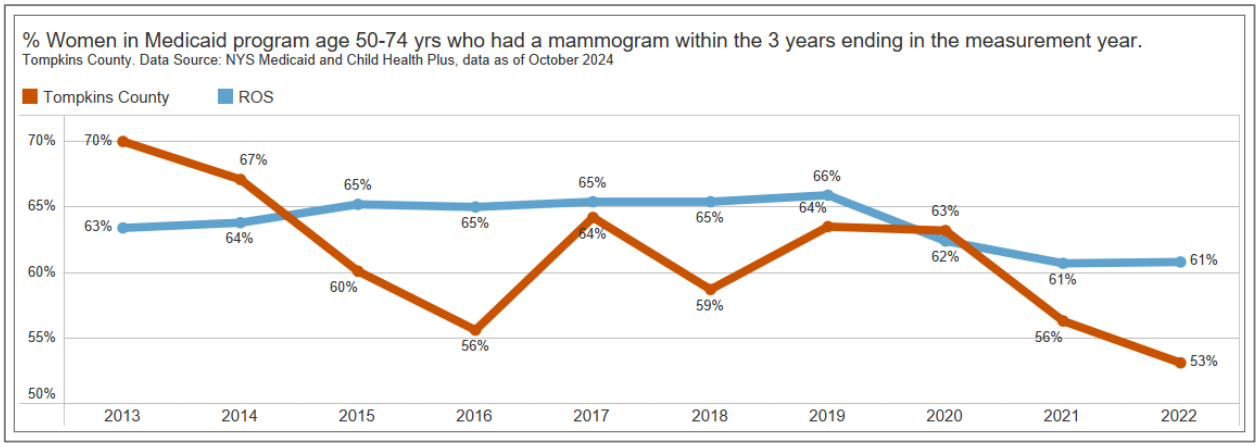

Figure 51 Trend for mammogram uptake among women in the Medicaid program

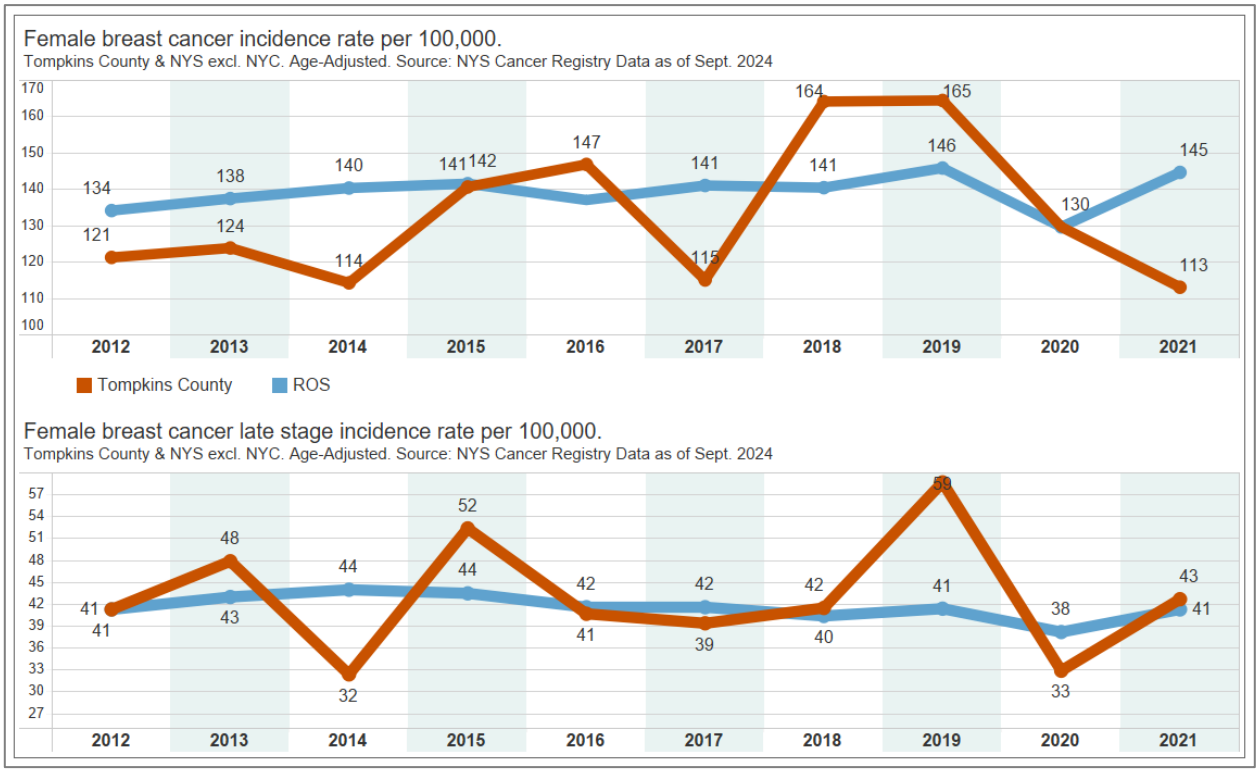

Figure 52 Trends for female breast cancer incidence

Disparities

The burden of cardiovascular disease, cancer, and diabetes is not distributed evenly. The risks of developing or dying from heart disease, cancer or diabetes are linked to a variety of social drivers of

health, such as race, ethnicity, gender, sexual orientation, age, disability, socioeconomic status, and geographic location. Heart disease is consistently among the leading causes of death in the United States, and diabetes consistently impacts the Black population to a greater degree than the White population. In Tompkins County, heart disease has been the first or second cause of death for the last decade, and a review of the associated racial disparity is warranted. As seen elsewhere, the racial gap with diabetes is clearly visible in Tompkins County. A comparison of Tompkins County across race and ethnicity is in. *(Table 2 and Figure 53)*

Tompkins County Health Indicators by Race and Ethnicity, 2020-2022

Mortality rates per 100,000 population. Data as of Nov. 2024. Source: health.ny.gov/community/health_equity/reports/county/tompkins.htm

Cause	Non-Hispanic White	Non-Hispanic Black	Non-Hispanic Asian / Pacific Islander	Hispanic	Total
Total mortality	673.6	875.4	361.2	268.4	655.8
Diseases of the heart mortality	125.4	178.1	56.2	56.0	123.0
Diabetes mortality	20.2	42.9	39.3	0.0	20.8
Coronary heart disease mortality	78.2	96.5	34.0	34.3	76.4
Congestive heart failure mortality	7.8	13.3	0.0	10.9	7.8
Cerebrovascular disease (stroke) mortality	23.5	68.6	18.3	39.9	24.5

Table 2 Chronic disease mortality X race

Cardiometabolic Diseases

Recent clinical data from local health systems provide additional insight into preventive care and chronic disease management among adults in Tompkins County. Among primary care patients aged 35 and older, roughly one in three (33.7%) had an HbA1c test within the past two years. Screening rates were similar among adults aged 35 to 44, with 31.9% completing an HbA1c test during the same period. Medication management among adults with hypertension also shows room for improvement. About 35% of adults with a hypertension diagnosis were actively taking an antihypertensive medication, increasing to 38% among those enrolled in Medicaid (HEDIS Warehouse, Cayuga Health, 2025).

While the rate of hospitalizations for diabetes in Tompkins County is far below that of the rest of the state outside NYC (ROS) *(Figure 54)*, the racial gap is equally as striking with more than double the incidence for the Black population as for the White. *(Table 2)* Similarly, Black residents experience nearly triple the rate of short-term diabetes complications (10.2 per 10,000) compared with 3.7 among White residents (NYS CHIRE, 2020-2022).

The Diseases of Heart hospitalization rate in Tompkins County is 44.7 per 10,000, less than half the statewide rate of 95.8 per 100,000 (SPARCS, data as of July 2024). Local racial differences are shown by potentially preventable heart failure hospitalizations at 25 per 10,000 among Black residents, compared to 16 per 10,000 among White residents (NYS CHIRE, 2020-2022). *(Figure 53)*

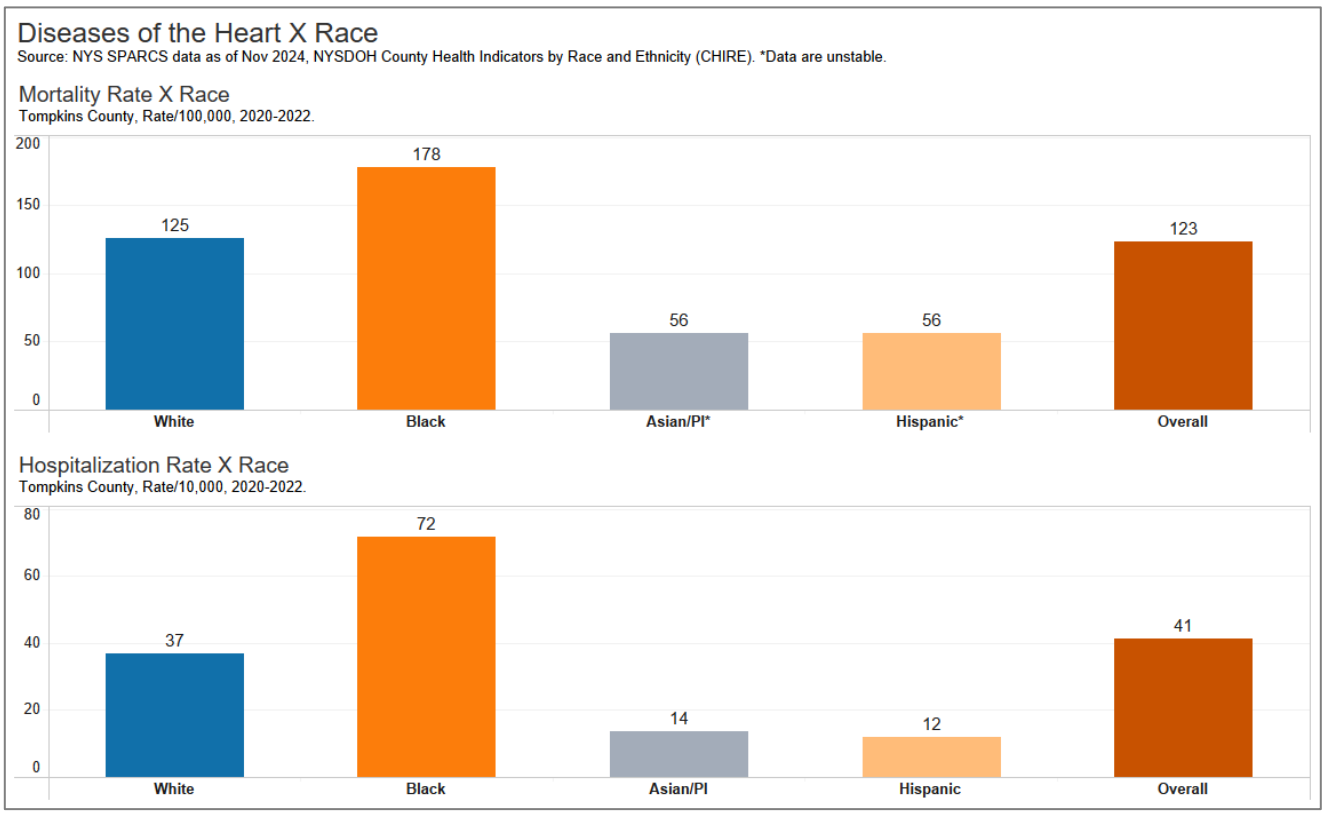

Figure 53 Diseases of the heart X race

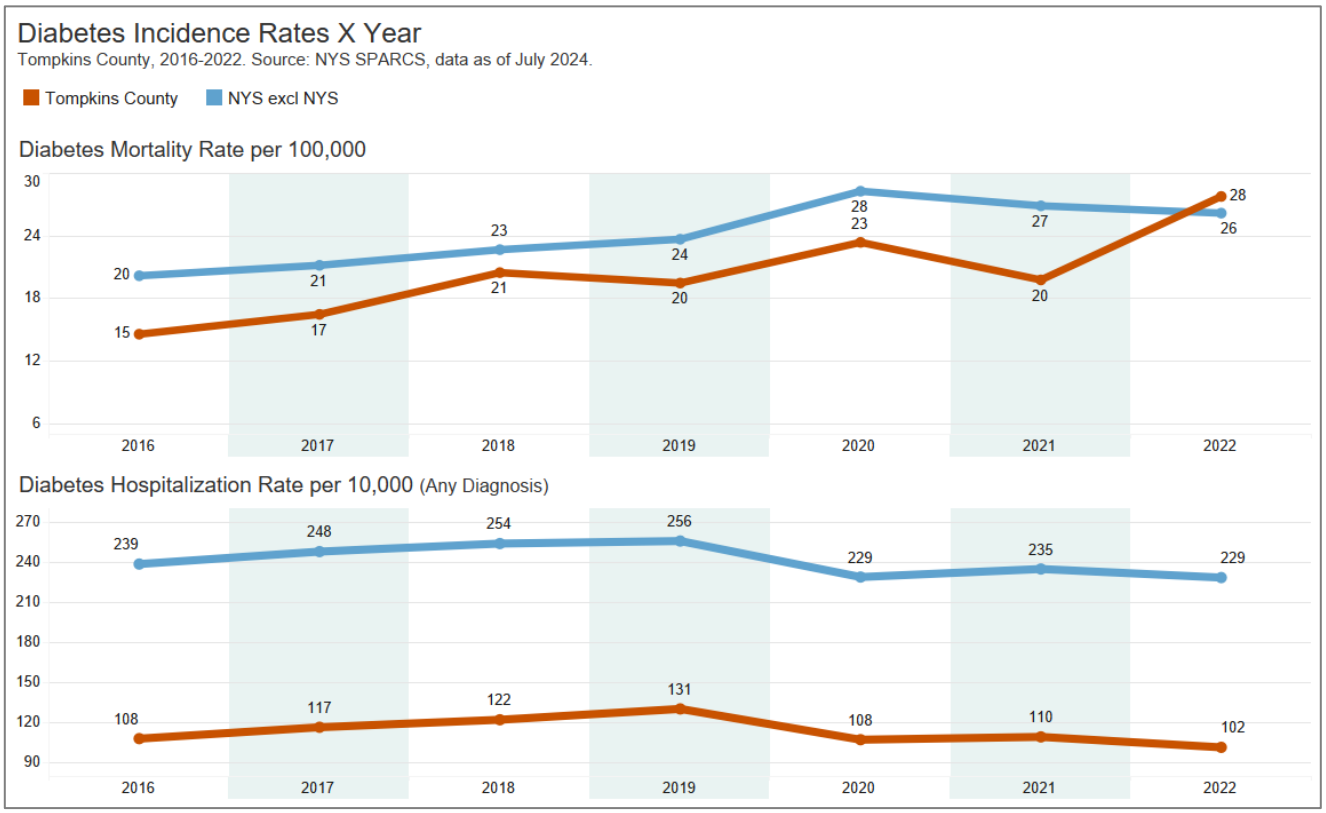

Figure 54 Trends for diabetes

Community voices highlight persistent access barriers. One resident shared, “They don't really make it easy with insurance... I had a snafu when I went to the nutritionist, because if you're not pregnant, it's not covered.” Another described traveling long distances for covered lab services. “.. And there was one place [covered by insurance] and then the other place was like 21 miles away. I went to [Hospital] like the outpatient part, and then [they] have it billed as an in-hospital stay for a hundred dollars.” (Maternal and Child Health Report 2025). Limited specialist availability, narrow insurance networks, and inconsistent coverage for preventive services were also frequently reported by the residents which further exacerbate these inequities in chronic disease management and outcomes.

Health Behaviors

Preventable risk factors for chronic disease are common. Twenty-one percent of Tompkins County adults report no leisure-time physical activity outside of work, and 34% consume no fruits or vegetables daily (BRFSS, 2021). Additionally, 17.3% of adults lack a regular healthcare provider, and 5.3% have no health insurance, underscoring gaps in preventive service access. These lifestyle and access barriers increase the risk of obesity, hypertension, and diabetes, conditions that contribute directly to cardiometabolic diseases.

The 2025 Community Health Survey asked residents whether their community has enough recreational spaces, such as parks, trails, and community centers, to support physical activity. Countywide, about two-thirds of residents responded positively, though perceptions varied by municipality. Danby (76%), Enfield (75%), and Lansing (75%) reported the strongest sense of adequate access, followed by the City of Ithaca (73%), Ulysses (72%), and the Town of Ithaca (72%). In contrast, Groton emerged as an area of concern, with only 44% of residents indicating sufficient recreational spaces; 35% “No” and 21% “Not sure.” Other municipalities, including Dryden (64%), Newfield (62%), and Caroline (68%), showed moderate satisfaction but still had residents expressing uncertainty or unmet needs. *(Figure 55)*

The respondents were also asked to identify barriers they encountered when accessing health services within the past year. For primary care, long wait times emerged as the most significant barrier, reported by 35% of respondents. An additional 25% cited a lack of available providers, and 16% reported difficulty scheduling an appointment. Less prominent factors included cost (9%), in-network coverage limitations (8%), and other insurance-related issues (3%). For cancer screening, long wait times (29%) and lack of providers (18%) were again notable concerns. Cost (13%) and in-network coverage (12%) were also cited, indicating that both logistical and financial barriers can impact preventive care access. *(Figure 56)*

To address the gaps and strengthen chronic disease prevention in Tompkins County, several initiatives are underway and in development. Countywide screening events for blood pressure, cancer, and blood sugar are regularly hosted in collaboration with TCWH, Cayuga Health, and other community-based organizations. The YMCA of Ithaca and Tompkins County is preparing to launch the CDC-certified Diabetes Prevention Program (DPP) and has already begun offering blood pressure self-monitoring education to adults at risk for cardiovascular disease. To improve cancer screening access, Guthrie Clinic’s “Mammo on the Move” mobile mammography van now brings on-site breast

imaging to rural areas, reducing transportation barriers and improving early detection rates. In addition, REACH Medical has received recent county funding to introduce a mobile mammography service focused on expanding access for underserved populations. Local healthcare practices such as Cayuga Health are also piloting extended Saturday screening hours to better accommodate working residents.

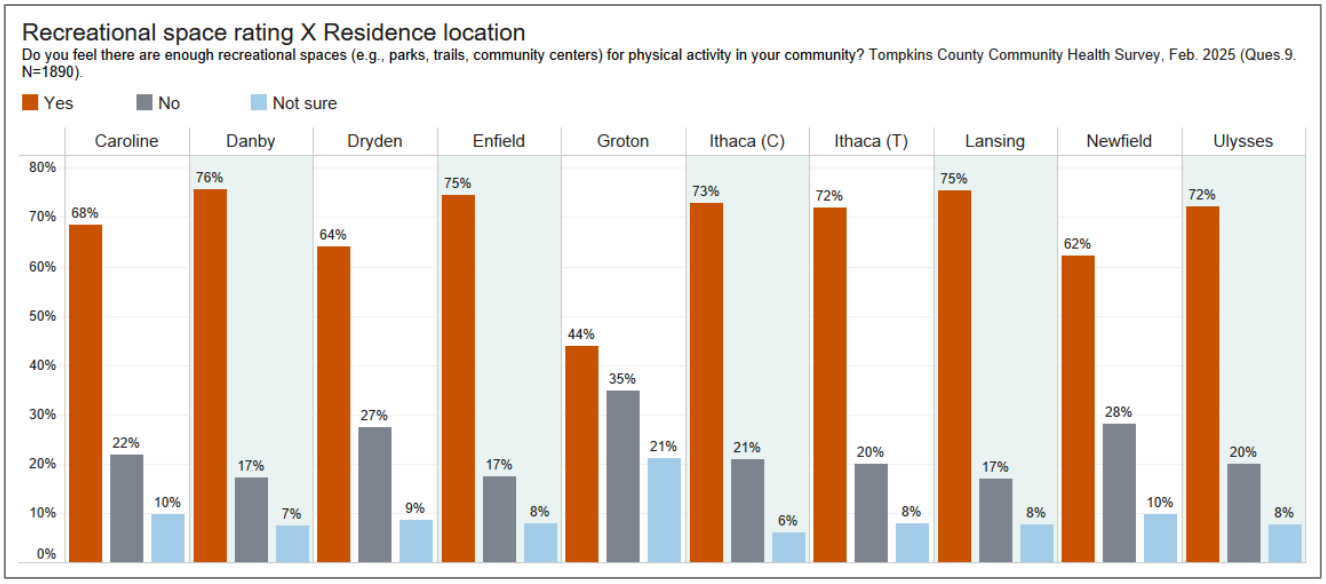

Figure 55 Availability of recreational space

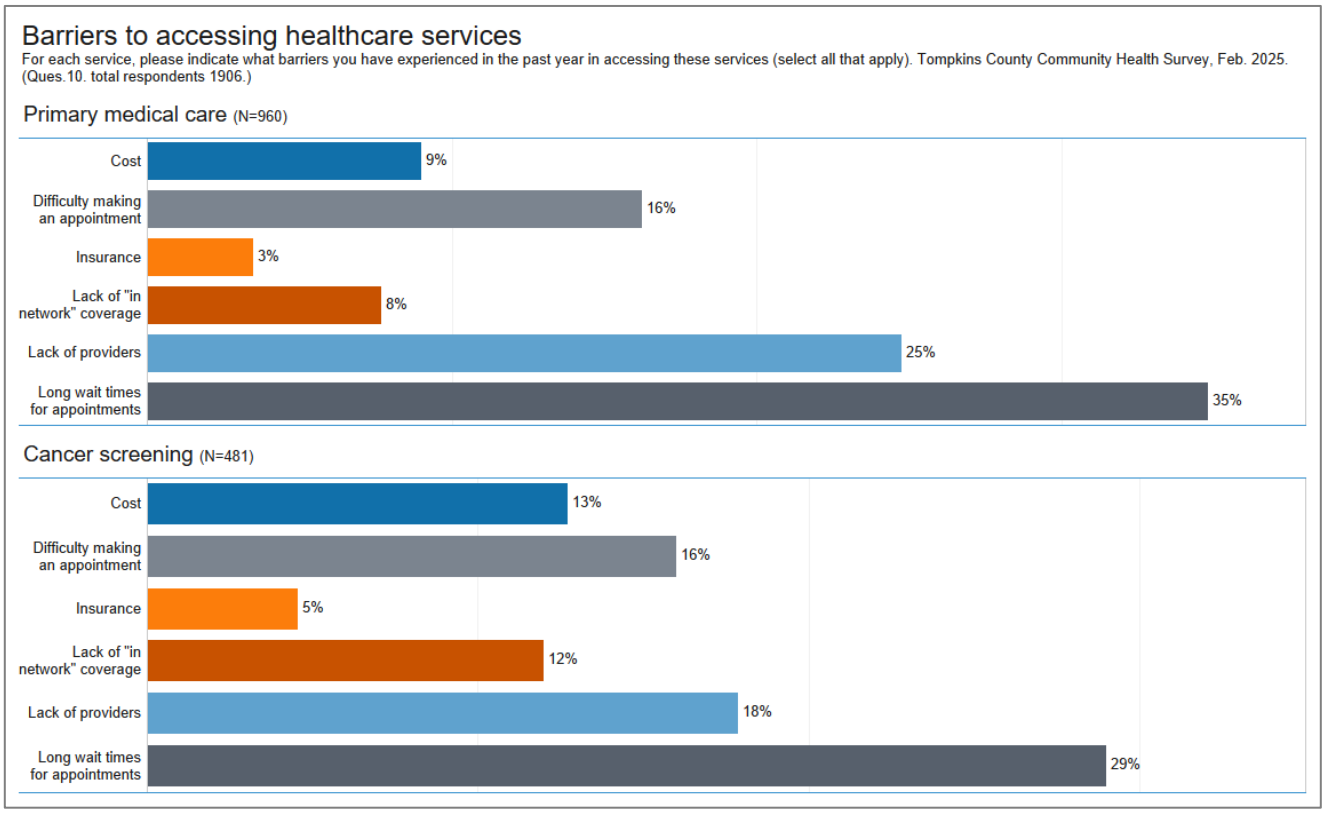

Figure 56 Barriers to accessing primary care and cancer screening

PREVENTION AGENDA PRIORITY: ORAL HEALTH CARE

Oral health is an essential component of overall wellbeing and health equity. Regular preventive dental care has been shown to support healthy development in children, reduce the burden of chronic diseases, and further reflects broader access to healthcare (Fu, D. et al., 2025). In Tompkins County, oral health access continues to be shaped by provider availability, insurance coverage and socioeconomic factors, particularly among children and Medicaid enrollees.

