Name of County - Organization(s): Tompkins County Whole Health (formerly Tompkins Health Department), Cayuga Health, a member of Cayuga Health
2024 Workplan
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Priority	**Focus Area**	**Goal Focus Area**	**Objectives**	**Disparities**	**Interventions**	**Family of Measures**	**Completed Year 1 Intervention(s)**	**Completed Year 2 Intervention(s)**	**Projected (or completed) Year 3 Intervention**	**Implementation Partner**	**Partner Role(s) and Resources**
Promote Healthy Women, Infants and Children	Focus Area 2: Perinatal and Infant Health	Goal 2.1: Reduce infant mortality and morbidity	Objective 2.1.2: Decrease the percentage of births that are preterm by 5% to 8.3 percent of live births. (adjust rates as needed)	Poverty - low-income, geographic, racial/ethnic, insurance status	2.1.2: Increase capacity and competencies of local maternal and infant home visiting programs	Participation rates in PICHC, MOMS Plus+, Child Development Council, infant mortality and morbidity rates	Planned a Perinatal and Infant Working Group to provide advisory and oversight support for the Perinatal and Infant Community Health Collaboratives (PICHC) Initiative in Tompkins County. Trained and planned for Community Health Workers (4 CHWs) to provide support through home visits to improve outcomes for perinatal and infant health. Redesigned the Tompkins County MOMS Plus+ program resulting in increased capacity to deliver maternal child health supportive services to residents of Tompkins County regardless of insurance status, with a focus on providing equitable access to care.	Cayuga Birthplace has recently hired a Lactation Education Coordinator that is working to standardize and improve lactation education in the birthplace and after discharge. TCWH and HSC have collaborated on forming a **Community Advisory Board** to evaluate and improve upon the PICHC program. The **Perinatal and Infant Working group** consists of 18 organizations collaborating on oversight for the PICHC Initiative.	The MOMS Plus program, which provides nurse prenatal and postpartum home visits conducted **567 MOMS home visits, and 214 enrolled clients**. PICHC (HiP Tompkins) Community Health Workers conducted **115 home visits** YTD served **62 enrolled clients** in 2024 who worked with Community Health Workers. A new name was developed for the local PICHC program, Healthy Infants Partnership (HiP Tompkins). The Community Action Board (CAB) engaged **8 individuals** who have lived experience giving birth and raising young children in Tompkins County. Four of the community members are participating regularly in CAB meetings and activities. As a project of the CAB, in partnership with Dr. Nia Nunn, TCWH hosted a **Sister Circle with Black women in April 2024 as part of Black Maternal Health Week**. The women shared birth stories and experiences. The CAB continues to meet to plan other Sister Circles and promote doula training for women of color in our community. Participants enrolled in the Child Development Council's Family Services program receive at least one visit per month. Frequency of visits is based on need but occurs at least monthly. In the period of January- October 2024, **87 individuals** have participated in Family Services in Tompkins County, receiving a total of **764 home visits**.	Community-based organizations	Partners in the working group will include: TCWH, Community Based Organization, Hospital and Healthcare Providers (including maternal and child health providers), School Districts, other Local Government and other stakeholders. Working group will advise and assist Local Health Department in delivering PICHC and MOMS Plus+ services. Leading partners will include TCWH, Human Services Coalition (CBO, working group facilitator), Cornell Cooperative Extension (key CBO partner), Child Development Council, and clinical providers including OBGYN Associates and Planned Parenthood, among others.

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Promote Healthy Women, Infants and Children	Focus Area 4: Cross Cutting Healthy Women, Infants, and Children	Goal 4.1 : Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations	By 2024: Reduce disparities in health care access for maternal and child health populations. Reduce disparities in health outcomes for maternal and child health populations.	Poverty - low-income, geographic, racial/ethnic, insurance status	4.1: Enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families across the life course.	Number of partners with TCWH PICHC and MOMS Plus+ Programs, maternal and child **insurance rates, Child Health Plus enrollment rates** as percent of eligibility	Cayuga Health and Human Services Coalition engaged with key partners to emphasize insurance enrollment, supports for birthing families, and parenting skills. Completed "We Ask Because We Care" campaign, increasing demographic data collection at Cayuga Medical Center and 42 outpatient practices, improving Cayuga Health's ability to identify and address disparities (including in maternal and child health outcomes as cited above).	ADC prioritizes treatment of pregnant people in accessing services. CHP actively works with HSC by **referring patients** to them **for health insurance** enrollment support. The YMCA offers scholarship opportunities for programs and services to ensure that anyone that could benefit from our services can **access** them. These scholarships provide families in Tompkins County access to childcare, summer camp, and youth and family programs. The Village provides resources to combat disparities, including transportation to medical appointments, clothing from community closet, and childcare resources. **HSC facilitates health insurance** enrollment, specifically through Medicaid and Child Health Plus.	Through HSC, **800 people were assisted by health insurance navigators** as of 11/2024. REACH offers **family and partnering counseling**. REACH offers weekly groups to patients, families, and 2 groups within Arthaus and Asteri per week. REACH hosts monthly multi-disciplinary meetings for other community based organizations attend to collaborate care and efforts. Outreach workers have contracts with organizations, shelters and permanent supportive housing spaces across the community. The LEAD department works directly with Ithaca Police Department and the Sheriff's Office to facilitate referrals and warm hand offs for people who are in need of social and health services but having high police contact. REACH community health worker staff continues expanding to better serve the community. We are working directly with the City of Ithaca to provide permanent in person support in the Commons area as well. The YMCA offers scholarship opportunities for programs and services to ensure that anyone that could benefit from our services can access them. These scholarships provide families in Tompkins County access to childcare, summer camp, and youth and family programs. **175 scholarships** were offered this year (unit = membership type, a unit could be a single adult/child, a couple, or a family of 6+). The Y provides adaptive programming for children with developmental disabilities (swim, sports, etc.), 68 children participated this year. CCE Student Resource Navigators received **197 referrals** for positive social needs screens. CCE is part of the first cohort of the Community Health & Resource	Community-based organizations	Partners in the working group will include: TCWH, Community Based Organization, Hospital and Healthcare Providers (including maternal and child health providers), School Districts, other Local Government and other stakeholders. Working group will advise and assist Local Health Department in delivering PICHC and MOMS Plus+ services. Leading partners will include TCWH, Human Services Coalition (CBO, working group facilitator), Cornell Cooperative Extension (key CBO partner), Child Development Council, and clinical providers including OBGYN Associates and Planned Parenthood, among others.

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									Network launching in 2025, which will make it much easier for health and social care providers to share information and initiate closed-loop referral to each other. The infrastructure being built through the 1115 waiver demonstration and CH&RN will both have huge impacts on our strategies to address health-related social needs in 2025. Much of 2024 has been spent preparing for those changes. The Child Development Council partners with many community organizations to help meet the needs of families enrolled in the Council's Family Services program, with social determinants of health at the forefront. The Council team attends various community meetings, invites representatives from community agencies in to share information about services offered and opportunities for collaboration, and offers enrolled families referrals and warm handoffs to the community resources and organizations that can help meet their needs. The Council's approach for all families is individualized based on their unique needs and goals and is one that is multigenerational. Welcome Little One is a free, preparing-for-baby series for first time caregivers, whether by birth, adoption, foster, kinship care, or surrogacy- all are welcome! The 4-part series offers hands-on activities to help welcome baby with confidence and competence. The series is held four times per year; spots are limited and registration is required.		