The dentist-to-population ratio in Tompkins County is 1660:1, suggesting limited provider availability compared to the state average of 1200:1 (County Health Rankings, 2022). Among children, 58% had a dental visit within the past six months, and another 25% within the past year. Additionally, 82% of children received fluoride treatment from a dentist or pediatrician (TCWH Oral Health Report, 2024).

Dental insurance coverage among children includes 54% privately insured, 24% enrolled in Medicaid, 13% in Child Health Plus, and 8% uninsured (TCWH Oral Health Report, 2024). Despite coverage, care utilization lags behind state averages. In 2023, only 27% of Medicaid enrollees and 45% of those aged 2-20 years received a dental visit — flagged as *moderate concern* — compared to 30% and 49% statewide. Preventive visits were slightly lower with 24% among all Medicaid enrollees and 43% among those aged 2-20 years (NYS CHIRS, 2014-2023). This was also flagged by the state as *moderate concern*. *(Figure 57)*

In the Community Health Survey, respondents reported that cost was the most common barrier for Oral health care, with 26% indicating affordability as a key issue. Lack of in-network coverage (19%) and insurance barriers (14%) also affected access. *(Figure 58)* Access is further constrained by limited Medicaid participation among dental providers with only two dentists in the County currently accepting Medicaid. Nearly 40% of parents reported difficulty finding a dentist who accepted their insurance. Almost half indicated they travel outside of the County, often for an hour or more, to obtain care for their children (TCWH Oral Health Report, 2024).

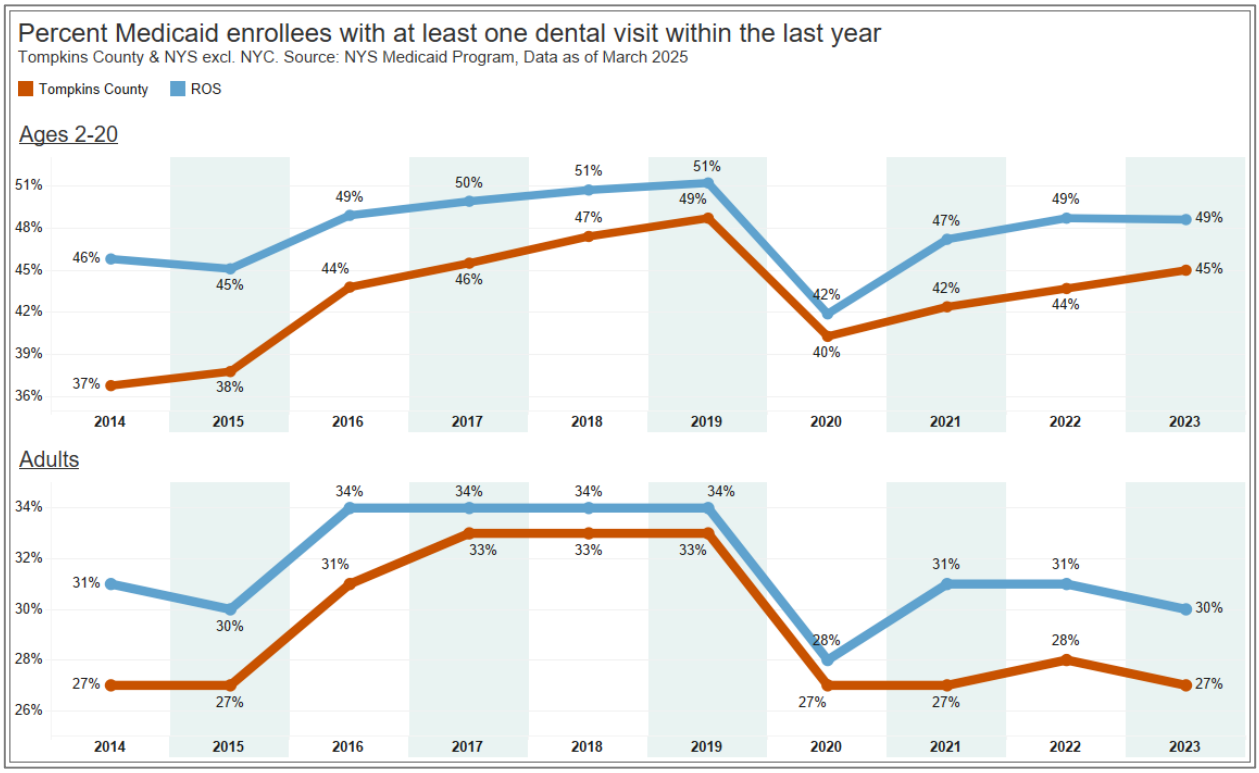

Figure 57 Utilization of dental care among Medicaid enrollees

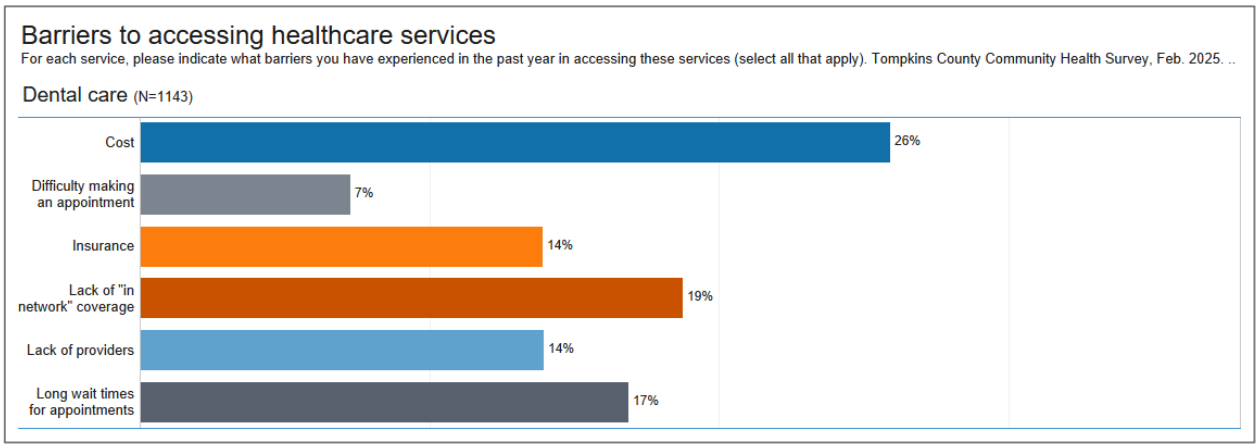

Figure 58 Barriers to accessing dental care

Healthy Children

PREVENTION AGENDA PRIORITY: PREVENTIVE SERVICES

Access to preventive care in early childhood is a cornerstone of long-term health and development. Timely immunizations, well-child visits, and lead screening protect children from preventable illnesses, support early detection of developmental and environmental risks, and reduce future healthcare costs. In Tompkins County, preventive service indicators demonstrate areas of strong performance alongside challenges that mirror state trends.

Immunization coverage among young children has varied in recent years. In 2024, 50% of children aged 24-35 months had completed the 4:3:1:3:3:1:4 immunization series, falling below both the

state rate of 59.3% and the NYS 2030 objective of 62.3%. The rate peaked in 2023 at 71.5%, raising the question of whether recent declines may be tied to misinformation/vaccination hesitancy, pandemic, or access-related challenges (NYS Immunization Information System and Citywide Immunization Registry, 2019-2024). *(Figure 59)*

Adolescent immunization performance shows a more encouraging pattern. Human Papillomavirus (HPV) vaccination completion among 13-year-olds reached 33% in 2024, surpassing the state average of 25.7% and exceeding the NYS 2030 target of 28.7%. *(Figure 59)* This progress reflects consistent outreach and school-level education efforts to promote cancer-preventing vaccines.

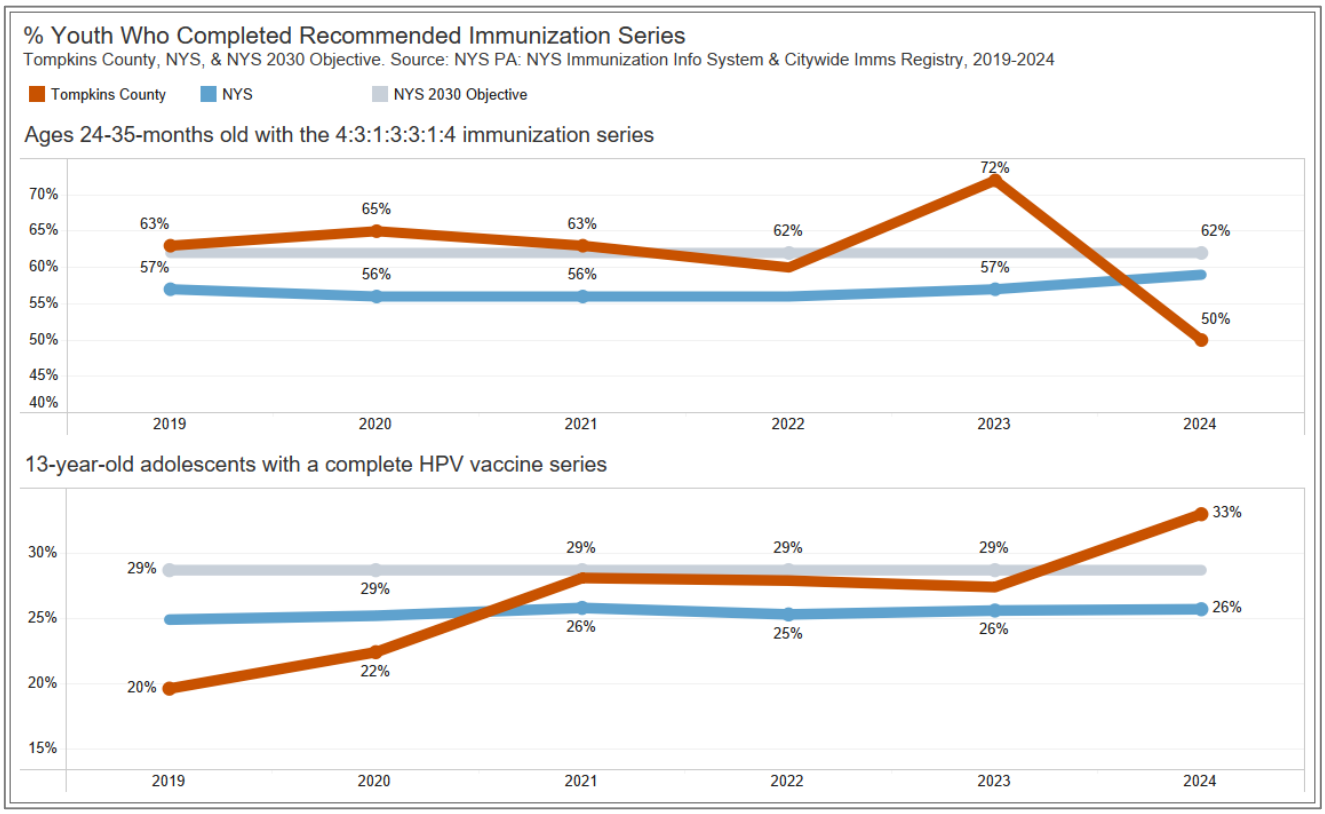

Figure 59 Trends for childhood vaccine uptake

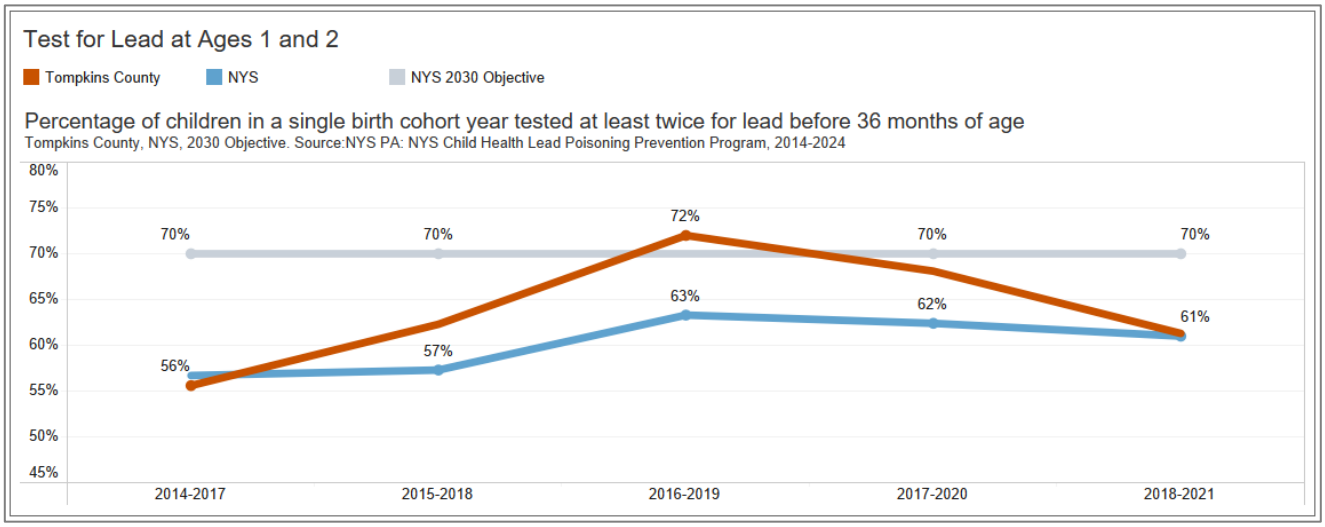

Figure 60 Trends for childhood blood lead level testing

The lead screening rates were highest during 2016-2019 at 72%, surpassing the state rate of 63.3% and the 2030 objective of 70%. Then the 2018-2021 rate declined to 61.3%. (NYS Immunization Information System; NYS Child Health Lead Poisoning Prevention Program, 2014-2024). (Figure 60)

Routine pediatric care indicators remain comparatively strong where 73.8% of children with government-sponsored insurance had six or more well-child visits in the first 15 months of life. This exceeded the statewide rate of 69.2%. Subsequently, 78.6% had at least two visits between 15-30 months, closely aligned with the state rate of 78.2% (NYS Medicaid and Child Health Plus Data, 2022).

These data reflect challenges in maintaining consistent immunization and lead screening coverage for young children. Efforts to strengthen preventive care are supported by local coalitions and cross-sector partnerships. These enhance the opportunity to ensure families with young children are established with a pediatrician, and that school age children are connected with a health home or pediatrician if they do not have one.

Local Preventive Coalitions and Networks

The Immunization Coalition of Tompkins County partners work to protect our community from vaccine-preventable diseases. Its mission is to reduce the spread of vaccine-preventable diseases across the lifespan through immunization education, advocacy, collaboration and community engagement. Goals of the coalition are to improve vaccination rates through the lifespan, reduce incidence of vaccine-preventable diseases and provide vaccine-preventable disease education to our community. Participating partners include: Ithaca is Immunized, NYSDOH, Cornell, Ithaca College and Tompkins-Cortland Community College, primary care offices, pediatric offices (Northeast Pediatrics, Buttermilk Falls, WellBeing), representatives from vaccine manufacturers (GSK, Merck), ICSD school health, CMC Infection Control/Employee Health, Office for the Aging, VaCS (Vaccine Conversations with Scientists).

The Lead Poisoning Prevention Network is a collaboration of local healthcare, non-profits and businesses working together to address and prevent lead-poisoning in our community. Partners include Eco-Testing (XRF device), Well Being Pediatrics, Buttermilk Falls Pediatrics, Ithaca Neighborhood Housing Services, Tompkins Community Action, Northeast Pediatrics, Cornell Cooperative Extension, Catholic Charities, Cornell Soil Lab, Child Development Council, Ithaca ReUse, and Open Doors English.

Prevention Agenda Domain: Education Access and Quality

PreK-12 Student Success and Educational Attainment

PREVENTION AGENDA PRIORITY: HEALTH AND WELLNESS PROMOTING SCHOOLS

Schools serve as vital environments for promoting student health, learning, and emotional wellbeing. Educational success in Tompkins County is shaped not only by academic instruction but also by the social, economic, and mental health conditions surrounding children and families. Persistent gaps in attendance, academic achievement, and connection to school, especially among communities facing structural racism and social injustice, reflect the need for integrated, health-promoting approaches across the education system.

School enrollment among youth ages 3-17 is 92.8% (US Census). Academic performance data indicate that 43.7% of 3rd graders and 38.6% of 4th graders met English Language Arts (ELA) standards, while 19.6% of 8th graders met math proficiency benchmarks (NYS KWIC Indicators, 2025).

But in all of this, chronic absenteeism (missing at least 10 percent of school days, or 18 days in a year, for any reason, excused or unexcused) remains a key challenge where 22.8% of students were chronically absent in 2022-23, failing to meet the HP2030 target of 16.4%. *(Figure 61)* District rates ranged from 17.7% in Lansing to 36.4% in Newfield (Everyone Graduates Centre Chronic Absence Report, 2021-22). *(Figure 62)* The disparities within these rates are evident. In the Ithaca City School District, chronic absenteeism affected 59% of Black students, 53% of economically disadvantaged students, 48% of Hispanic/Latino students, and 45% of students with disabilities, compared with 29% of White students (Horn Research, 2024). Similar patterns were observed in Lansing School District, where absenteeism among economically disadvantaged students (31%) and students with disabilities (32%) were significantly above its low district-wide rate (Horn Research, 2024).

Local behavioral health data add nuance to this picture. While 69.7% of students reported opportunities for prosocial behavior (for e.g., There are lots of chances to be part of class discussions or activities, and have positive interactions with parents and trusted adults), fewer than half (49%) felt they were rewarded for exhibiting such behaviors (CLYDE Youth Survey, 2023). Prosocial behavior refers to positive, empathy-driven actions that support others and strengthen connection, such as sharing, cooperating, comforting, or participating in class activities. These indicators point to both social strengths and missed opportunities for reinforcement within school culture.

Qualitative input reveals that chronic absenteeism often reflects deeper systemic challenges. One key informant observed, “Some students are chronically absent because the education system doesn’t work for them.” It was also emphasized that parental mental health and financial strain contribute significantly. “If the parent is struggling with mental health... with having basic needs met, those students are going to struggle even more... And it's not even because the parents don't care or they're disengaged. It's because they are struggling themselves." (Key Informant Interview, 2025). Students and staff alike cited social disconnection, economic pressure, and the lingering effects of the pandemic as barriers to consistent engagement (Horn Research, 2024; CCE Youth Mental Health Report, 2025).

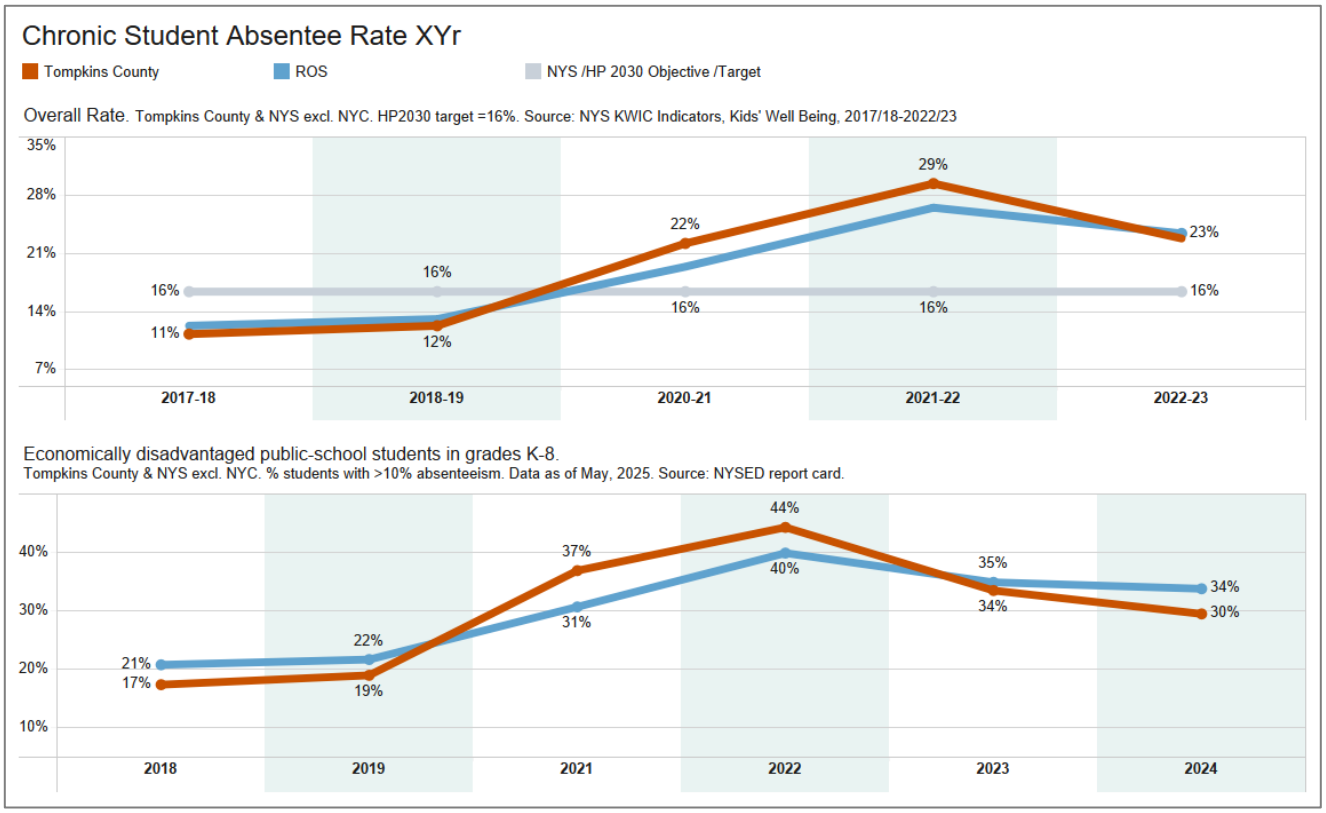

Figure 61 Trends for chronic absenteeism in schools

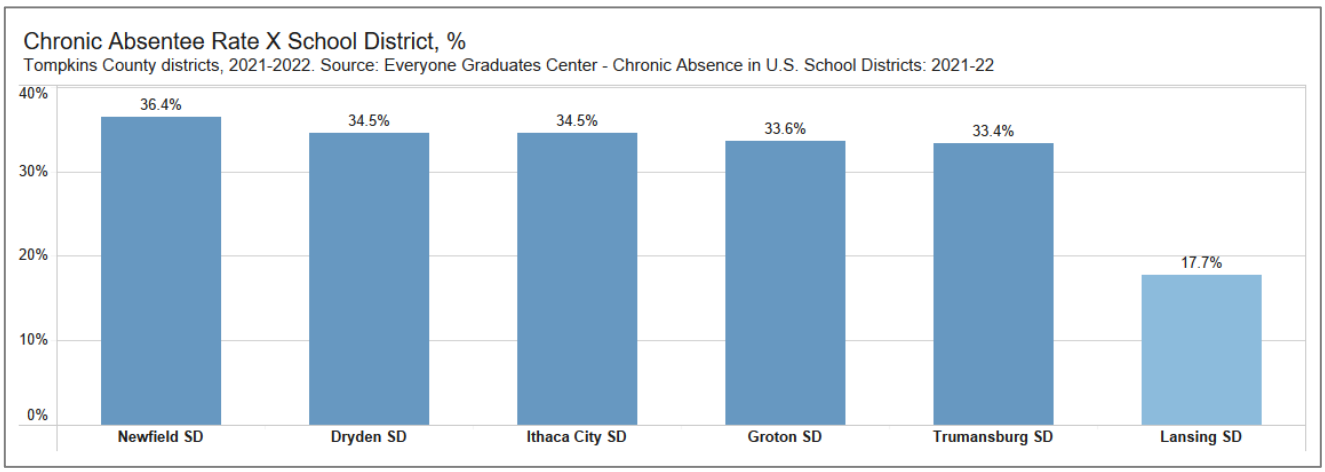

Figure 62 Chronic absenteeism X local school district

While disparities in academic performance and attendance remain, the expansion of school-based mental health services reflect meaningful progress. TCWH extends direct school-based mental health support through satellite offices in five Ithaca City schools, including Enfield and Caroline Elementary, DeWitt and Boynton Middle, and Ithaca High, and in two to three schools each in the Dryden, Trumansburg, Groton, and Newfield districts. An additional community site operates at the Village at Ithaca. In 2024, TCWH clinicians provided mental health counseling to 295 unique students across these locations, totaling 3,201 appointments (TCWH Mental Health Clinic, 2024).

The School Health Systems team at Tompkins-Seneca-Tioga (TST) BOCES has been instrumental in building the new Psychiatric Education for Pediatric Providers (PEPP) Certificate Program. This pilot program aims to address the shortages in mental health care providers and meet the increasing psychiatric needs within the community. Launched in September 2024, the certificate program provides intensive training to prescribing pediatric providers in our region, by board certified adolescent and pediatric psychiatrists and psychologists from all across NYS. The 40-week PEPP program is expected to significantly enhance the ability of local providers to treat and manage psychiatric cases for students from kindergarten through 12th grade. Further strengthening the connection between healthcare and education, many of the clinicians selected for this program are primary care providers who already serve the TST BOCES community and may already be familiar faces to students in our districts.

Additionally, through coordinated partnerships, TST BOCES and TCWH are strengthening the link between health and education. TST BOCES advances social-emotional learning (SEL) through its Youth Development Services initiative. In parallel, its Career and Technical Education (CTE) pathways offer hands-on learning in health sciences, engineering, and human services, supporting career readiness and economic stability. These programs work in tandem with school-based mental health clinics to create safe, supportive environments for learning and growth (TST BOCES, 2024).

HEALTH CHALLENGES AND ASSOCIATED RISK FACTORS

If one looks closely, the Health Indicators reveal that Tompkins County's leading health challenges do not occur in isolation but instead reflect a tightly interwoven set of economic pressures, behavioral health needs, and structural inequities that shape residents' daily lives. Housing instability, financial hardship, and time constraints create persistent stress and strain that ripple across other factors affecting mental health, access to preventive care, nutrition, chronic disease management, and safety.

Mental health concerns, including depression, loneliness, suicidal ideation, and substance misuse, are emerging as some of the most urgent issues across age groups, particularly among youth and young adults. Chronic disease prevention and management remain areas of concern due to variations in screening access, lifestyle risk factors, and gaps in continuity of care. At the same time, preventable injuries, violence, and disparities in maternal and child health outcomes point to the built environment, public safety systems, and healthcare landscape.

While Tompkins County performs better than state averages and benchmarks in some areas, these successes coexist with persistent inequities in poverty, food security, housing stability, mental health, oral health, and chronic disease burden. The overarching picture is one where economic stressors, service access barriers, and social inequities interact to create disproportionate health risks for specific populations and neighborhoods. These interconnected challenges underscore the need for coordinated equity-centered approaches across sectors.

Contributing Causes of Health Challenges

The health challenges identified in this CHA stem from a combination of behavioral, environmental, socioeconomic, and structural factors that operate across multiple Prevention Agenda domains.

Economic conditions remain the backbone of many health issues. These include (but are not limited to) a high cost of housing, childcare costs, and median wages below state and national levels. Even as the overall poverty rate declines, families with low-wage jobs continue to experience the "benefits cliff" (when a small increase in a person's earnings causes them to suddenly lose their eligibility for public assistance programs, resulting in a net financial loss), leaving many without adequate support despite ongoing need. The County's persistent housing affordability crisis, where low vacancy rates, multi-year waitlists for subsidized housing, and rising rents can contribute to elevated rates of homelessness, particularly among BIPOC residents, youth, individuals returning from incarceration, and those with behavioral health conditions. Economic pressures also contribute to food insecurity, difficulty paying for basic needs, and persistent housing instability, which in turn impact stress, mental health concerns, and residents' capacity to engage in preventive care.

This financial strain also interacts with behavioral health needs. Community Health Survey results revealed a clear inverse relationship between household income and the frequency of stress or

anxiety about meeting basic needs. Residents with lower incomes consistently reported experiencing higher levels of stress, while those with higher incomes reported notably less. Roughly 1 in 3 adults surveyed reported experiencing loneliness and isolation in the past year, and an increased reliance on substances was reported as a coping mechanism. Structural barriers, including long waitlists and limited availability of providers, and shortages in trauma-informed services create significant obstacles to timely treatment and early intervention.

Geographic and built-environment factors also influence health risks, particularly for residents in rural areas. Uneven access to recreational spaces can limit opportunities for physical activity in municipalities. Survey respondents were mostly positive about the availability of recreational spaces, though fewer than half of those in the rural town of Groton reported enough spaces. Access to nutritious food is also shaped by transportation barriers and low participation in federal nutrition programs, especially among families whose incomes exceed eligibility thresholds but who still struggle to afford groceries. While survey respondents generally rated their neighborhoods as safe, in recent years Tompkins County has experienced increases in property crime, higher index crime rates compared with the statewide average, and a sharp rise in assault-related emergency department visits.

Maternal and child health disparities reflect similar system-level challenges. Lower rates of early prenatal care stem from a combination of limited OB/GYN and midwifery capacity, long wait times at the County's primary prenatal clinic, and insurance-related restrictions that reduce provider choice. When families cannot secure appointments within the first trimester, due to coverage gaps, referral delays, or provider turnover, the window for early risk assessment and preventive support narrows, each shown to increase risk for higher rates of preterm birth and low birth weight.

Preventive pediatric indicators show parallel gaps. Declining childhood immunization rates and reductions in lead screening reflect an opportunity to improve coordination between pediatric practices, WIC, and family-support programs. Families with lower incomes or unstable housing may face additional obstacles to consistent access to preventive services in early childhood, including attending routine visits, managing transportation, and securing follow-up care.

Chronic disease risks are shaped by a combination of factors such as insufficient physical activity and low fruit and vegetable intake, and barriers that limit access to preventive screenings and early detection. These circumstances can link to trends in high rates of late-stage breast cancer and disparities in preventable hospitalizations for heart disease and diabetes. Access barriers further concentrate risk among lower-income residents. The County's shortage of Medicaid-accepting dental providers (only two dentists serve Medicaid-insured patients) demonstrates how limited provider capacity can impact routine preventive care and delay detection of conditions that influence overall health.

All together, these contributing causes demonstrate that the County's health challenges arise from broader systemic and structural conditions. These factors compound over time, creating complex patterns of need that require a coordinated, upstream, equity-centered response.

Health Disparities

Health disparities in Tompkins County are significant, persistent, and evident across nearly every Prevention Agenda domain. These disparities reflect differences in access to resources, exposure to risk, and the structural functioning of local systems.

Racial and ethnic disparities are among the most pronounced. Black residents face disproportionately high rates of poverty, food insecurity, homelessness, chronic disease mortality, and preventable hospitalizations. These disparities are not isolated but reflect overlapping barriers in housing access, employment opportunities, transportation, and healthcare. In maternal and infant health, Black birthing people experience lower rates of early prenatal care and significantly higher rates of preterm birth and low birth weight. These outcomes are often tied to inequities both within healthcare systems and from economic and social factors.

Youth and young adults also experience a cluster of disparities. Mental health concerns, including depression, loneliness, suicidal ideation, and substance use, are more prevalent in this age group than among older adults. LGBTQ+ youth are overrepresented among those experiencing homelessness and face unique developmental and social stressors. Educational disparities mirror these patterns where chronic absenteeism disproportionately affects Black students, economically disadvantaged students, Hispanic/Latino students, and students with disabilities, reinforcing disparities in academic achievement and long-term socioeconomic opportunity.

Income and insurance-related disparities further deepen inequities. Medicaid-insured residents face shortages of accepting providers, longer wait times, fewer behavioral health and dental options, and limited access to specialty care. These barriers lead to lower rates of preventive visits, delayed treatment, and higher rates of preventable complications. Families with lower incomes also struggle with transportation barriers, food insecurity, and difficulties accessing childcare. These conditions in turn affect participation in preventive services including but not limited to maternal health, chronic disease management, and child development.

Geographic disparities add another layer. The City of Ithaca has the highest concentration of poverty and housing instability. In rural municipalities, transportation limitations disproportionately affect older adults, families with lower incomes, and those without reliable vehicles. Groton stands out for lower perceptions of safety and of access to physical activity spaces. These neighborhood-level differences shape opportunities for physical activity and limit access to timely health services.

These disparities demonstrate that the benefits in Tompkins County are not shared equally across all communities. Structural inequities rooted in economic, racial, geographic, and insurance-related factors continue to shape health opportunities and outcomes. Addressing these disparities requires sustained, equity-centered strategies that invest in communities experiencing the heaviest burdens and remove systemic barriers to health and wellbeing.

COMMUNITY ASSETS AND RESOURCES

Tompkins County is a resourceful and resilient community, defined by collaboration, creativity, and a shared commitment to addressing social needs and inequities. Residents and partners also continually work to strengthen the local environment and community systems to promote health and wellbeing. Local governments and agencies maintain a strong commitment to diversity, inclusion, and equity across the workforce and in program implementation. The County benefits from an integrated system of healthcare resources supported by a broad network of towns, villages, schools, cultural centers, and community organizations that promote healthy living and social connection throughout the lifespan. Cross sector coordination has continued to grow through initiatives such as the community health referral network and the 211 system. These collaborative structures help residents, especially communities facing structural racism and social injustice, be better able to access both health services and the cultural, recreational, and social resources available across the County.

The cultural and artistic landscape of Tompkins County is central to its identity and wellbeing. The County offers a wide range of opportunities for participation and enjoyment in music, theater, visual art, dance, and intellectual programming. Seasonal community markets, festivals, and celebrations promote the diversity of cultures, agencies, artists and music, and food and agriculture. Among medium-sized communities in the U.S., Ithaca, N.Y. ranks second for arts vibrancy (SMU DataArts, 2024).

Participation in the arts is an important component of health and wellness. It serves not just as an enrichment activity but also as a health behavior that can support mental, emotional, and social well-being. (Rodriguez, A. Community Health Equity Research & Policy, 2024). Arts engagement can heal trauma, build belonging, and support place-making. Arts strategies and interventions can be co-designed with and engage populations that are historically marginalized and/or do not have traditional pathways and access to the arts. Tompkins County has abundant opportunities for participating in the arts, but many have fees associated and may not be viewed as spaces for everyone. The public art landscape in the County, especially in the City of Ithaca, has increased over the past decade through the public mural projects, many of which have community paint days that invite people to join the project, and put the art in the public realm. Our community has an opportunity to further cultivate cross-sector partnerships with anchor institutions, such as the hospital, health department, schools, art organizations, social service agencies, and others to promote the arts and health.

COVID-19 Community Resilience Mural

IN RESPONSE to the Covid-19 pandemic, TCWH partnered with County Office for the Aging and Ithaca Murals to produce a mural that encourages staying up to date with vaccines. It honors the strength and confidence of Ithaca resident Millicent Clarke-Maynard or "Millie," one of the first older adults to receive a vaccine. The mural memorializes the lives lost during the pandemic but also reminds the community that there is hope in uniting and protecting each other. It was unveiled to the community in July 2024.

One of the artists stated, "The opportunity to use art to highlight public health messaging was an honor to be a part of. I am so thrilled with how this mural turned out and hope that the community will connect with the message of hope, resilience and togetherness that the artists brought to life on this wall."

The County is also rich in geographical diversity, known for its gorges and numerous hiking trails that provide a range of opportunities for physical activity and engaging with nature. The website IthacaTrails.org lists over 70 different trails, searchable by activity, difficulty, and ecology. Some are connected with one of the three State Parks within the County, and others are stewarded by local municipalities and nonprofits. One notable example 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 for walkers, joggers, bicyclists, in-line skates, mobility-impaired users, and parents with strollers.

Recognizing that community members themselves are essential assets in this system, Tompkins County values the aspirations, knowledge, and lived experiences that individuals bring to collective health improvement efforts. These human and organizational assets span multiple domains of the social drivers of health, including Economic Stability, Social and Community Context, Neighborhood and Built Environment, Healthcare Access and Quality, and Education Access and Quality, reflecting how local strengths are interconnected across systems. By understanding and mobilizing these resources, Tompkins County is better equipped to address root causes of health disparities and advance equitable opportunities for all residents to achieve optimal health and well-being.

Together, these assets and resources illustrate the depth and diversity of Tompkins County's community infrastructure. The County is supported by a broad network of health and human services organizations, educational institutions, transportation systems, cultural partners, and grassroots initiatives that collectively support residents' wellbeing. Leveraging this ecosystem is essential to identifying gaps, aligning efforts across sectors, and developing strategies within the Community Health Improvement Plan that address the root causes of health disparities. These community assets thus remain central to building a healthier, more connected, and more resilient future for all residents.

TOMPKINS COUNTY WHOLE HEALTH (TCWH)

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

Public Health Services

The core public health services of TCWH are comprised of the Divisions of

- Health Promotion
- Environmental Health
- Community Health Services
- Children with Special Health Care Needs.
- Public Health Preparedness

HEALTH PROMOTION

HPP focuses on evidence-based programs to reduce the risk of chronic disease among Tompkins County residents. These programs include:

- **The Tobacco Control Program** (Tobacco Free Tompkins, T-Free Zone), a partner in NYS Advancing Tobacco Free Communities, works to eliminate all exposure to secondhand smoke

and vape aerosol, de-normalize tobacco use, and reduce youth initiation through outreach, policy, and environmental change.

- **The Healthy Neighborhoods Program (HNP)** provides free home safety visits to promote healthy homes. The program is funded by a grant from the New York State Department of Health. HNP visits are conducted in-person or virtually, with the option for a contact-free drop off of home safety products based on client preference. The objective of this program is to promote healthy homes in specific target areas of Tompkins County by pursuing the following goals:
    - Prevent Indoor Air Pollution
    - Prevent Asthma Hospitalizations
    - Prevent Residential Fire Deaths
    - Prevent Lead Poisoning
    - Reduce Indoor Tobacco Use
    - Pest control
- **Community Health Worker Program** is a public health initiative where a Community Health Worker (CHW) serves as a link between the members and services in the community. CHWs meet clients where they are to provide on-going connection and support. They focus their attention on Social Drivers of Health, including education, income, employment, housing, and access to health care, in order to define and address these factors and help bridge the gaps and disparities they create. They also provide a safe, trusting environment to promote agency, encouraging and practicing tools and strategies to create next steps for community members as they continue to navigate community systems. CHW's are also involved with the following:
    - **Healthy Infants Partnership of Tompkins County** (HiP Tompkins) where they connect families with services to improve the overall health and well-being of mothers, pregnant or birthing people, and their infants. HiP CHWs work one on one with clients to ensure they are aware of community services, and that they have the knowledge and skills to seek out and receive needed care and services. They make referrals and coordinate care to improve the health outcomes of their clients. They are also trained to help people of child-bearing age and their families with any health care or related issues which could impact their health, their pregnancy, and/or care of their infant. HIP CHWs help & support any person of childbearing age via home visits, or at a TCWH location or other public space if needed.
    - **Children and Youth with Special Health Care Needs** (CYSHCN): The CYSHCN program supports families with children and youth from birth to age 21 who have, or are suspected of having, chronic physical, developmental, behavioral, or emotional conditions requiring services beyond typical care. The program helps families navigate health and social service systems by providing information, referrals, and short-term case management to connect them with medical providers, care coordination agencies, insurance and Medicaid resources, and supports related to housing, food, transportation, and other social needs. CYSHCN also collaborates with community partners to identify and address gaps in access, promote education about the needs of children with chronic conditions or disabilities, and strengthen care pathways.

- **Community Health Improvement Program (CHIP)**. HPP leads the County's Community Health Improvement (CHI Tompkins) process in partnership with a broad network of community organizations, using the MAPP 2.0 framework to guide assessment, priority setting, and coordinated action. The process includes regular meetings of a multi sector Steering Committee, shared data review, and partner engagement in planning and feedback activities. CHI Tompkins is grounded in three core values that shape the County's approach to health equity: data-based decision making, sustainable systems that support long term coordination and resource alignment, and collaborative partnerships.
- **Public Health Communications**. HPP also leads public health communications for TCWH. This includes developing clear, accessible, and equity-centered messaging, press releases, coordinating outreach campaigns, and supporting partners in sharing timely information with the community.

ENVIRONMENTAL HEALTH DIVISION

The Environmental Health Division (EH) provides educational and regulatory programs including, Onsite Wastewater Treatment Systems, Rabies Control, Lead Poisoning Prevention, Adolescent Tobacco Use Prevention Act (ATUPA) program, Food Program, and Water Systems, including harmful algal blooms (HABs) and Hydrilla.

- **Rabies Control Program** investigates and monitors animal bites involving dogs, cats, wildlife, and bats. The program also organizes free rabies vaccination clinics throughout the County to help protect both people and pets from rabies.
- **The Adolescent Tobacco Use Prevention Act (ATUPA)** The act was passed to enforce compliance with NYS's minimum legal age for retail tobacco sales. It encompasses cigarettes, cigars, bidis, gutka, chewing tobacco, powdered tobacco, nicotine water, herbal cigarettes, shisha, electronic cigarettes, and smoking paraphernalia. In 2017, Tompkins County became the sixth county in NYS to raise the minimum age for tobacco purchasing from 18 years old to 21. ATUPA is governed by NYS Public Health Law where the sale of tobacco products to individuals under age 21 is prohibited.

COMMUNITY HEALTH SERVICES

Community Health Services (CHS) Team works collaboratively to support the health and well-being of our community by providing multiple programs and services to Tompkins County residents. These include health and support services for families such as immunizations, maternal and child health, oral health, communicable and vector-borne disease surveillance and response, reproductive health, and lead poisoning prevention.

- **Moms PLUS+ program** is a home visiting nurse program that provides maternal child health supportive services, free of cost, to residents of Tompkins County regardless of insurance status. Moms PLUS + is designed to improve equitable access to quality maternal child health care, increase lactation support for parents choosing to breast and chest feed and enhance the coordination of care with other community partners.
- **Oral Health Program** helps to improve oral health in the community by providing oral health tips, resources, and information about dental care providers and dental insurance options.

- **Women Infants and Children (WIC) Program** The Supplemental Nutrition Program for women, infants, and children is a federally funded program provided by TCWH. WIC improves the health status of eligible women, infants and children (up to five years) through the purchase of nutritious foods, health education, breastfeeding promotion and support and referrals to local health and human service agencies.
- **Lead Poisoning Primary Prevention Program** protects children from lead exposure by identifying high-risk housing, educating residents, inspecting properties, and controlling lead paint hazards to make homes lead safe.
- **Immunizations** The Department also 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.
- **Other essential programs** Communicable disease surveillance and case management, tuberculosis, disease contact investigation and treatment, and anonymous HIV counseling and testing.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

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.

- **Early Intervention Program (EI)**, housed under CSCN, provides specialized services for children from birth to age three who have developmental delays or diagnosed conditions that place them at high risk for delays.

PUBLIC HEALTH PREPAREDNESS

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.

Mental Health Services

The Mental Health Services of TCWH aims 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 (CSB), the County's Mental Health Services is now part of TCWH.

MENTAL HEALTH CLINIC

Services provided in the clinic include adult therapy, children and youth therapy, peer support services, and additional services such as forensic services, psychiatric services, medication therapy, and long acting injectables.

Clinicians provide treatment for youth and families who may be affected by mental health conditions such as depression, anxiety, or trauma. Partnerships with schools allow care to be provided at many school-age children and youth. Currently services are offered at 9 schools.

PERSONALIZED RECOVERY ORIENTED SERVICES (PROS)

PROS is a comprehensive recovery-oriented program for adults with severe and persistent mental illness. The main goal of the program is to help people work on all aspects of their life — social, work, education, housing, finding purpose — when mental health or substance use creates barriers. The outcome of participating in PROS includes an improvement in overall quality of life, a decrease in hospitalizations, and movement towards goals. Each class cycle lasts 12 weeks, but you may begin whenever you are ready. Some examples of favorite classes have been, Change Triangle, Coping with Panic, Strengthening Social Skills, Financial Wellness and Healthy Relationships.

Personalized Recovery Oriented Services (PROS)

In August 2025, “PROS Journeys: Stories in Art” showcased mixed media artwork by individuals engaged in personal growth with the PROS Program (Personal Recovery Oriented Services).

The goal of the showcase was to celebrate the courage and creativity of individuals engaged in the program. Outcomes in PROS for participants include an improvement in overall quality of life, a decrease in hospitalization and movement towards personal goals.

One of the participants stated, “I do art, because it helps me with processing my emotions.” (PROS, 01)

Tompkins County has many community organizations and services, so while not all the services are listed, a selection of the assets and resources in the County are provided below.

COMMUNITY BASED ORGANIZATIONS

Cayuga Health/Centralus Health

Cayuga Medical Center (CMC), a member of Cayuga Health System, is a 212-bed federally designated Sole Community Hospital. Annually, CMC serves over 150,000 patients with approximately 7,500 inpatient discharges, 8,000 inpatient and outpatient surgeries, 30,000 emergency visits, 45,000 urgent care visits, and 15,500 hematology/oncology visits. Over 60% of CMC's inpatient discharges are for patients with Medicare or Medicaid, and about 2% for patients without insurance. CMC is dedicated to providing excellent care to all patients, regardless of their ability to pay and offers a Financial Assistance Program, which helps to cover the cost of services for patients with a household income at or below 300% of the Federal Poverty Level. Tompkins County represents the majority of CMC's primary service area, and the majority of CMC patients are Tompkins County residents. In 2025, Cayuga Health joined with Arnot Health to operate together as Centralus Health.

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

Cayuga Addiction Recovery Services (CARS)

Affiliated with Cayuga Health System in 2023, Cayuga Addiction Recovery Services is an OASAS-licensed provider with a 60-bed Residential Addiction program in Trumansburg, a Comprehensive Outpatient and Opioid Treatment Program in Ithaca, and a soon-to-be launched Mobile Medication Unit In 2021, CARS expanded its services to meet the needs of incarcerated individuals, providing medication assisted treatment in the Tompkins County Jail and several nearby prisons. In 2026, CARS will open an intensive crisis stabilization center and medically supervised withdrawal and stabilization center.

Center for Community Transportation (CCT)

CCT works with local transportation providers, educators, planners, decision-makers, advocates, and users to fulfill the mission of enhancing transportation access in the community while reducing its negative environmental and economic impacts. CCT's mission-focused services and activities include

Ithaca Carshare, Bike Walk Tompkins, and Ithaca Bikeshare, emphasizing social equity and environmental sustainability in this era of new transportation options and emerging mobility trends.

BIKE WALK TOMPKINS

A nonprofit organization dedicated to creating a community where walking, biking and rolling are safe and convenient for all people. They provide education, advocacy and services to support and promote active transportation for better health, less emissions and greater access to transportation.

ITHACA CARESHARE

Ithaca Carshare is a nonprofit, membership-based service that provides 24/7 access to vehicles on an hourly basis. Members can reserve cars through the website, mobile app, or by phone. Each vehicle is accessed and locked using a personal membership card, and cars are returned to the same location after use. Members pay an annual or monthly membership fee along with hourly and mileage rates. The cost of membership includes gas, insurance, maintenance, cleaning, and permanent parking, making Ithaca Carshare a convenient and sustainable transportation option for the community.

Civic Ensemble

Civic Ensemble creates theatre that explores and explodes the social, political, and cultural issues of our time. We bring audiences of different races, classes, and experiences together in a public forum on the American experiment.

Community School of Music and Arts

CSMA is a dynamic meeting place for artists, community members and educators to explore ideas, artistic expression and creativity together. Our passion is to make outstanding arts education accessible to students of all ages, skill levels and socioeconomic backgrounds.

Community Justice Center (CJC)

The Community Justice Center is a joint venture funded by the City of Ithaca and Tompkins County meant to implement Reimagining Public Safety initiatives developed starting in 2021. The CJC maintains a data dashboard and hosts community resource hubs throughout the County to provide residents with access to information regarding County social services and benefits.

Cornell University

Cornell University is a privately endowed research institution and a partner of the State University of New York. As New York State's federal land-grant university, Cornell holds a unique position within the Ivy League, combining academic excellence with a strong commitment to public engagement. The university strives to advance knowledge across disciplines while improving the quality of life in New York State, the nation, and the world. Cornell enrolls 16,128 undergraduate students and 10,665 graduate and professional students, is home to 2,950 faculty members, and has produced 52 Nobel Laureates. The Cornell MPH program is a key partner in the Community Health Improvement

process with support from students and staff. The program is centered around Equity, Sustainability, and Engagement.

Cornell Cooperative Extension Tompkins County

Cornell Cooperative Extension Tompkins County enables people to improve their lives and communities through partnerships that put experience and research knowledge to work. CCE delivers education programs, conducts applied research and encourages community collaboration. Topics include commercial and consumer agriculture, nutrition and health, youth and families, finances, energy efficiency, economic and community development, and sustainable natural resources.

Crisis Alternative Response and Engagement (C.A.R.E.) team

The C.A.R.E. Team in Tompkins County is a law enforcement and mental health co-response team formed by the TCWH and the Sheriff's Office. The team responds to 911 calls where mental health is the primary need by de-escalating crisis situations, connecting individuals with appropriate community treatment and support services, and providing in-person follow-up support within 24–48 hours to help prevent unnecessary hospitalizations or involvement with the criminal justice system. As of 2024, TCWH also partnered with City of Ithaca Police Department to operate another CARE team.

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

This local agency delivers hot meals directly to clients and employs a Registered Dietitian who provides meal planning, nutrition assessments, counseling, and education. Its mission is to provide meals and other nutrition services that promote dignity, well-being, and independence for older adults and others in need throughout Tompkins County. Meals are delivered either to clients' homes or to one of four congregate meal sites.

Gadabout

Gadabout is a safe, reliable, and affordable transportation system in Tompkins County that provides services to individuals who are 55 and older, residents of Tompkins County, those who are ADA-certified (under 55 with a disability), or Medicaid recipients. The service offers rides to doctor's offices, shopping centers (with a limit of eight grocery bags), and personal residences. The cost of

each trip depends on the location, and riders may pay the driver with cash, check, or Gadabout tickets.

Guthrie

Guthrie Medical Center is an integrated, not-for-profit healthcare system serving northern Pennsylvania and southern New York. It includes the Guthrie Robert Packer Hospital in Sayre, PA, the Guthrie Cortland Medical Center in Cortland, NY, Ithaca City Harbor, and regional office in Ithaca. The medical center has primary care physicians and specialists who provide comprehensive services, including women's health care, gastroenterology, orthopedics, pediatrics and adult/geriatric care.

Human Services Coalition of Tompkins County (HSC)

The Human Services Coalition plays a central role in strengthening the local health and human services network. Its mission is to identify community needs, coordinate planning efforts, and enhance service delivery across Tompkins County. HSC brings partners together to share resources, reduce duplication, and advance system-level solutions that support resident wellbeing.

COMMUNITY HEALTH ADVOCATES (CHA)

Community Health Advocates assists individuals, families, and small businesses in navigating New York's complex health care and insurance systems. As an all-payer program, CHA provides one-to-one assistance, outreach, and education to help residents use their health insurance, understand coverage, and access needed care. This statewide network ensures that support is available regardless of insurance type or enrollment status.

HSC CONTINUUM OF CARE - HOUSING FIRST

The Ithaca / Tompkins County Continuum of Care System (CoC NY-510), led by the Human Services Coalition, is a local network of public, private, and not-for-profit agencies working collaboratively to end homelessness in Tompkins County. This collaborative process is accomplished through bi-monthly CoC meetings as well as several sub-committees that address issues including the development of new supportive housing, barriers to entry into housing and homeless services, and at-risk youth. The Human Services Coalition also serves as the collaborative applicant in the Continuum of Care Program Competition which funds several supportive housing projects in the City of Ithaca.

HEALTH INSURANCE NAVIGATORS

Health Insurance Navigators offer free, confidential support to help residents enroll in comprehensive health insurance through the NY State of Health Marketplace. Navigators guide individuals and families through eligibility, plan options, and enrollment, ensuring that coverage meets their needs and reducing barriers to accessing preventive and medical care.

211

211 is a community information and referral system that connects residents with services that address basic needs, health and mental health supports, housing, transportation, crisis intervention, and more. Trained community service specialists listen, assess needs, and provide tailored referrals, with follow-up when appropriate. This centralized access point strengthens the County's social support infrastructure by helping residents find appropriate services quickly and efficiently.

Ithaca-Tompkins County Transportation Council (ITCTC)

The Tompkins County planning and transportation team is led by ITCTC, the County's Metropolitan Planning Organization (MPO). The ITCTC is charged with facilitating County-wide transportation planning.

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 Neighborhood Housing Services (INHS)

Ithaca Neighborhood Housing Services (INHS) works with individuals and families of moderate income to help them find and maintain high-quality, affordable housing. The organization provides low-interest loans to first-time homebuyers, manages well-maintained rental units, rehabilitates older homes, offers home repair assistance to seniors, and supports the construction of new LEED-certified green homes. INHS serves Tompkins County and the surrounding counties.

Ithaca College

Ithaca College is a private, residential college located in the City of Ithaca. The college offers a range of undergraduate and graduate programs that integrate liberal arts education with professional studies. Ithaca College emphasizes experiential learning, community involvement, and student well-being, preparing graduates to contribute meaningfully to their communities and professions both locally and globally. The college also serves as an important community partner in Tompkins County, supporting educational advancement, public health initiatives, and collaborative programs that promote health, equity, and community development. The campus community includes approximately 4,200 undergraduate students, 500 graduate students, and 721 faculty members.

Law NY

The Legal Assistance of Western New York, Inc. is a non-profit law firm that provides free legal aid to people with civil legal problems in Western New York. Their resources are very expansive, covering services in health, housing, employment, family, income, and more.

Local Mental Health Resources

Local mental health resources and providers support people in our community who are experiencing mental health crises or mental health-related distress. This is a list is not all inclusive, but provides a selection of local mental health resources:

- TCWH Mental Health Services
- Advocacy Center
- Cayuga Medical Center
- Family and Children's Service
- The Mental Health Association in Tompkins County

Local Substance Use Prevention/Harm Reduction Services

This is a list of local resources and support in the County:

PREVENTION SERVICES:

- Suicide Prevention and Crisis Service
- Opioid Overdose Prevention Program by Southern Tier AIDS Program (STAP)
- Mental Health Association in Tompkins County
- Project COPE hosted by The New York State Office of Addiction Services

TREATMENT SERVICES:

- Cayuga Addiction Recovery Services (CARS)
- R.E.A.C.H. Medical

RECOVERY SERVICES:

- Suicide Prevention and Crisis Service
- Tompkins County Suicide Prevention Coalition
- The Sophie Fund, Inc.
- Substance Abuse and Mental Health Services Administration (SAMHSA)

(Note - This list is not comprehensive)

Local Food Pantries and Community Cupboards

This is a list of resources in the County: Find food help near you | Food Bank of the Southern Tier

REACH Project, Inc

It 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.

Racker

It is a nonprofit organization that supports people with disabilities and their families to lead fulfilling lives by providing opportunities to learn and be connected with others. They offer programs and services to more than 3,500 people in Tompkins, Cortland, and Tioga counties. Their service areas encompass preschool special education, clinical therapies, mental health treatment programs, residential opportunities, and community support services for all ages.

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.

Tompkins County Office for the Aging (COFA)

Tompkins County Office for the Aging assists older adults and persons with long term care needs to live independently in their homes and communities with quality of life and dignity. COFA provides a range of programs and services including personal emergency response system devices, insurance counseling and benefit programs, long term care ombudsman program, and congregate and home-delivered nutrition programs. It also facilitates transportation options for seniors and coordinates in-home services such as personal care aide support to help residents with daily activities.

Tompkins Cortland Community College (TC3)

TC3 is a public institution within the State University of New York (SUNY) system serving Tompkins, Cortland, and Tioga counties. The college provides accessible and affordable higher education opportunities, including associate degree programs and transfer pathways to four-year institutions.

Tompkins Consolidated Area Transit (TCAT)

Tompkins Consolidated Area Transit, Inc. (TCAT) provides essential public transportation throughout Tompkins County, supporting mobility and equitable access to education, employment, healthcare, and community services. Operating seven days a week across 25 urban, campus, and rural routes, TCAT connects residents to Cornell University, Ithaca College, Tompkins Cortland Community College, and major commercial and residential centers. TCAT's mission emphasizes social, environmental, and economic wellbeing through safe, reliable, and affordable transit. Its fare structure remains accessible, with adult single rides at $1.50, reduced fares for seniors and people with disabilities at $0.75, and free rides for youth through the FreeRyde program. Cost-effective pass

options further support affordability, including one day, weekly, and monthly passes for frequent riders.

One Call, One Click Transportation Center/Tompkins Transportation Scout

A partnership between Tompkins County, GO ITHACA, the 211 Helpline at the Human Services Coalition, and other partners, this initiative: provides community members with information and resources around transportation options, reduces barriers to accessing transportation for social drivers of health-related transportation needs, and helps to develop new community solutions.

Tompkins County Worker's Center

The vision of the Tompkins County Workers' Center is that all people are respected in the workplace, have a Living Wage, the right to organize, quality health care, housing, childcare, transportation, and access to healthy food and water. They support, advocate for, and seek to empower each other to create a more just community and world.

Tompkins County Youth Services

The Tompkins County Youth Services Department invests time, resources, and funding in communities to enable all youth to thrive in school, work and life. Youth Services works with non-profit agencies to run programs for children, youth, and families.

YMCA of Ithaca and Tompkins County

The YMCA of Ithaca and Tompkins County (or the Y) is a long-standing community nonprofit that provides accessible health, recreation, youth, and wellness services to residents across the County. Its facility includes indoor pools, a full-size gymnasium, racquetball courts, fitness and cardio spaces, multipurpose activity rooms, and child-care programs, supporting a broad range of offerings such as aquatics, group fitness, youth development, summer camps, after-school and chronic disease prevention programs. Through financial assistance and reduced-cost memberships, the Y works to reduce cost barriers and expand access to physical activity and wellness opportunities for individuals and families of diverse incomes.

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Public Health
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Accredited Health Department
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Public Health Accreditation Board

COMMUNITY HEALTH ASSESSMENT

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Table of Contents

Executive Summary

Prevention Agenda Priorities

Through the Community Health Assessment process, Schuyler County has identified three priority areas for 2025-2030. They are:

- Poverty
- Primary Prevention, Substance Misuse, and Overdose Prevention
- Preventive Services for Chronic Disease Prevention and Control

Data Review

Both primary and secondary data sources and a blend of quantitative and qualitative data were used to identify the priorities for 2025-20230. Those sources include the New York State Department of Health Vital Statistics, County Health Rankings, US Census Bureau, Behavioral Risk Factor Surveillance System (BRFSS), Statewide Planning and Research Cooperative System (SPARCS), community members through focus groups and surveys conducted by the Pivital Public Health Partnership.

Partners and Roles

Schuyler County's CHIP Team is a diverse partnership of organizations and community members that participated in the Schuyler County Community Health Assessment (CHA) process. The makeup of this team ensured broad stakeholder input and representation from populations experiencing health disparities.

Schuyler County CHIP Team

Organizations Represented:

Schuyler County Public Health
Schuyler Hospital, Centralus Health
- Schuyler Primary Care
- Arnot Health, Community Health Dept.
- Cayuga Medical Center
- Seneca View Nursing Facility
- Cayuga Health Partners

Schuyler County Mental Health
Schuyler Head Start
My Place
Schuyler County Department of Social Services
Schuyler County Office for the Aging
Community Members
The Arc of Chemung-Schuyler
Finger Lakes Community Health
Food Bank of the Southern Tier
FLACRA
Cornell Cooperative Extension of Schuyler
Cancer Services Program of the Southern Tier
Catholic Charities
Watkins Glen Chamber of Commerce
Common Ground Health
Pivital Public Health Partnership
Schuyler County Sheriff's Office
Schuyler County Administrator's Office
Schuyler County Planning Department
Justice Center of the Southern Tier
Pro Action
Finger Lakes Gateway
URMC Center for Community Health & Prevention
Montour Falls & Watkins Glen Libraries
211 Helpline & The Institute for Human Services, Inc.

Sectors Represented:	
Public Health	Healthcare Professionals
Local Government	Youth-Serving Organizations
Businesses	Community-Based Organizations
Substance Use Treatment Agencies	Law Enforcement
Mental Health	Community Members
Populations Served:	
All residents	Those with disabilities
Marginalized population groups	Local businesses
Children	Senior population

The CHIP Team members followed the MAPP 2.0 Framework for this CHA, completing a review of partner representation, providing input on focus group questions and groups to approach, regularly reviewing and interpreting primary and secondary data that was collected, contributing to root cause analysis of key themes, and completing the prioritization of priorities that resulted with our three focus areas.

Interventions and Strategies

Evidence-based interventions, strategies or activities that align with the New York State Department of Health's Prevention Agenda will be identified in the resulting Community Health Improvement Plan (CHIP) that will be finalized by June 2026. Schuyler County Public Health, Schuyler Hospital, and other community partners will be included on the CHIP to try to improve measures related to Poverty; Primary Prevention, Substance Misuse, and Overdose Prevention; and Preventive Services for Chronic Disease Prevention and Control.

Progress and Evaluation

Process measures will be identified and included in the CHIP by June 2026 that are SMART or SMARTIE objectives. SMART objectives are those that are Specific, Measurable, Achievable, Relevant, and Time-bound. SMARTIE objectives are those plus Inclusive and Equitable. Progress data will be collected by Public Health from CHIP team partners quarterly and will be tracked using Clear Impact, a performance measure program.

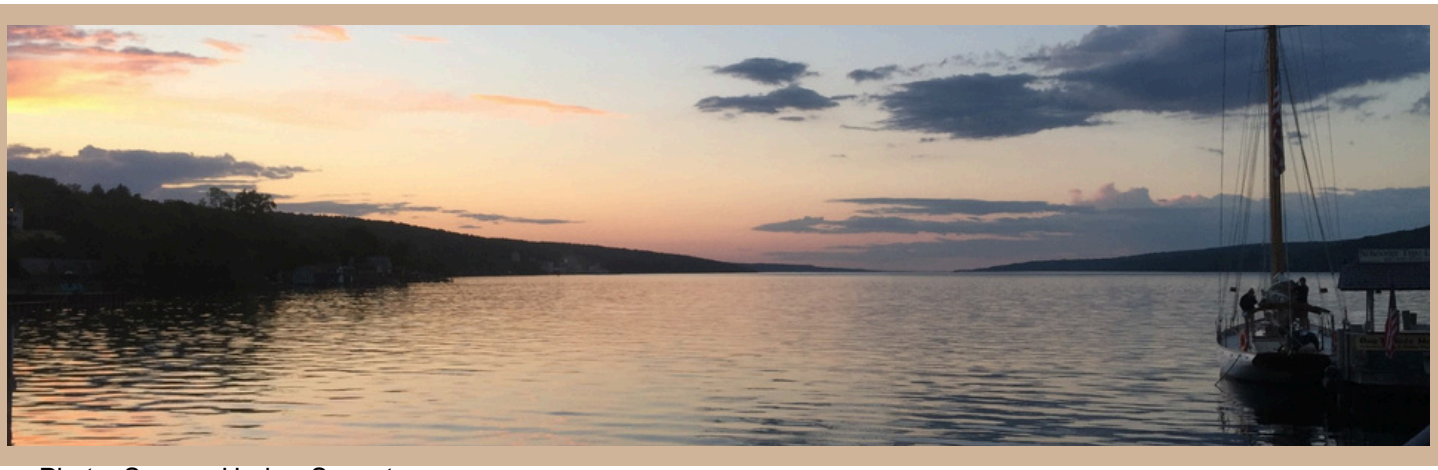
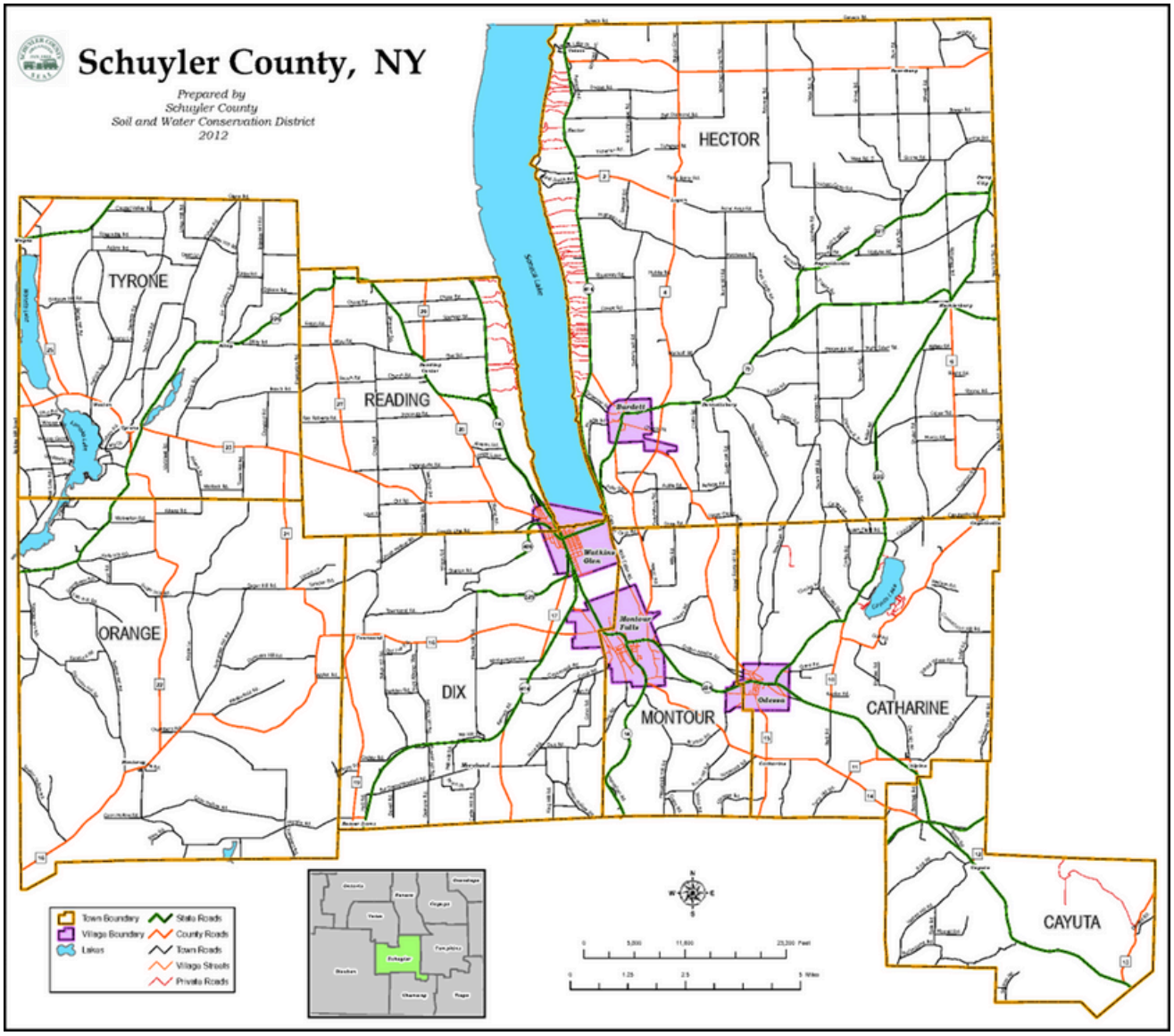


Photo: Seneca Harbor Sunset

Service Area

Schuyler County is a rural county located in the Finger Lakes region of New York State. It is bordered on the northeast by Seneca County, on the east by Tompkins County, on the south by Chemung County, on the west by Steuben County, and on the northwest by Yates County. Seneca Lake bisects a portion of the county, forming the western border of the Hector township and the eastern border of the Reading township.

Map: 1



Three smaller lakes – Waneta, Lamoka and Cayuta—can also be found in the county. Waneta Lake is located within the Town of Tyrone, Lamoka Lake is also located in the Town of Tyrone and continues into the Town of Orange. Cayuta Lake is in the Town of Catharine. The Finger Lakes National Forest is in the northern part of the county in the Town of Hector, and Watkins Glen State Park is in the center of the county in the Village of Watkins Glen.

The county is comprised of 12 municipalities: four villages – Burdett, Montour Falls, Odessa and Watkins Glen – and eight towns – Catharine, Cayuta, Dix, Hector, Montour, Orange, Reading, and Tyrone.

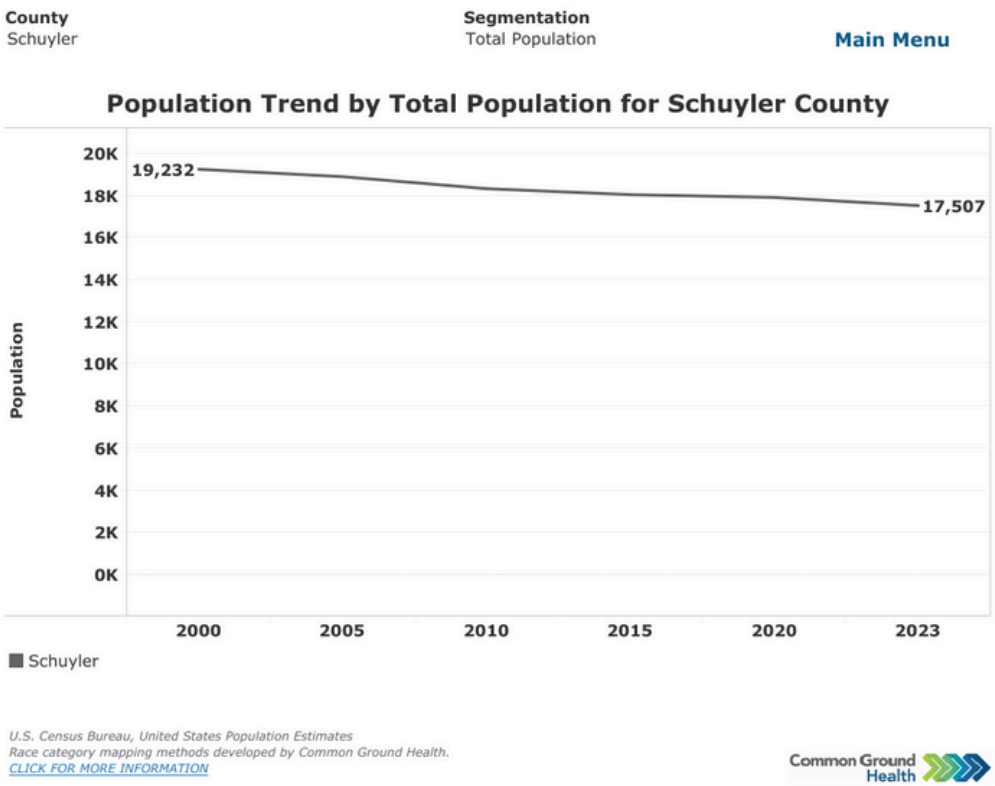
The population of the county is relatively small, but with the various tourist attractions – Watkins Glen State Park, Watkins Glen International Raceway, Seneca Lake, and wineries and breweries – the number of people within the county can swell dramatically. This is important for considerations of service access and the impact on the community.

The county houses Schuyler Hospital, which is a 16-bed critical access hospital in Montour Falls, NY with a 120-bed skilled nursing facility attached. For 100 years, Schuyler Hospital has been the healthcare provider for all ages in and around Schuyler County. Schuyler Hospital offers in-patient care, short-stay surgery, emergency room, primary care, diagnostic services, and other procedures. The hospital has evolved into a network of providers, programs, and services that reaches throughout Schuyler County and into southern Yates and Seneca Counties to meet the healthcare needs of a population of over 32,000 residents.

Demographics

As of 2023, Schuyler County was home to 17,507 residents. Schuyler County's population has been trending downward, as seen in Figure 1. Schuyler County is the second least populous county in New York state.

Figure: 1



The largest population centers are found in the Village of Watkins Glen (zip code 14891) and Town of Dix (zip codes 14891 and 14812), which includes the hamlet of Beaver Dams (zip code 14812), as seen in Map 2. As a rural county, small populations can be found throughout the county, so it is important to make sure that service delivery is not just focused in the center of the county but that efforts are specifically made to reach the whole county.

Map: 2

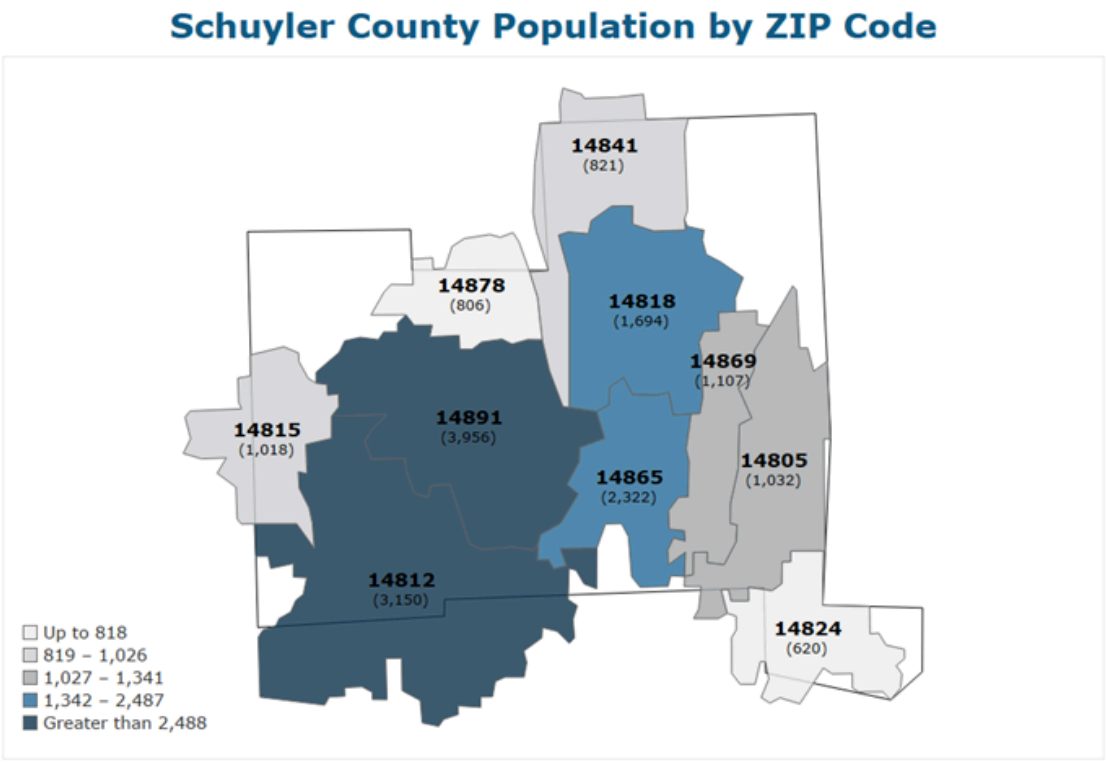
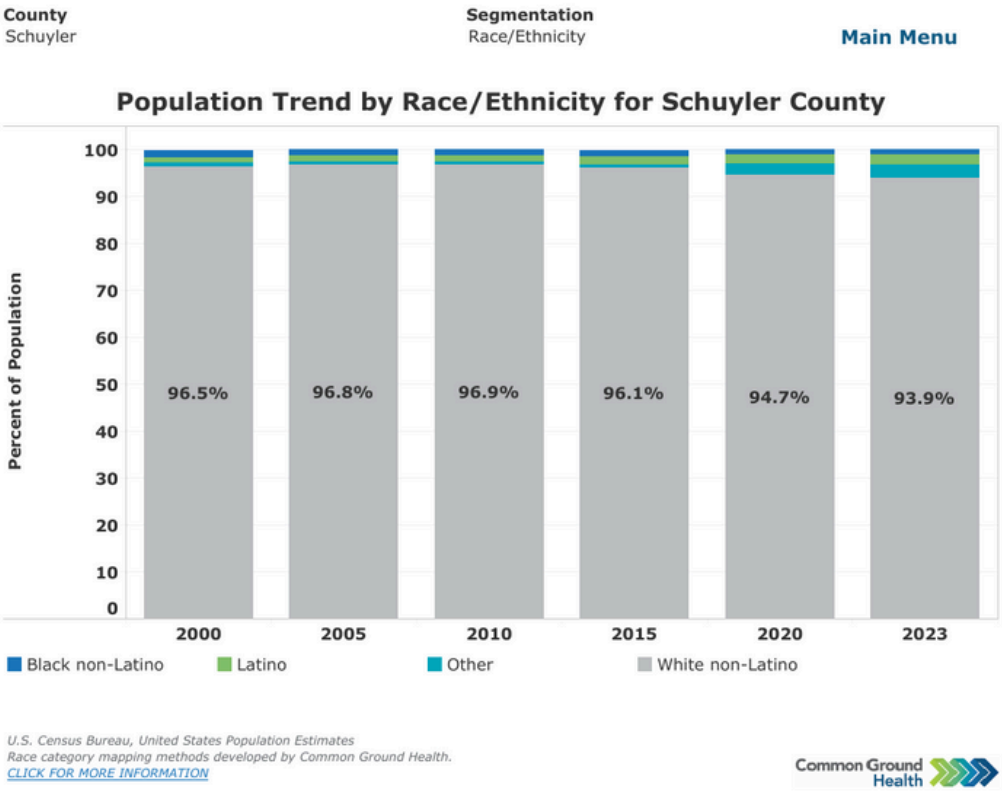


Figure: 2

Race/Ethnicity

The residents of Schuyler County are primarily white non-Latino, which accounted for nearly 94% of the populations in 2023. Black non-Latino accounted for 1.1%, Latino accounted for 2.2% and 2.9% of the population are other races or ethnicities.



Age and Sex

The largest age group in Schuyler County is represented by those who are 35 to 64 years old, followed by the 65 and older age group as seen in Figure 3. However, Schuyler County's largest growth in an age group has been seen in the 65+ population from 2012-2023, as seen in Figure 4. This growing aging population has implications for long-term care needs and higher health risk factors.

Figure: 3

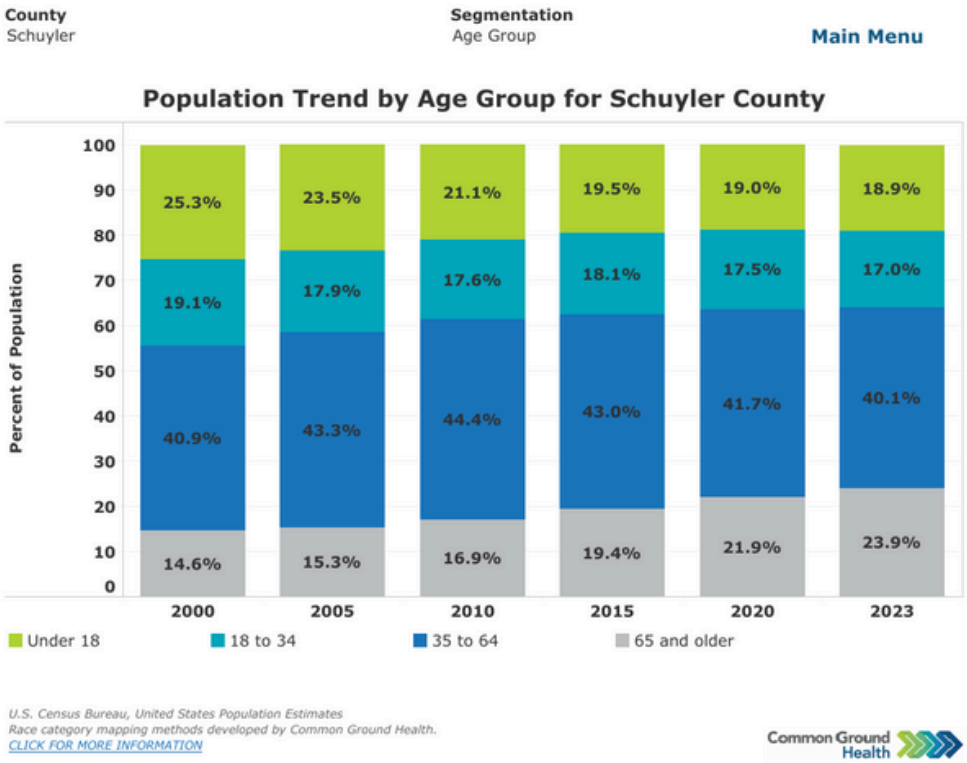
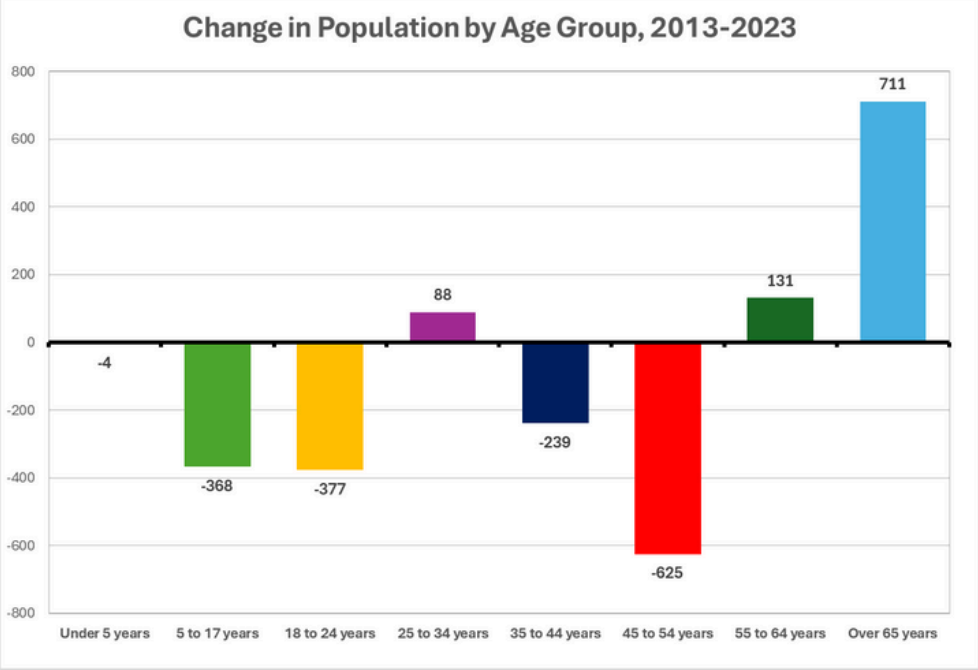


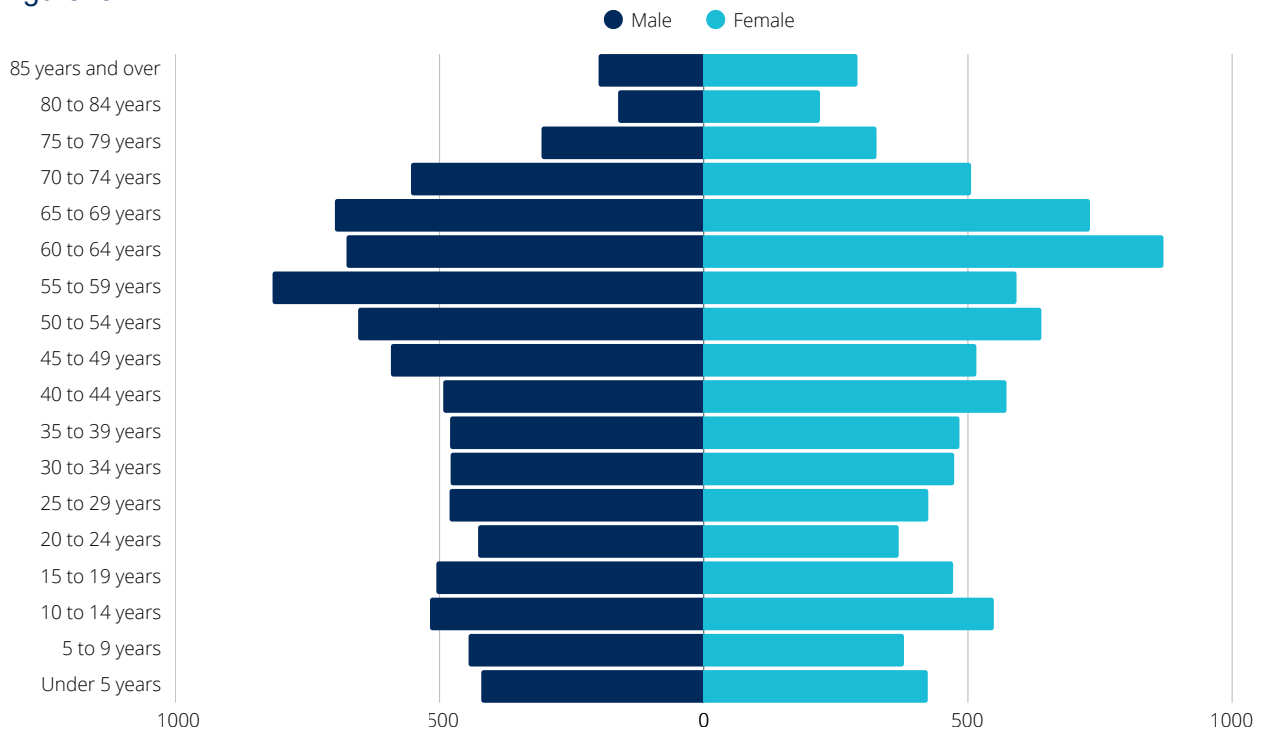
Figure: 4



U.S. Census Bureau, U.S. Department of Commerce. ACS Demographic and Housing Estimates. American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP05, 2013 and 2023. Accessed on 29 Dec 2025.

Schuyler County's population pyramid shows the number of county residents by sex and age (Figure 5). The percentage of the county that is female is nearly 50% (49.7%) and the median age in Schuyler County is 47.4 years.

Figure: 5

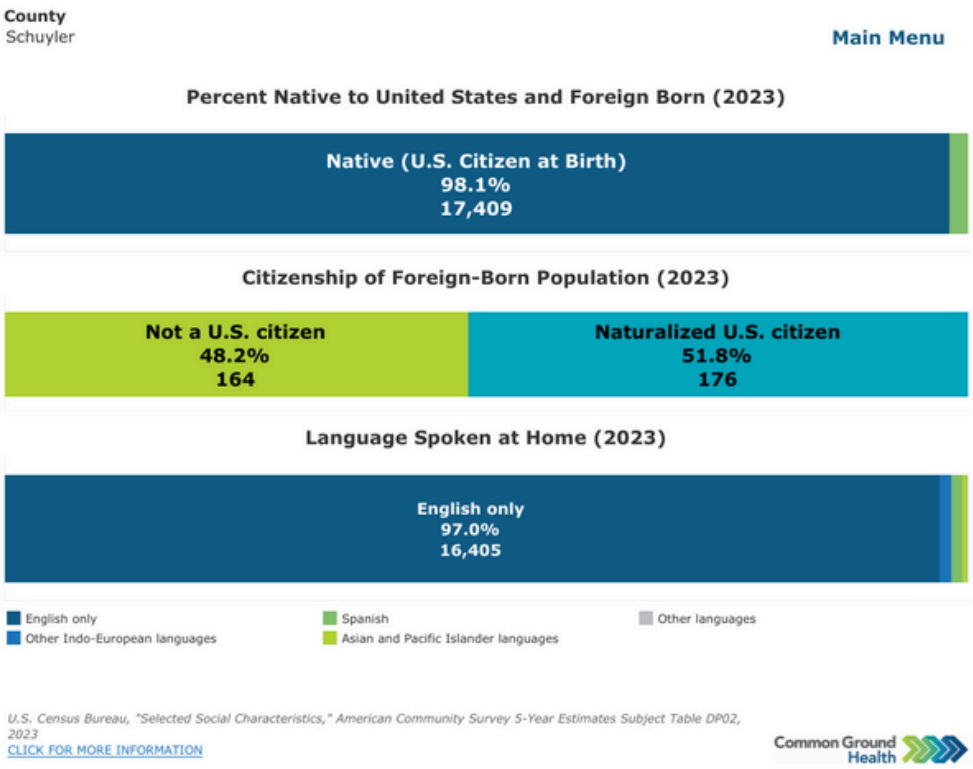


U.S. Census Bureau, U.S. Department of Commerce. (n.d.). Age and Sex. American Community Survey, ACS 5-Year Estimates Subject Tables, Table S0101. Retrieved December 29, 2025

Languages Spoken within Schuyler County and Immigrant/Migrant Status

As of 2023, English was the dominant language spoken at home, accounting for 97% of households, followed by 1.3% other Indo-European languages, 1.1% Spanish, and .5% Asian and Pacific Islander languages. Nearly all Schuyler County residents are US citizens at birth. Of those residents who were not born in the United States, about half have become citizens as of 2023.

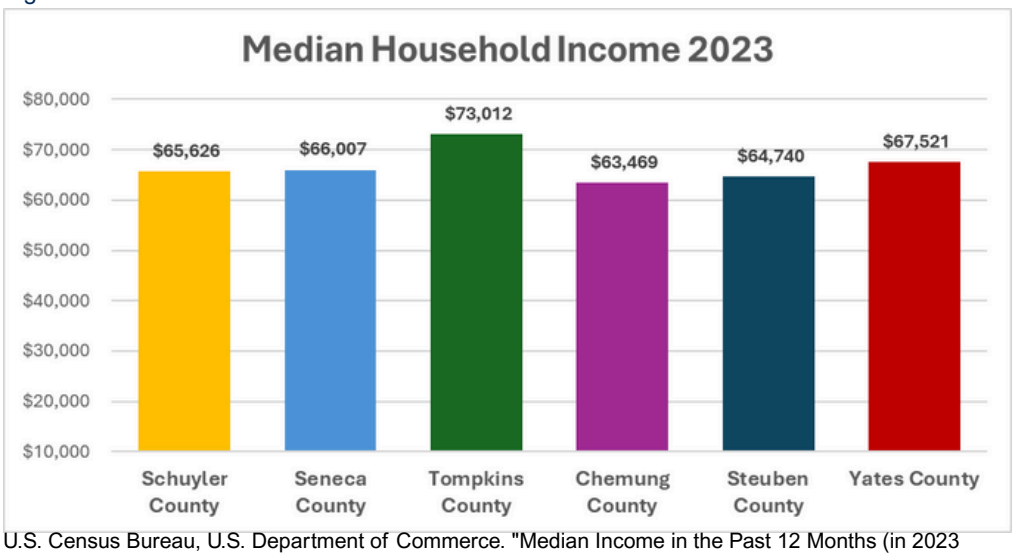
Figure 6



Income

Schuyler County's median household income is just below the average ($66,950) of its surrounding counties as of 2023. Notably, it is more than $7,000 lower than Tompkins County and it is 14% less than the state median income of $76,680. These disparities could make a difference in a family's activities or options available.

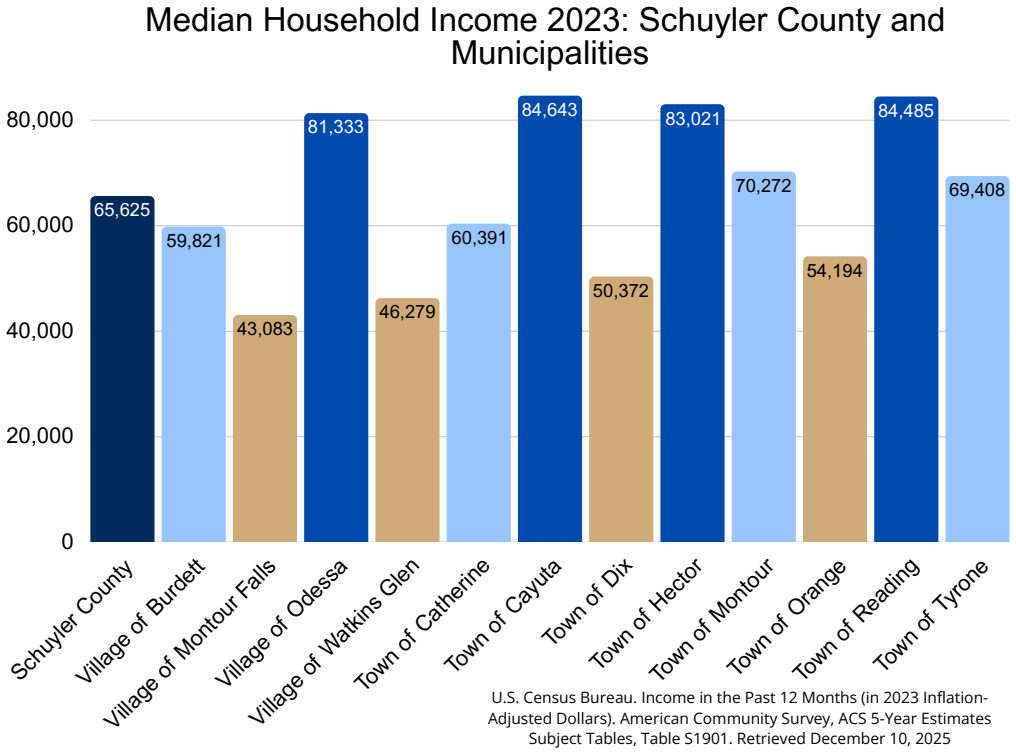
Figure 7



U.S. Census Bureau, U.S. Department of Commerce. "Median Income in the Past 12 Months (in 2023 Inflation-Adjusted Dollars)." American Community Survey, ACS 5-Year Estimates Subject Tables, Table S1903

Within Schuyler County there is a variance in median income by municipality, with residents of the Village of Odessa and Towns of Cayuta, Hector and Reading rising well above the county's median income and the Villages of Montour Falls and Watkins Glen falling well below as seen in Figure 8.

Figure 8



U.S. Census Bureau. Income in the Past 12 Months (in 2023 Inflation-Adjusted Dollars). American Community Survey, ACS 5-Year Estimates Subject Tables, Table S1901. Retrieved December 10, 2025

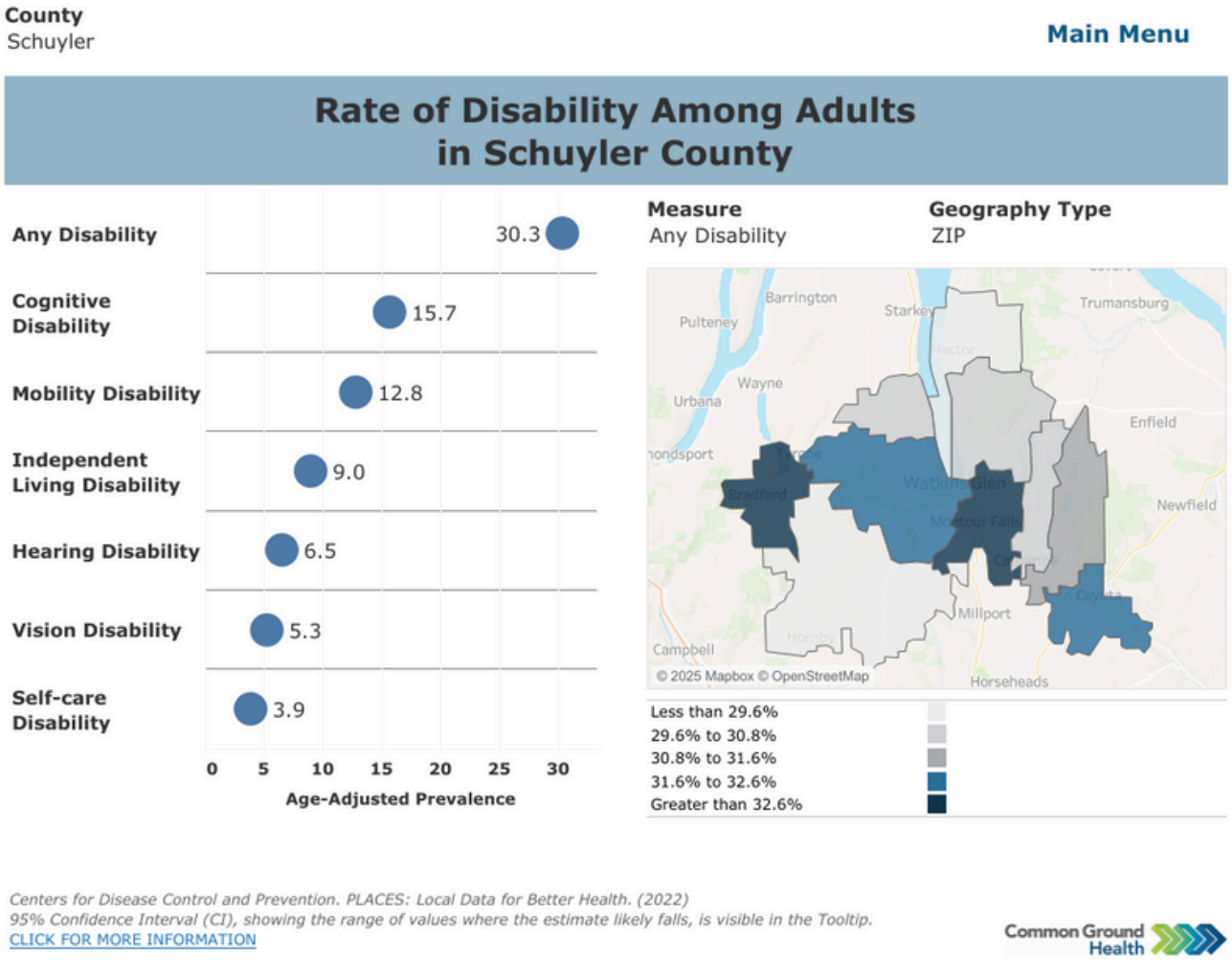
Veterans

Veterans often have unique health needs, including chronic conditions, mental health concerns and service-related injuries. According to the US Census Bureau in 2023, 8.9% of Schuyler County's population aged 18 or older (service age) are veterans, which is higher than New York State's average of 3.6% for the same year. Almost 70% of Schuyler veterans are age 55 and older.

Disabilities

Schuyler County also has a sizeable rate of adults who have a disability. As of 2022, 30.3% of residents have some form of disability in Schuyler County, with 15.7% having a cognitive disability. Those with disabilities may require more care, transportation needs, and housing adaptations and could face challenges when seeking these needs as well as face barriers to employment.

Figure 9, Map 3

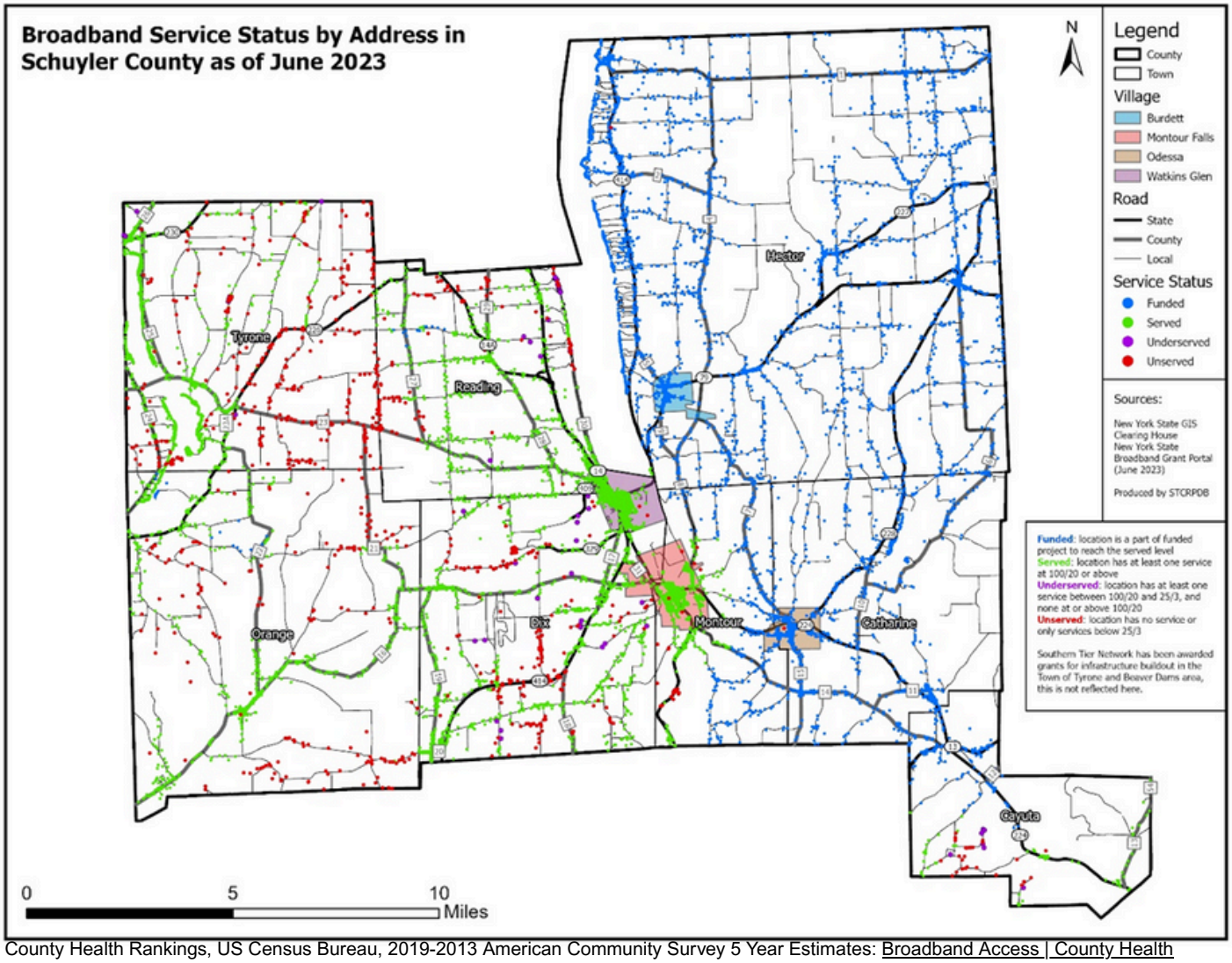


Centers for Disease Control and Prevention. PLACES: Local Data for Better Health. (2022)
95% Confidence Interval (CI), showing the range of values where the estimate likely falls, is visible in the Tooltip.
CLICK FOR MORE INFORMATION

Broadband Access

In Schuyler County, although 85% of households have broadband access, there are still portions of the county that are underserved or do not have broadband access (Map 4). The goal in New York State is to have access to broadband services available to all addresses by 2030. The Southern Tier Network has been awarded funding to buildout access in the Town of Tyrone and the Hamlet of Beaver Dams (parts of the Town of Orange and Dix) areas.

Map 4



County Health Rankings, US Census Bureau, 2019-2013 American Community Survey 5 Year Estimates: Broadband Access | County Health Rankings & Roadmaps.

Housing Stability and Affordability

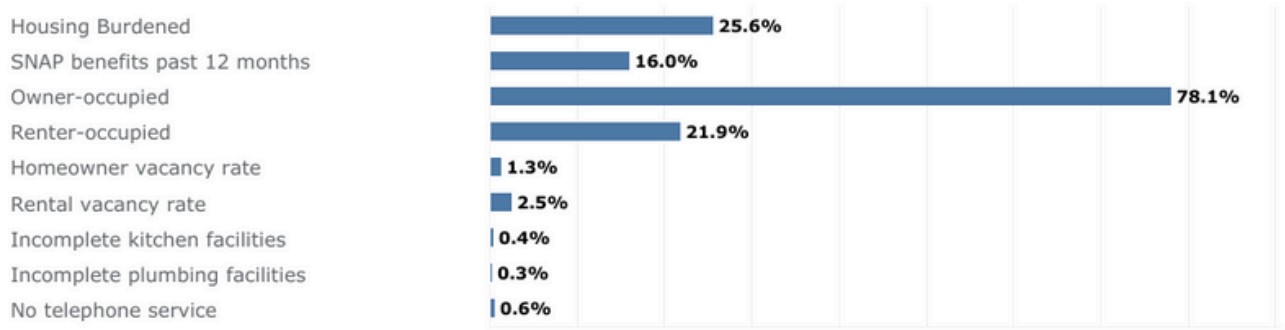
In Schuyler County, nearly 80% of homes were owner-occupied in 2023. Per a housing study conducted by the Schuyler County Planning Department in 2025, seasonal housing has replaced more than 100 units of owner occupied housing. Additionally, the median sales price for a single family home has more than doubled since 2019 with an average of $200,000. More than one out every four households are considered housing burdened, meaning their housing costs are more than 30% of their household income. By 2035, it is estimated that the county will need an additional 1,076 housing units to meet the demand.

Figure 10

County
Schuyler

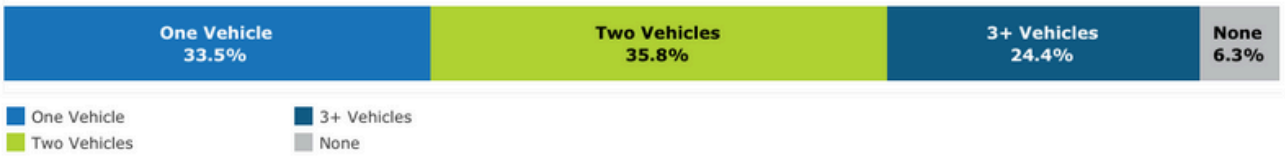
Main Menu

Housing Characteristics for Schuyler County (2023)



Commuting Method for Workers 16 and Older (2023)

Vehicles Available in Occupied Households (2023)



U.S. Census Bureau, "Selected Economic Characteristics," "Selected Housing Characteristics," "Poverty Status" American Community Survey 5-Year Estimates Subject Tables DP03, DP04, and S1701 2023
CLICK FOR MORE

Common Ground Health

Mobility

The majority of residents (nearly 77%) commute alone, and about 70% of households have one or two vehicles (Figure 10). Just over 6% of households have no vehicles, and nearly 8% work from home or use public transportation.

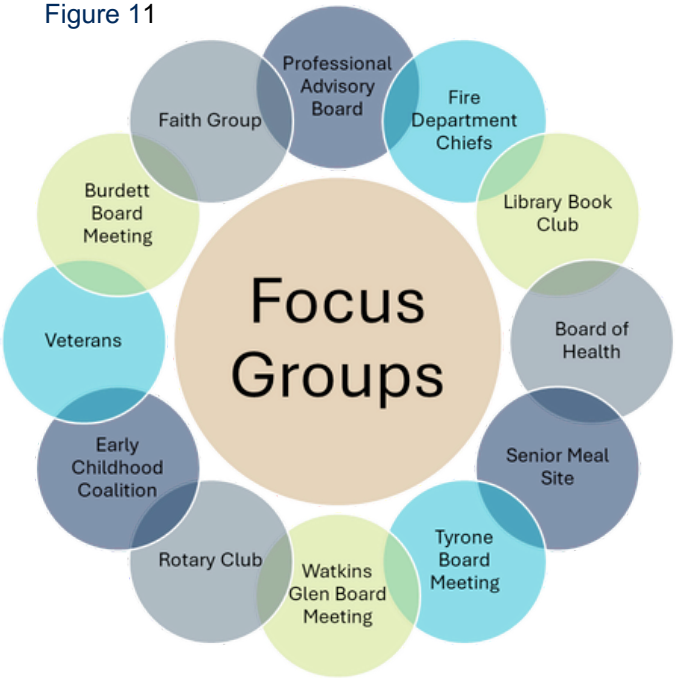
Photos: Watkins Glen Grand Prix Festival

Community Health Assessment Process

Schuyler County utilized the National Association of County & City Health Officials (NACCHO) Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework to develop the Community Health Assessment. The CHIP Team met every other month in 2024 and then monthly in 2025 to complete the steps outlined in the MAPP 2.0 process, including determining who and what organizations should be included in the process, reviewing data that was collected from both primary and secondary sources, discussing key themes that emerged from the data, completing a root cause analysis of those key themes, and participating in a prioritization process that led to the resulting three priority areas.

MAPP 2.0 includes three assessments. First, CHIP Team partners completed the Community Partner Assessment (CPA), providing valuable organizational data and insights. For the Community Context Assessment (CCA) the team brainstormed groups or individuals who should be engaged in focus groups to ensure diverse perspectives were included. Public Health conducted 12 focus groups in March through May of 2025.

Figure 11



The Community Status Assessment (CSA) was completed by the Pivital Public Health Partnership, in which they compiled secondary data from many sources, including:

- US Census Bureau and the American Community Survey (5-year estimates)
- New York State Department of Health
- County Health Rankings
- Centers for Disease Control and Prevention
- Behavioral Risk Factor Surveillance System
- New York State's Statewide Planning and Research Cooperative System (SPARCS)
- New York State Education Department
- Healthy People 2020

The findings from all three assessments were shared with the CHIP Team during monthly meetings where members were encouraged to ask questions, provide feedback, and share their interpretation of the data.

After completing the three assessments, Pivital triangulated the data to identify cross-cutting themes for each county. For Schuyler County, Pivital identified the following seven themes:

1. Healthy Children: Preventive Services
2. Preventive Services for Chronic Disease Prevention and Control
3. Oral Health Care
4. Poverty
5. Mental Wellbeing
6. Substance Use
7. Injuries and Violence

Photo: Community Engagement Activity at the Falls Harvest Festival

Next, the CHIP Team reviewed data on the identified themes and then used the Five Whys process in which the team asked "why" at least five times to identify root causes for each theme in September. In the beginning of October, Schuyler County Public Health tabled at the Falls Harvest Festival, engaging the community and asking them to identify their top three health priority areas from the main seven themes. Community members indicated mental health, poverty, and substance use were top areas of concern.

To further streamline the Mental Wellbeing and Substance Use overarching themes into the specific Prevention Agenda priority areas within those categories, the CHIP Team completed a priority matrix using the eight priority areas included under the Mental Wellbeing and Substance Use theme. The CHIP team identified Adverse Childhood Experiences; Primary Prevention, Substance Misuse and Overdose Prevention; and Suicide as priority areas for consideration alongside the original themes.

Subsequently, 8 issue profiles were developed from the themes to provide a comprehensive understanding of each topic. The profiles included an overview of the issue and its significance, a clear issue statement, comparison data for Schuyler County and New York State, a description of the populations affected, contributing factors, existing community assets and opportunities, identified gaps and challenges, and recommendations aligned with the Prevention Agenda.

Issue Profiles

1. Healthy Children: Preventive Services
2. Preventive Services for Chronic Disease Prevention and Control
3. Oral Health Care
4. Poverty
5. Suicide
6. Adverse Childhood Experiences
7. Primary Prevention, Substance Misuse, and Overdose Prevention
8. Injuries and Violence

At the end of October, CHIP Team members individually used those issue profiles, the data that had been presented throughout the year, and their experience and knowledge of community resources to complete a Health Assessment Prioritization matrix to rank the priority areas based on criteria:

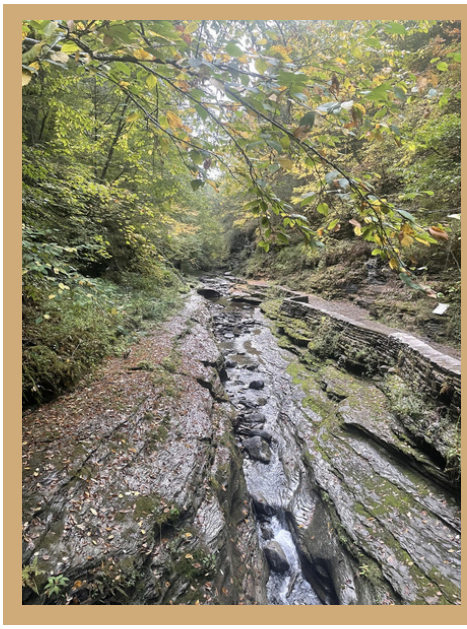
1. Relevance of the issue to community members
2. Magnitude/severity of the issue
3. Impact of the issue on communities impacted by inequities
4. Availability and feasibility of solutions and strategies to address the issue
5. Availability of resources (time, funding, staffing, equipment) to address the issue.

This prioritization process resulted in the identification of Schuyler County's three Prevention Agenda Priorities to address in its Community Health Improvement Plan (CHIP) through 2030.

New York State's Prevention Agenda 2025-2030 outlines the key health priorities that will be addressed at the state level to improve the health and wellbeing of New York state residents. It serves as the framework for local health departments and their partners to create their Community Health Improvement Plans after identifying the specific priorities that will be addressed in each county.

The prevention agenda includes five domains based on the Social Determinants of Health. Schuyler County will be focusing on the three priorities noted within their corresponding domains.

1. Economic Stability
   - *Priority*: **Poverty**
2. Social and Community Context
   - *Priority*: **Primary Prevention, Substance Misuse, and Overdose Prevention**
3. Neighborhood and Built Environment
4. Health Care Access and Quality
   - *Priority*: **Preventive Services for Chronic Disease Prevention and Control**
5. Education Access and Quality



Photos: Watkins Glen State Park

Health Status

Domain: Economic Stability

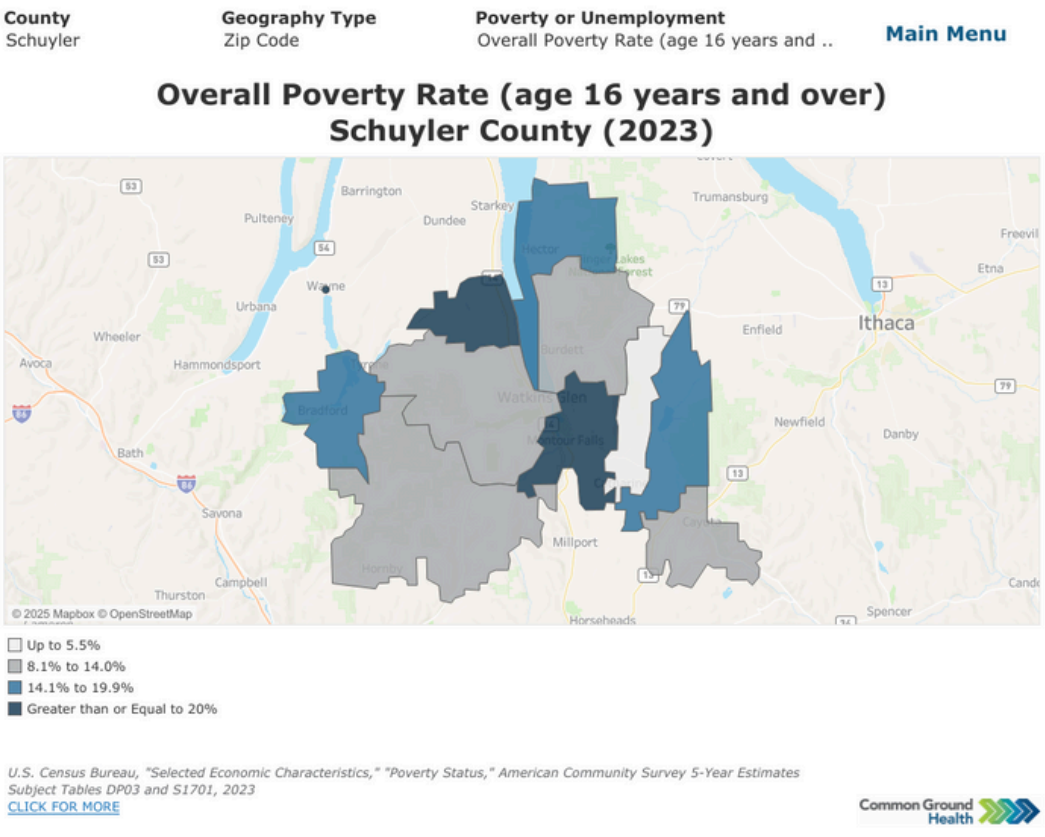
Priority: Poverty

Poverty contributes to poorer health outcomes, limited access to care, and negatively impacts physical and mental health. Among children, poverty is associated with educational and developmental delays. Poverty also disproportionately affects women, people living in rural areas, and people of color. Addressing poverty can reduce economic disparities and improve the health and wellbeing of many residents.

Map 5 illustrates how poverty disproportionately impacts residents across the county. By municipality, median household income ranges from a low of approximately $43,000 in the Village of Montour Falls to nearly $85,000 in the Town of Cayuta (Figure 8). These values fall roughly $20,000 below and above, respectively, the Schuyler County median household income.

Issue Statement:
*Poverty is a growing concern in Schuyler County - **15% of residents live below the poverty line** (including 19% of children and 9% of seniors) and **food insecurity is worsening.***

Map 5



Who is Affected

- Low-income families and individuals
- Children and adolescents in financially unstable households
- Seniors living on fixed incomes
- Renters facing rising housing costs
- Single mothers or parents
- Middle-income residents vulnerable to rising costs

Contributing Factors

Data from the Community Status Assessment, Community Partners Assessment, Community Context Assessment, and Root Cause Analysis of the problem of poverty were used to identify the following contributing factors:

- Shortage of living wage jobs as the rising cost of living outpaces wage growth
- Many jobs are seasonal i.e. hospitality/tourism-related
- Small businesses are slow to or cannot afford to increase wages
- Limited affordable and quality housing
- Tourism increases housing pressure as short-term rentals reduce availability
- Lack of affordable childcare, which is an even bigger burden for single parents
- Transportation barriers limit access to jobs and services
- Resistance to growth/development due to preferences for a small-town character
- Stigma and/or a lack of awareness of support programs
- Housing programs are overburdened and there is a lack of funding for affordable housing development

Community Assets and Opportunities

There is a strong community interest in reducing poverty. Many partners already support poverty reduction or provide services to people living in poverty including Centralus Health, Finger Lakes Community Health, Head Start, Pro Action, FLX Gateway, Schuyler County Public Health, Schuyler County Planning Department, and Cornell Cooperative Extension. There are also established state and local programs/organizations that provide direct support to individuals and families in the area, such as WIC, SNAP, Medicaid, Catholic Charities, Arbor Housing, the Watkins Glen Housing Authority, libraries, the Food Bank of the Southern Tier, and school/facility/faith-based food pantries. Additionally, FLX Gateway provides resources to support small businesses and foster economic development in the county.

Gaps and Challenges

- Addressing poverty is complex and multi-faceted
- Lack of living wage year-round jobs
- Business challenges
  - Rural areas tend to be less attractive to large businesses/ employers
  - Local resistance to change or growth can limit business expansion
  - Small businesses often cannot afford to increase wages or hire more staff
  - Potential disconnect between workforce availability/skills and business needs
- Limited public transportation

Table 1

Indicator	Schuyler County Estimate	Schuyler County Change from Baseline	New York State Average
Population living in poverty (2023)	15.1%	+9%	13.7%
Population living in poverty age 65+ (2023)	8.9%	+75%	12.7%
Population living in poverty under age 18 (2023)	19%	-14%	19%
Population lacking adequate access to food (food insecurity) (2022)	14%	+17%	13%
Area Deprivation Index (1 least disadvantaged to 10 most disadvantaged)	8.9	-2%	5.5

Note: Red text indicates worsening trend, and green text indicates improving trend. Baseline year for poverty data is 2018. Baseline year data for Area Deprivation Index is 2015.
Data sources: US Census Bureau, 2019-2013 American Community Survey 5 Year Estimates; Kind AJH, Buckingham W: Making Neighborhood Disadvantage Metrics Accessible: The Neighborhood Atlas.

Domain: Social and Community Context

Priority: Suicide

Suicide impacts not just the individual, but families, schools, health care systems, and entire communities. Often suicide indicates deeper issues such as isolation, substance use, economic stress, or limited access to mental-health services.[1]

The suicide mortality rate in Schuyler County is 16 deaths per 100,00 people, which is double the New York State average (8 per 100,000). While the mortality estimate is unstable due a small number of deaths and small population size, additional indicators raise concern. Intentional self-harm emergency department visits are higher than the state average (779 compared to 343 per 100,000) and show an upward trend, suggesting an increased number of potential suicide attempts or severe mental health crises (Table 2).

[1] Source:https://www.cdc.gov/suicide/facts/index.html

Table 2

Indicator	Schuyler County Estimate	Schuyler County Change from Baseline	New York State Average
Suicide mortality rate per 100,000 adjusted age (2022)*	16	-20%	8
Suicide mortality rate per 100,000 among youth age 15-19 (2022)	0	0%	5.6
Intentional Self-Harm Emergency Department visit rate per 100,000 adjusted age-sex (2023)	779	+133%	343

Note: Red text indicates worsening trend, and green text indicates improving trend. Baseline year for suicide data is 2018. Baseline year for ED visit rates is 2017.
Data sources: County Health Rankings, National Center for Health Statistics Mortality Files: Suicides* | County Health Rankings & Roadmaps. NYSDOH SPARCS data 2017-2023, age-sex adjusted by Common Ground Health.
* Estimate is unstable

Priority: Primary Prevention, Substance Misuse, and Overdose Prevention

Primary prevention encompasses approaches to prevent substance misuse (improper substance use) and overdoses. Substances include alcohol, prescription medications, cannabis, and other substances like opioids and stimulants.

When not addressed, substance use, misuse, and overdose negatively impact residents' quality of life. Substance use and misuse contributes to the development of chronic diseases and places strain on the local health and emergency systems. Similarly, overdoses also stress these systems and can be fatal.

Issue Statement:

Substance use, including opioid use, is a significant concern in Schuyler County. Although recent estimates for overdose deaths may be unstable, **both drug-related and opioid-specific overdose death rates are higher** than the state averages (39.8 and 21.4 deaths per 100,000 respectively).

Long-term trends also show that these **rates are rising**. In addition, **emergency department visits** rates related to substance use (2,868 per 100,000) and **admissions for opioid treatment** (567.3per 100,000) **are above state averages and continue to rise.**

Who is Affected

- Youth and adults across all age groups
- Low-income residents face higher barriers to care and fewer alternatives to substance use
- Residents without access to transportation or positive social support networks
- Rural residents, where distance, stigma, and lack of services compound challenges

Contributing Factors

Data from the Community Status Assessment, Community Partners Assessment, Community Context Assessment, and Root Cause Analysis of the problem of poverty were used to identify the following contributing factors:

- Limited community gathering spaces for connection
- Limited accessible treatment/rehabilitation services
- Social stigma around substance use and treatment
- Shortage of prevention specialists
- Poverty can compound stress, limits access to care, increases transportation and housing challenges

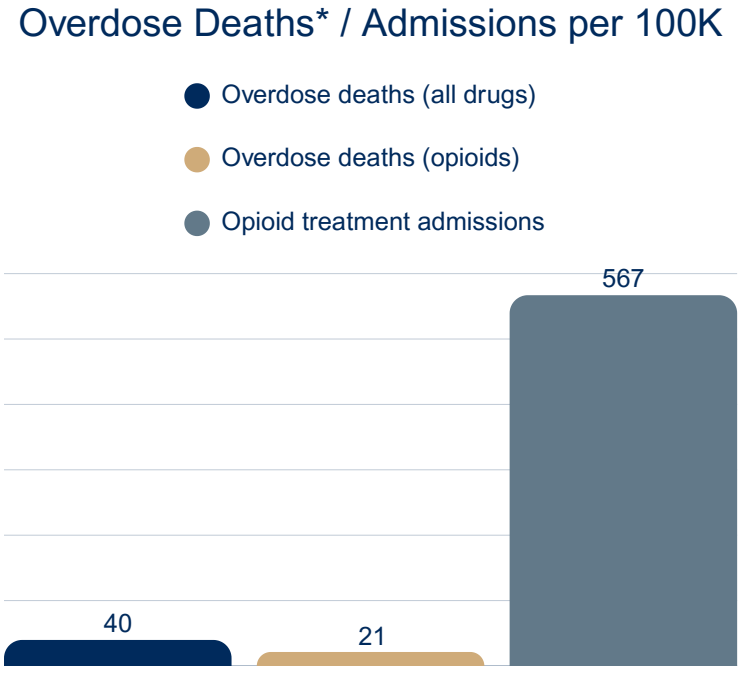
Community Assets and Opportunities

There is a strong community interest in addressing substance use. Several partners already work in this area, providing preventative or treatment services, including Centralus Health, Cornell Cooperative Extension of Schuyler County, Finger Lakes Community Health, Schuyler County Mental Health, Schuyler County Public Health, and Finger Lakes Area Counseling and Recovery Agency (FLACRA). Additionally, the Schuyler County Coalition on Under Drinking and Drugs (SCCUDD) focuses on preventing substance use among youth. Potential opportunities to expand services could focus on tele-prevention health and peer support services. The recent opioid settlement funds will also aid in Public Health's work on data collection.

Gaps and Challenges

- Limited number of providers and accessible treatment/rehabilitation services, which increases wait times for appointments
- Limited public transportation and rural isolation
- No consistent or substantial public health funding for prevention programs
- Services are often reactive (e.g., ER visits) rather than preventive, which can be exacerbated by the shortage of providers
- Social stigma around substance use

Figure 12



Vital Statistics Data: New York State Opioid Data Dashboard. Office of Addiction Services and Supports (OASAS). NYSDOH SPARCS data 2017-2023, age-sex adjusted by Common Ground Health. *estimates are unstable

Table 3

Indicator	Schuyler County Estimate	Schuyler County Change from Baseline	New York State Average
Overdose deaths from any drug per 100,000 adj age (2022)*	39.8	+3880%	31.3
Overdose deaths from any opioids per 100,000 adj age (2022)*	21.4	+2040%	21.0
Admissions for opioid treatment per 100,000 age 12+	567.3	+192%	456
Substance Use Disorder Emergency Department visit rate per 100,000 adj age-sex (2023)	2,868	+255%	1,646
Opioid Use Disorder Emergency Department visit rate per 100,000 adj age-sex (2023)	179	+14%	211
High school students using marijuana in past 30 days (2024)	6.7%	-63%	n/a
High school students using prescription drugs in past 30 days (2024)	2.5%	-70%	n/a

Note: Red text indicates worsening trend, and green text indicates improving trend. Baseline years for overdose deaths any drugs is 2013, and deaths any opioids and admission for opioids treatment is 2014. Baseline year for ED visit rates is 2017. Baseline year for youth marijuana and prescription use is 2013.
Data sources: Vital Statistics Data: New York State Opioid Data Dashboard. Office of Addiction Services and Supports (OASAS). NYSDOH SPARCS data 2017-2023, age-sex adjusted by Common Ground Health. Schuyler County Drug and Alcohol Youth Survey.
* Estimate is unstable

Priority: Adverse Childhood Experiences

Adverse childhood experiences (ACEs) include potentially traumatic events in childhood (before age 18) including neglect, abuse, and other challenges such as divorce, domestic violence, or living with caregivers with a mental illness or substance use disorder.

When not addressed, ACEs can negatively impact residents' quality of life. People that have experienced multiple ACEs are at an increased risk of chronic diseases, mental health issues, substance use, and other poor outcomes later in life. Together these conditions place strain on the local health and emergency systems.

In Schuyler County, adverse childhood experiences are a significant problem with nearly 50% of adults reporting two or more adverse childhood experiences. This is higher than the state average at 40.5%. The trend shows that ACEs have risen by 32% since 2016, highlighting the need for intervention early in life and continued supportive treatment and management along the life course.[2]

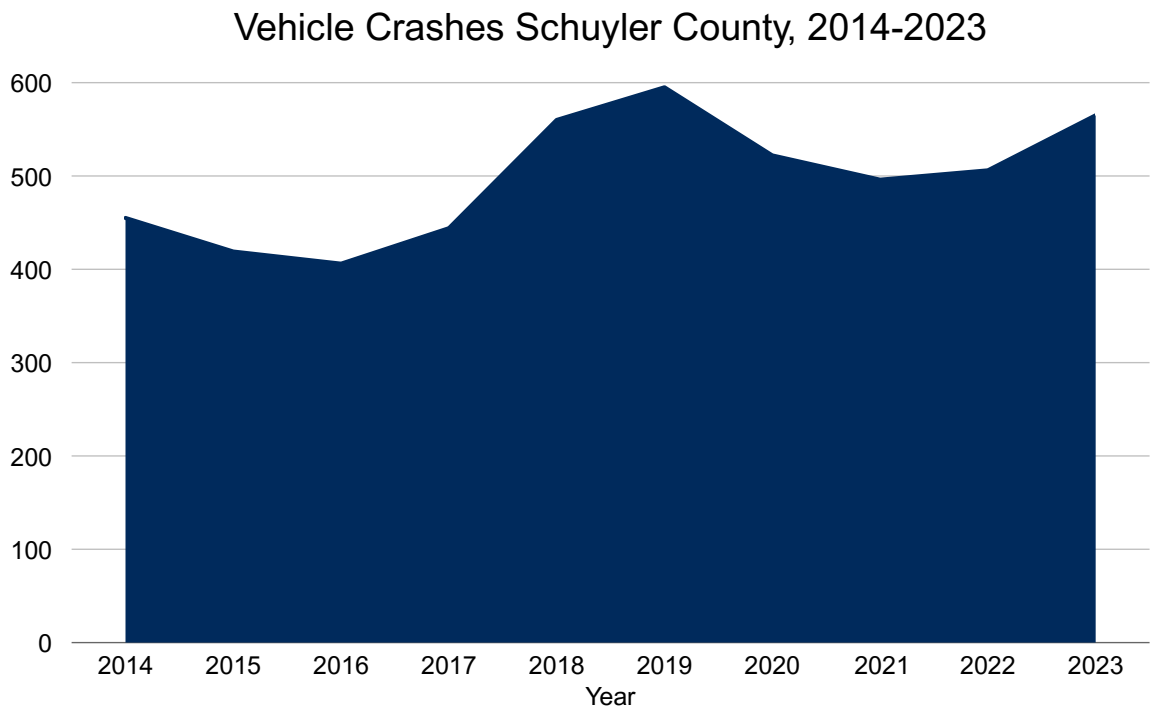
Domain: Neighborhood and Built Environment

Priority: Injuries and Violence

In Schuyler County, unintentional injuries are the fifth leading cause of death and include causes such as motor vehicle crashes, falls, and drug overdoses. These injuries and related harms are largely preventable. By addressing their underlying causes, the county can save lives, improve residents' quality of life, and reduce healthcare costs.

Figure 13 illustrates the increase in vehicle collisions between 2014 and 2023.

Figure 13



NYS Department of Motor Vehicles. Motor Vehicle Crashes - Case Information: Three Year Window. Last Updated November 10, 2025. https://data.ny.gov/Transportation/Motor-Vehicle-Crashes-Case-Information-Three-Year-/e8ky-4vqe/about_data

Table 4 shows that residents in Schuyler County face rising rates of injury-related deaths, with an unintentional injury death rate (66 deaths per 100,000) that exceeds the New York state average (54 deaths per 100,000). While motor vehicle crash deaths have declined to 9 per 100,000, one-third of motor vehicle deaths involve alcohol—a proportion that is rising and signaling the need for further intervention.

[2]Source: NYS Behavioral Risk Factor Surveillance System

Table 4

Indicator	Schuyler County Estimate	Schuyler County Change from Baseline	New York State Average
Unintentional injury death rate per 100,000 adj age (2022)	66.3	+46%	54.1
Unintentional injury death rate (death before age 75) per 100,000 adj age (2022)	62	+57%	46.9
Injury death rate per 100,000 adj age (2022)	65	+18%	60
Motor vehicle crash deaths per 100,000 adj age (2021)	9	-25%	6
Violent crime rate per 100,000 population (2022)	68.1	-17%	206.6
Percentage of driving deaths with alcohol involvement	33%	+230%	22%
Falls Emergency Department visit rate per 100,000 adj age-sex (2023)	3,664	-2%	2,008

Note: Red text indicates worsening trend, and green text indicates improving trend. Baseline year for unintentional injury death rates is 2015. Baseline year for injury deaths, motor vehicle crashes, and driving deaths is 2018. Baseline year for violent crime is 2015. Baseline year for ED visit rates is 2017.
Data sources: NYSDOH Vital statistics Unit: New York State Leading Causes of Death. County Health Rankings, National Center for Health Statistics-Mortality Files; Census Population Estimates Program: Injury Deaths | County Health Rankings & Roadmaps. County Health Rankings, National Center for Health Statistics-Mortality Files; Census Population Estimates Program: Motor Vehicle Crash Deaths* | County Health Rankings & Roadmaps. NYS Office of Justice Research and Performance: https://data.ny.gov/Public-Safety/Index-Violent-Property-and-Firearm-Rates-By-County/34dd-6g2j/about_data. County Health Rankings, Fatality Analysis Reporting System: Alcohol-Impaired Driving Deaths | County Health Rankings & Roadmaps. NYSDOH SPARCS data 2017-2023, age-sex adjusted by Common Ground Health.

Domain: Health Care Access and Quality

Pivital Public Health Partnership, in collaboration with the eight Finger Lakes local health departments, administered the Access to Care Survey between July and November 2024 to obtain primary, population-based data on access and barriers to care across the region. The survey, offered in multiple formats and languages, included questions on having a regular source of care, use of routine and preventive services, delays in care due to cost or transportation, experiences with behavioral health care, insurance status, and key demographic characteristics, and yielded more than 1,700 completed responses from residents of the eight counties.

Key findings from the survey showed that people in the eight counties still face problems when trying to get health care:

- Not enough providers: It is difficult for many people to find a doctor, dentist or mental health provider, especially in rural areas.
- Transportation issues: Many people do not have reliable ways to get to appointments, especially if they do not own a car or if they live far away from care.
- Insurance problems: People without insurance and those who have Medicaid often have a harder time getting care. They may have to wait longer or travel farther.
- Unequal access: Non-White, rural and Plain community (Amish/Mennonite) members face compounded barriers, with reduced routine/preventive care and higher rates of appointment access challenges.
- Community strength: People also shared many positive things, like strong local groups, caring volunteers, helpful nonprofit organizations, and local hospitals.

The report also identified emerging issues within the Finger Lakes region:

- Health care workforce shortages: Behavioral health, in particular, along with other health care workers are in demand. Rural communities have a difficult time attracting talent because of aging infrastructure and rate of pay.
- Telehealth expansion: While telehealth may be expanding in many areas of the country, limited broadband access makes its dissemination problematic in rural areas.
- Insurance policy changes: Impending cuts to Medicaid may impact access to care and increase out-of-pocket costs.
- Supplemental Nutrition Assistance Program (SNAP): Expected changes to eligibility may mean residents are forced to choose between food and medical care, including prescriptions.
- Integration of care: New models of care are being piloted in many areas but face funding and coordination challenges in the Finger Lakes region.
- Equity gaps: Mortality rates among minority populations are higher than other groups. Additionally, higher Medicaid-dependence is linked with higher food insecurity issues which impact overall health.
- Innovative care models: Social Care Networks and Urgent Care expansion will help to alleviate some rural health concerns and issues.

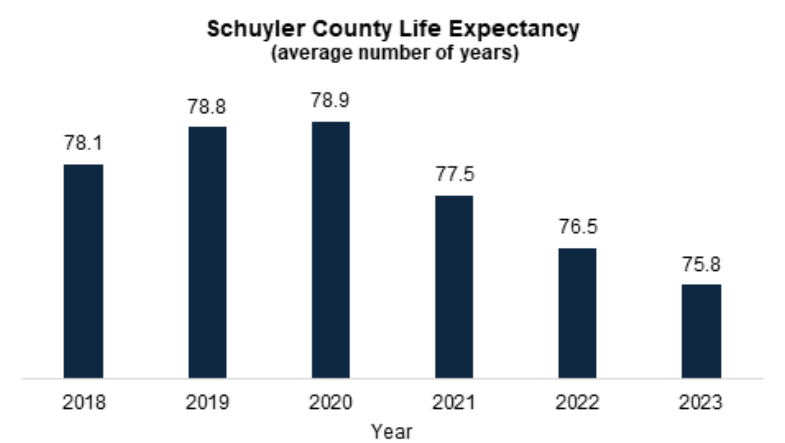
Priority: Preventive Services for Chronic Disease Prevention and Control

Chronic diseases – such as cardiovascular disease, cancer, diabetes, and lung diseases like chronic obstructive pulmonary disease – are linked to lifestyle factors like physical inactivity, poor diet, and smoking. These chronic conditions disproportionately impact rural communities. By addressing the root causes, we can reduce health disparities, improve quality of life, lower long-term healthcare costs, and promote healthier aging.

In Schuyler County, life expectancy has been declining with the average number of years one is expected to live falling to 75.8 years as of 2023.

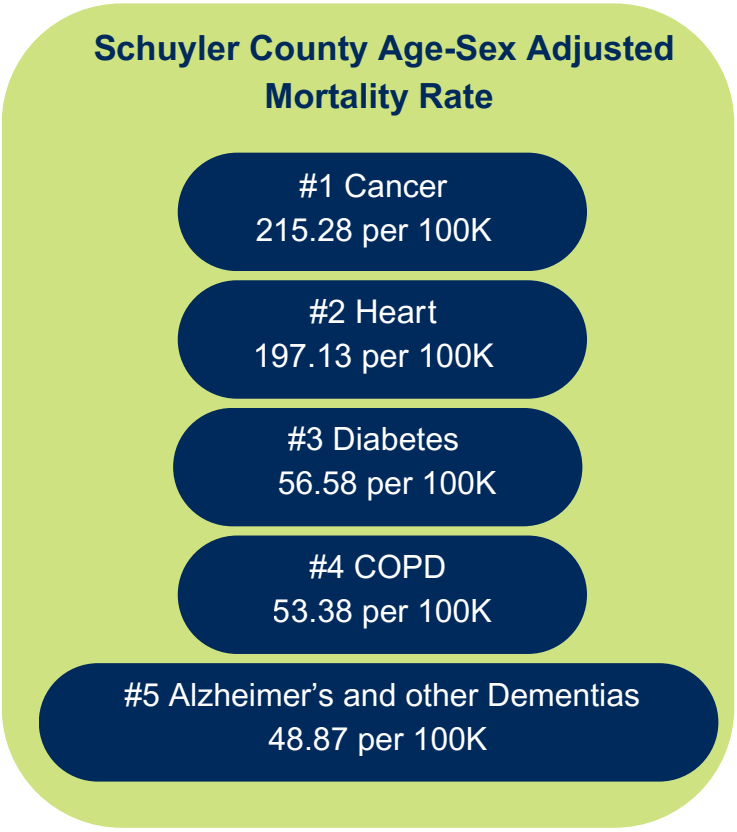
Chronic diseases account for the top five leading causes of death in Schuyler County (Figure 15).

Figure 14



County Health Rankings; National Center for Health Statistics Mortality Files. https://www.countyhealthrankings.org/health-data/population-health-and-well-being/length-of-life/life-span/life-expectancy?year=2025&county=36097

Figure 15



Source: NYS DOH Vital Statistics, 2022 .Analysis by Common Ground Health

Who is Affected

- Adults aged 40 and over, but many of the risk factors can start at younger ages
- Low-income residents face higher barriers to accessing healthcare
- Rural residents, where distance, social isolation, and lack of services compound challenges
- Residents with multiple chronic risk factors such as obesity, physical inactivity, and tobacco use

Issue Statement:
Adults aged 40 and over in Schuyler County experience **higher premature death, heart disease, and cancer death rates compared to New York State averages**. Data shows 420 premature deaths per 100,000, compared to 327 statewide; 66 heart disease deaths per 100,000 versus 55 statewide; and 123 cancer deaths per 100,000, versus 73. **The rates are not only elevated but continue to rise,** signaling a growing public health concern.

Contributing Factors

Data from the Community Status Assessment, Community Partners Assessment, Community Context Assessment, and Root Cause Analysis of the problem of rising chronic disease related deaths were used to identify the following contributing factors:

- Unhealthy diets and lifestyles
  - Limited awareness of chronic disease preventive strategies
  - Limited access to preventive services
- Shortage of providers
  - Underuse of preventive screenings and services
  - Financial/insurance barriers
- Limited public transportation
- Food insecurity and poor food access
  - Healthy foods are inaccessible and unaffordable
  - Food deserts exist, especially in rural areas
  - Limited time, knowledge, and facilities to prepare healthy meals which results in reliance on convenience foods
- Built environment, particularly in rural areas, is not conducive to year-round physical activity e.g. lack of sidewalks, gyms

Community Assets and Opportunities

There is community interest in improving preventive services for chronic disease prevention and control. Many partners already are involved in chronic disease prevention and control, including Centralus Health, Finger Lakes Community Health, Head Start, Pro Action, Schuyler County Public Health, Wilmot Cancer Institute, Southern Tier Tobacco Awareness Coalition (STTAC), Cornell Cooperative Extension, and the Arc of Chemung-Schuyler. Additionally, Public Health and other partners conduct outreach to promote chronic disease awareness and prevention. Warmer months also allow for easier outdoor physical activity, with local attractions like the Watkins Glen State Park, the Finger Lakes National Forest, the Finger Lakes Trail and other local walking trails.

Gaps and Challenges

- Lack of providers (especially specialists) and increased wait times for appointments and distance residents need to travel for care
- High cost and limited access to healthy foods, especially in food deserts/more rural areas
- Lack of time or knowledge to participate in healthful behaviors e.g. physical activity and preparing healthy meals
- Limited public transportation

Priority: Oral Health Care

Oral health is a key component of overall health and wellbeing. Common oral health conditions include dental cavities, gum disease, and tooth loss. Poor oral health can impact physical health and is linked to chronic diseases like heart disease, diabetes, and obesity. It also affects social connections and self-esteem.

Promoting good oral health can improve school attendance, support healthy aging, improve quality of life, and help reduce costly emergency dental treatments.

Who is Affected

- Oral health is important for all residents, with seniors being particularly vulnerable
- Medicaid enrollees, including low-income adults, children, and people with disabilities
- Rural residents, where distance, and lack of services compound challenges
- Uninsured or underinsured, who may not prioritize oral health

Issue Statement:
Dental visit rates are **improving** in Schuyler County, with nearly **60% of adults reporting a recent dental visit**; however, among **Medicaid enrollees dental utilization ranges from only 20 - 50%**, despite improving trends

Contributing Factors

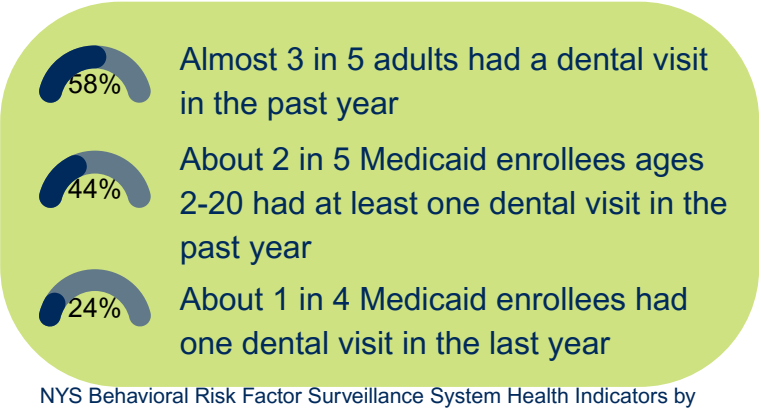
Data from the Community Status Assessment, Community Partners Assessment, Community Context Assessment, and Root Cause Analysis of the problem of rising chronic disease related deaths were used to identify the following contributing factors:

- Shortage of dental providers, especially providers that accept Medicaid
- Underfunding of oral health services in Medicaid means lower reimbursement rates for providers, and limited services are covered
- Limited public transportation affects residents who may need to travel out of the county for services
- Oral health is often not seen as part of overall health because of how the health system silos oral health and general healthcare
- Low health literacy on oral health

Community Assets and Opportunities

There is modest community interest in improving oral health care. Positive trends for dental visits suggest there may be growing awareness and demand for services. School-based dental hygiene programs provide on-site oral health services, and there are potential opportunities to explore mobile dental services and expanding outreach.

Figure 16



NYS Behavioral Risk Factor Surveillance System Health Indicators by County and Region, Recent Dental Visit, data 2019; NYS Medicaid Program, data October 2024.

Gaps and Challenges

- Few partners are involved in oral health care
- Lack of dental providers, increased wait times for appointments and distance residents need to travel
- Affordability of services, even with health insurance, is a challenge for residents
- Oral health is undervalued
- Limited public transportation

Table 5

Indicator	Schuyler County Estimate	Schuyler County Change from Baseline	New York State Average
Ratio of population to dentists (2022)	3,530:1	-21%	1,200:1
Medicaid enrollees with at least one preventive dental visit in the past year (2023)	15.7%	+5%	26%
Children (ages 2–20) in government-sponsored insurance with at least one dental visit (2022)	51%	+6%	55%
Medicaid enrollees (ages 2–20) with at least one preventive dental visit (2023)	36.5%	+40%	45.2%

Note: Red text indicates worsening trend, and green text indicates improving trend. Baseline year for dental health providers is 2019. Baseline year for dentist visits including Medicaid is 2014.Baseline year for child government sponsored visit is 2013.
Data sources: County Health Rankings, CMS, National Provider Identification, data 2023: Mental Health Providers | County Health Rankings & Roadmaps. NYS Behavioral Risk Factor Surveillance System Indicators by County and Region, Recent Dental Visit, data 2019. NYS Medicaid Program, data October 2024. NYS Medicaid Program and Child Health Plus, data October 2024.

Priority: Healthy Children Preventive Services

Immunizations protect children from serious communicable diseases like measles, tetanus, and whooping cough, many of which can cause severe illness or even death. Health screenings help detect potential issues early, allowing for timely treatment and improved outcomes.

These preventative measures not only keep children healthy but also help protect the wider community. They support children's school readiness, reduce healthcare costs, and contribute to long-term wellbeing.

Issue Statement:

Although progress on **childhood and adolescent immunizations** and children's **lead screening** in Schuyler County is encouraging, **completion rates remain below New York State averages**. Data shows 61% of children in the county completed the full immunization series compared to 71% statewide. HPV vaccination rates are lower with 25% of adolescents completing the series compared to 37% statewide. Lead screening rates for 1 and 2 year olds have improved to 64%.

Who is Affected

- Infants and young children under age 5
- School aged children and adolescents
- Families in rural or isolated areas where public transportation and access to care is more limited e.g. in some parts of Tyrone, there are pockets with low vaccine completion rates.
- Mennonite families that may be reluctant to vaccinate due to beliefs
- Caregivers with low health literacy, exposure to health misinformation, or mistrust of healthcare system

Contributing Factors

Data from the Community Status Assessment, Community Partners Assessment, Community Context Assessment, and Root Cause Analysis of the problem of poverty were used to identify the following contributing factors:

- Low health literacy, vaccine misinformation, personal beliefs, distrust of public health and medicine
- Limited access or ineffective communications from trusted community members
- Missed opportunities at child wellness visits for lead screening
- Lack of awareness about the risks of lead exposure and environmental sources
- Substandard housing conditions
- Limited options for pediatric care

Community Assets and Opportunities

Community interest exists for improving preventive services for healthy children. Several partners already support and/or provide preventive services, including Centralus Health, Finger Lakes Community Health, Head Start, Pro Action, and Schuyler County Public

Health. School and daycare requirements encourage vaccine compliance. Public Health conducts outreach and education around immunizations and provides immunizations to those who are uninsured or underinsured, including the Mennonite population.

Gaps and Challenges

- Lack of providers and increased wait times for appointments
- Inconsistent messaging from healthcare providers
- Vaccine hesitancy fueled by misinformation and politicization
- Limited visibility or awareness of lead as a public health risk
- Limited public transportation

Table 6

Indicator	Schuyler County Estimate	Schuyler County Change from Baseline	New York State Average
Children with full 4:3:1:3:3:1:4 immunization series (2025)	61.4%	+20%	71%
Adolescents age 13 with complete HPV series (2025)	25%	+91%	37%
Children age 1 with a lead screening (2024)	64.9%	+27%	
Children age 2 with a lead screening (2024)	964.1%	+17%	

Note: Red text indicates worsening trend, and green text indicates improving trend. Baseline year for is 2017.
Data sources: New York State Immunization Information System (NYSIIS)

Community Service Plan

The 2025-2030 New York State Prevention Agenda is the State Health Improvement Plan, a six-year initiative aimed at improving health and reducing health disparities among New York residents. It serves as a blueprint for improving population health by setting state-level goals, priorities, and evidence-based strategies. This iteration of the Prevention Agenda focuses on addressing the root causes of disparities by adopting the Healthy People 2030 SDOH framework.

Growing out of our collaboration with Schuyler County Public Health, Tompkins County Whole Health, and Cornell Public Health to conduct an assessment of community health needs and assets, and aligning with the New York State Prevention Agenda, our three-year implementation plan, also known as our Community Service Plan, focuses on economic stability by addressing food security and poverty; social and community context by addressing substance misuse; and health care access and quality through preventative services for chronic disease prevention and control.

Economic Stability: Programs, Progress, and Plans

Nutrition Security & Poverty

Consistent access to affordable, healthy food is an important factor in reducing hunger and preventing chronic disease, especially for vulnerable populations at high risk for nutrition-related health disparities. Food insecurity disproportionately impacts low-income families, children, seniors, single parents (especially mothers), people with disabilities, and Black and Hispanic/Latino households due to systemic factors like poverty, unemployment, high living costs, and structural inequities. To address food insecurity, the Prevention Agenda details evidence-based strategies that address systems, policies, and structural barriers to accessing healthy food such as expanding food access points, increasing child and adult enrollment in government nutrition programs, and championing innovative practices, such as produce prescription programs.

New York State's Prevention Agenda explicitly encourages hospitals, local health departments, and community-based organizations to shape their policies and programs to reach and support families and individuals living in poverty. Since many programs to address poverty are embedded in communities, the guidance recommends improving public awareness of existing programs and building upon existing public health infrastructure to address the negative health impacts associated with poverty.[2]

Screening & Referrals for Health-Related Social Needs

To address nutrition security and increase uptake of programs that address poverty, Cayuga Health continues to expand and improve its systems, policies, partnerships, and practices to screen patients for unmet social needs and facilitate referrals to the most appropriate local resources. In 2021, Cayuga Health initiated a social needs screening and referral pilot program with one primary care practice. Now, there are thirteen primary care practices screening patients for health- related social needs and connecting patients with unmet needs to resource navigators. With funding from the New York State Department of Health, Cayuga Health is partnering with the Human Services Coalition to develop and support a network of local organizations that can receive and respond to social care referrals using a secure, digital platform. Cayuga Health also partners with Cornell Cooperative Extension Tompkins County to train and supervise undergraduate students as resource navigators. This partnership is a powerful way to invest in the diversity of the future healthcare workforce by building the skills of future healthcare leaders from communities underrepresented in medicine.

Food as Health - Healthcare as an Access Point for Food and Addressing Food Inequity

To spark cultural change and promote food as a key facet of healthcare, Cayuga Health launched a dual initiative throughout 2024 and 2025 consisting of 1) Community Cupboards and 2) Home-delivered Produce Boxes. Born from the concept of a "Food Farmacy," this program was launched with the help of a $300,000 award from the Cornell University FIG Lab DINNERS in NY project (Developing Integrated Networks for a Nutritious, Equitable, Resilient Food System in New York). Funded by the USDA Local Food Procurement Assistance program, through the New York Food for New York Families sub-award with NYS Department of Agriculture and Markets, DINNERS in NY aimed to increase the distribution of NYS grown, nutrient-dense agricultural products to food insecure residents by engaging with community-based nonprofits, institutional feeding programs and small to mid-sized farms. Through this collaboration with Cornell, Cayuga Health was able to partner with local farms and food producers to stock the Community Cupboards and deliver Produce Boxes, serving to strengthen the local farm economy while improving community food security.

[2] NYS Prevention Agenda 2025-2030, Economic Stability

The Community Cupboards were strategically placed at three highly-trafficked Cayuga Health clinic locations: Ithaca Mall, Cayuga Park, and Schuyler Hospital. On a regular schedule, fridges and shelves were stocked with fresh produce and pantry staples available for patients, staff and loved ones to take, no questions asked. One grant-funded staff member and a team of volunteers worked diligently to maintain fridge temperatures, stock and label the food, answer questions and promote the local farms. With the conclusion of grant funding, and looking to 2026 and beyond, the YMCA of Ithaca & Tompkins County will serve as the next stewards of the Community Cupboards, aligning their own mission and efforts to address food insecurity.

Staff, farmers and volunteers were all key to the success of the Community Cupboards.

The home-delivered produce boxes were a more targeted approach to providing fresh, nutritious food to those with difficulty accessing it. When a patient reported on the social needs screening form that they were experiencing food insecurity, they were connected with resource navigators to set them up with home-delivered produce boxes, as well as other resources to aid in long-term food access. By delivering food to the home, and discussing food with the patient behind closed doors or over the phone, this initiative aimed to address issues of unreliable transportation, food deserts, and stigma/shame surrounding food insecurity. The results were encouraging: patient survey responses throughout the program highlighted the different ways they benefited from the produce boxes.

Patients described financial, social, and health benefits of receiving the Food Boxes.

After receiving one last injection of funding from Excellus BCBS to close out the 2025 growing season, the produce boxes are now supported through New York State's Medicaid 1115 waiver. The 1115 waiver launched regional Social Care Networks that contract with community-based organizations to provide enhanced services, including food prescriptions, to Medicaid Managed Care members. When a Medicaid Managed Care member is screened for food insecurity in an inpatient or primary care setting, they are connected with a resource navigator to determine whether and which enhanced nutrition services they would be eligible to receive. There are two local organizations, Rural Health Network of South Central NY and the YMCA of Ithaca & Tompkins County that our resource navigators can connect Medicaid Managed Care members to receive food prescriptions (dairy, produce, meat, grains and spices) in the form of nutrition vouchers or food boxes.

Community Dining

Building on a shared commitment to health equity and improving the social determinants of health for older adults, in 2025 Cayuga Health initiated a new partnership with Foodnet Meals on Wheels to expand access to nutritious meals and community connection for older adults in Tompkins County. Community Dining lunches are now served weekly at Cayuga Health's location at The Shops at Ithaca Mall, offering a welcoming environment where older adults can access healthy food, meaningful conversation, and critical health resources close to home.

Foodnet Meals on Wheels is the only local organization that prepares and delivers hot meals directly to clients in Tompkins County. Foodnet operates the Senior Nutrition Program, which includes the Community Dining program, under a contract from the Tompkins County Office for

the Aging (COFA). This latest expansion of the long-standing Community Dining program creates a new, accessible option in the Lansing area and is made possible through support from Cayuga Health.

The lunch is open to anyone aged 60 or older, but advance registration is required. Each hot, freshly prepared meal is designed by a Registered Dietitian to provide at least one-third of the daily nutritional requirements for an older adult. Meals include 2% milk, with skim and Lactaid options available upon request. There is no charge for eligible participants, though voluntary and confidential contributions are welcomed to support program sustainability. In addition to meals, Community Dining events often feature educational sessions on topics like nutrition, scam awareness, and preventive health. The new Ithaca Mall location extends COFA's 50-year tradition of providing nutritious meals and social support to older adults in Tompkins County.

Social & Community Context: Programs, Progress, and Plans

Primary Prevention, Substance Misuse, and Overdose Prevention

In 2023, Cayuga Health affiliated with Cayuga Addiction Recovery Services. The affiliation was a first step in connecting services within Cayuga Health with those offered by Cayuga Addiction Recovery Services and adding additional complementary services to fully address the needs of the individuals with substance use disorder and/or behavioral health challenges. The affiliation aims to improve access to the full continuum of care for any individual in need and establish accountability for reaching community health goals that are otherwise impossible under a highly fragmented system of disparate organizations.

Intensive Crisis Stabilization Center

To address a critical gap in behavioral healthcare, Cayuga Addiction Recovery Services, in affiliation with Cayuga Health, will open an Intensive Crisis Stabilization Center in Tompkins County in 2026. Outside of Cayuga Medical Center's emergency department, Tompkins County currently lacks a safe, therapeutic environment with 24/7 clinical support for people experiencing mental health and substance use-related crises. Primary pathways for individuals in crisis include the emergency department, jail, temporary shelter, or remaining home or unhoused and potentially unsafe. These settings are often unable to provide the right level of care to stabilize behavioral health crises, leaving schools, law enforcement, treatment providers, and families with impossible decisions and delays in care that can result in the further escalation of preventable crises. Intensive Crisis Stabilization Centers fill this substantial gap by providing urgent treatment to people experiencing acute mental health or substance use crises, diverting them from more restrictive settings when possible.

At the Intensive Crisis Stabilization Center, people of all ages from Tompkins County and the surrounding counties will be able to receive voluntary, short-term, and urgent behavioral health services 24/7 in a safe, therapeutic, and non-restrictive environment. The center will also function as an integral part of a comprehensive crisis response system, enabling Cayuga Addiction Recovery Services, Cayuga Health, and a network of community partners to collaboratively enhance the local continuum of care and demonstrably reduce behavioral health disparities and challenges in our community.

Crisis stabilization services will be provided for up to 24 hours in a welcoming, non-threatening, non-stigmatizing setting, by a highly trained multidisciplinary team including medical and psychiatric providers, nurses, behavioral health clinicians and peer support specialists. This team will rapidly triage and assess acute crisis symptoms and provide clinically appropriate and least restrictive interventions, including but not limited to psychosocial assessments and psychiatric diagnostic evaluations, crisis counseling and education, medication administration and monitoring, medication assisted treatement, management of mild-to-moderate withdrawal and intoxication symptoms, ongoing observation, peer support services, and case management.

The Intensive Crisis Stabilization Center, jointly licensed by the New York State Office of Mental Health and Office of Addiction Services and Supports, will be co-located with both Medically Supervised Withdrawal and Residential Stabilization services, offering a “no wrong door” entry and ensuring seamless patient transitions between services as appropriate. Staff will also collaborate with patients, families, and community partners to develop clear plans for smooth transitions to the next appropriate level of care and/or community resources for ongoing support, including referrals to Cayuga Addiction Recovery Services’ existing residential rehabilitation and comprehensive outpatient substance use treatment programs.

Medically Supervised Withdrawal & Stabilization Center

In 2024, Cayuga Addiction Recovery Services applied for and was awarded $600,000 in annual state aid from the New York State Office of Addiction Services and Supports to operate a Withdrawal and Stabilization Center providing Medically Supervised Withdrawal inpatient services and Residential Stabilization services. This 40-bed facility is anticipated to open in 2026, and will operate 24 hours per day, 7 days a week, with the primary goals of treating moderate withdrawal symptoms and non-acute physical or psychiatric complications as well as providing a safe environment for the subsequent stabilization of withdrawal symptoms before transitioning to another level of care.

Access to Evidence-Based Treatment for Substance Use Disorders

Cayuga Addiction Recovery Services offers several critical licensed services to individuals diagnosed with substance use disorder and provides access to FDA-approved medications for opioid use disorder, such as buprenorphine and methadone. Cayuga Addiction Recovery Services' OASAS-certified residential rehabilitation program in Trumansburg, NY serves up to 60 adult males with substance use disorder and co-occurring mental health disorders. The residential unit offers individual, group and family therapy sessions, 12-step recovery meetings, medical evaluations and care, vocational counseling services, medications for opioid use disorder (MOUD), and mental health services, including cognitive behavioral therapy, dialectical behavior therapy, LGBTQ+ support therapy, and trauma therapy. The unit supports individualized pathways to recovery and helps individuals, especially those new to recovery, learn relapse prevention strategies that work for them.

Cayuga Addiction Recovery Services' Outpatient and Opioid Treatment Programs (OP/OPT) are CARF-accredited (CARF is an independent, nonprofit accreditor of health and human service providers) and are located in Ithaca and Cortland, NY. The Cortland location currently offers OTP services to 85 patients, with OP services scheduled to begin in March 2026. The OP/OTP programs offer assessments, individual, group and family sessions, peer services, medication management, Hepatitis C treatment, and acute medical care. Patients with opioid use disorder can receive MOUD, including buprenorphine, daily methadone dosing, and case management services. The OP offers walk-in or "on-demand" services including substance use disorder assessments, crisis counseling services, and case management. The Ithaca OTP serves over 150 patients, 2 state correctional facilities, and 5 county jails.

Healthcare Access & Quality: Programs, Progress, and Plans

Preventative Services for Chronic Disease Prevention and Control

Many people across New York State live with more than one chronic disease. Chronic diseases such as heart disease, stroke, cancer, chronic obstructive pulmonary disease, diabetes, and obesity are the leading causes of disability and death in New York State and substantially reduce one's overall quality of life. Social and structural inequities disproportionately impact people from groups that experience discrimination and bias. In NYS, the prevalence of high blood pressure is also considerably higher among Black non-Hispanic adults (37.7%) and American Indian or Alaskan Native non-Hispanic adults (41.3%) when compared to White non-Hispanic adults (31.3%). White non-Hispanic individuals are more likely to be diagnosed with cancer, but their Black non-Hispanic counterparts are more likely to die. Asthma morbidity and mortality rates among Black non-Hispanic and Hispanic communities remain consistently higher when

compared to other racial and ethnic populations. In 2021, asthma emergency department visit rates for Black non-Hispanic children aged 0-17 (160.2 per 10,000) were 5 times higher than White non-Hispanic children (18.1 per 10,000). The prevalence of diabetes and obesity among Black non-Hispanic and Hispanic adults is also greater.[3]

Early screening and detection, the promotion of self-management skills, and increased access to providers and referral services can largely impact the incidence and severity of chronic diseases. To improve overall quality of life and reduce health inequities, the New York State Prevention Agenda encourages hospitals, local health departments, and community-based organizations to work collaboratively to promote access to evidence-based prevention and management. By introducing and promoting evidence-based policies, practices, and interventions; and prioritizing people from groups that experience discrimination and bias, Cayuga Health can assist with dismantling systemic barriers and allowing all people to achieve optimal health.[3]

Community-Based Health Screening, Risk Assessment, and Navigation

In response to the community-identified needs, in 2021 Cayuga Health initiated a coalition of local organizations including Tompkins County Whole Health, Cornell Public Health and the Center for Health Equity, Cancer Resource Center of the Finger Lakes, Cortland County Public Health, Food Bank of the Southern Tier, the Human Services Coalition, Cornell Cooperative Extension Tompkins County, and the YMCA of Ithaca & Tompkins County to offer health screening, risk assessment, and health and social care navigation in places where people live, work, play and pray. Community leaders have graciously welcomed us into their spaces including food pantries, soup kitchens, gardens, recreation centers, schools, and community celebrations.

Over a 4-year period, employees and volunteers from the coalition participated in over 80 events and engaged with thousands of community members about their health. Based on the availability of health and social care providers at each event, we offered point of care blood glucose testing, COVID vaccines, pre-diabetes risk assessments, blood pressure screening, cancer screening guidance and survivorship support, primary care and endocrinology appointment scheduling, health insurance, housing, and transportation navigation, and community food and nutrition resources.

Our implementation strategy for 2026-2028 builds upon the relationships and trust developed through these events. We aim to increase the number of events that offer pre-diabetes risk assessment, blood pressure screening, primary care scheduling, and referrals to the YMCA's evidence-based health initiatives. These include the National Diabetes Prevention Program,

[3] NYS Prevention Agenda 2025-2030, Healthcare Access and Quality

LiveStrong for adult cancer survivors, and a blood pressure self-monitoring program. We also aim to expand these activities to include Schuyler County, and create and distribute a guide for chronic disease prevention and self-management resources.

Community Partnership-Building

In May 2025, the Cornell Center for Health Equity and the Cayuga Center for Health Equity Transformation co-hosted a half-day event with 50 local leaders to envision new and innovative ways to understand and address the root causes of health inequities. Participants were selected to ensure a diversity of expertise and spheres of influence in the room. There were 15 Cornell faculty and staff, 14 healthcare and population health practitioners from Cayuga Health and Reach Medical, and 23 leaders from community-based organizations and local health departments. The event was structured to help form and prepare teams to develop proposals that establish or strengthen partnerships that enable meaningful involvement of community stakeholders in data-driven research, policy-making, practice, advocacy, or education to advance health equity.

To support data-driven proposals, the event included a data walk with 48 posters that offered a mix of publicly available county-level data, electronic medical record data from Cayuga Health Partners, and needs assessment data from Tompkins County Whole Health and the Rural Health Institute of NY, stratified by county, race, ethnicity, and social needs wherever possible. Each data station invited participants to consider the gaps and disparities revealed by the data and opportunities for collaboration. Participants synthesized the comments to identify community health priorities, then voted on their top priorities. Teams came together around topics of mutual interest and discussed how they might work together to use and improve local data to understand the sources of health inequities and how to overcome them.

Access to Care

Financial Assistance

The Financial Assistance Policy of Cayuga Health, which includes Cayuga Medical Center, Schuyler Hospital, Cayuga Medical Associates, Cayuga Addition Recovery Services, Cayuga Health Transport, and Visiting Nurse Services is available to a patient who are uninsured and/or underinsured with a demonstrated inability to pay. Financial assistance applies to medical necessary services that are provided and billed by the entities above including emergency room care. If a patient is having trouble paying their medical bill, they may qualify for a discount. Patients are encouraged to complete and submit a financial assistance application, which are available in registration areas, online at Cayugahealth.org, or by calling 607-274-4400.

Generally, uninsured and underinsured patients may be eligible for full financial assistance when their family household income is less than 200% of the Federal Poverty Level ("FPL"). Patients with household income greater than 200% but less than or equal to 400% of FPL may be eligible for discounted care.

Federal Poverty Level	Discount Amount
Below 200% FPL	Waive all charges
200% - 300% FPL	**Uninsured patients**: Sliding scale up to 10% of the amount that would have been paid for the services(s) by Medicaid. **Underinsured patients:** Up to a maximum of 10% of the amount that would have been paid pursuant to such patient's insurance cost sharing.
301% - 400% FPL	**Uninsured patients**: Sliding scale up to 20% of the amount that would have been paid for the services(s) by Medicaid. **Underinsured patients:** Up to a maximum of 20% of the amount that would have been paid pursuant to such patient's insurance cost sharing.

All applicants will receive a written approval or denial information including appeal instructions within 30 days of receipt of a completed application.

Language Access

Cayuga Health is committed to providing equitable, patient centered care and effective communication by ensuring that no patient, family member, visitor, or guest is excluded or discriminated against due to language or communication needs. To support this commitment, Cayuga Health updated its Language Access Policy, enhanced staff training, and identified a new language service provider to better meet patient needs across the health system.

The updated policy aligns with Cayuga Health's mission and values and complies with applicable federal and New York State regulations, including federal and state nondiscrimination requirements and Culturally and Linguistically Appropriate Standards. We provide language access services free of charge for patients, their family members, and visitors so that patients are able to actively participate in and understand their healthcare.

In 2025, our efforts to improve language access through a multidisciplinary process with an advisory committee that included key organizational stakeholders, patient representatives, and community members, reflecting a shared commitment to equitable access to care. Based on this process and patient and staff feedback, Cayuga Health identified a new language access services vendor to improve service quality and accessibility. The new vendor provides faster access to interpreters, expanded language coverage, improved electronic health record integration, and a modern web-based and mobile enabled platform. These enhancements strengthen Cayuga Health's ability to provide consistent, reliable, and compliant language services to ensure access to high quality healthcare for all.