Community Health Assessment 2022-2024

Community Health Improvement Plan 2022-2024

Tompkins County Whole Health
Cayuga Medical Center, a member of Cayuga Health
Ithaca, New York
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Tompkins County Community Health Improvement Plan, 2022-2024

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

IDENTIFICATION OF PREVENTION AGENDA PRIORITIES

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

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

Disparities and Health Equity

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

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

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

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

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

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

Process and Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHIP Intervention Working Groups

Food Insecurity Screening / Social Determinants of Health Working Group

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

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

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

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

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

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

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

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

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

Cancer Screening

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

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

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

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

Prenatal Care

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

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

School-Based Health

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

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

GOALS, OBJECTIVES, AND INTERVENTION STRATEGIES AND ACTIVITIES

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

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

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

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

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

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

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

PREVENT CHRONIC DISEASE

Focus Area 1: Healthy Eating and Food Security

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

Goal 1.3: Increase Food Security

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

Prevention Agenda (PA) interventions:

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

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

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

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

Focus Area 4: Chronic Disease Preventive Care and Management

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

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

Goal 4.1: Increase cancer screening rates

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

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

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

PA interventions include:

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

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

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

Performance will be monitored with following measures:

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

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

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

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

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

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

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

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

PA interventions include:

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

More specifically, Tompkins CHIP partners will do the following:

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

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

PROMOTE WELL-BEING AND PREVENT SUBSTANCE USE DISORDERS

Focus Area 1: Promote Well-Being

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

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

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

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

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

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

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

Associated Activities:

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

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

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

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

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

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

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

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

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

Tompkins CHIP partners will do the following:

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

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

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

1.2.2 Implement Mental Health First Aid

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

PA intervention: 1.2.2 Implement Mental Health First Aid

Tompkins County CHIP partners will do the following:

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

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

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

Tompkins CHIP partners will do the following:

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

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

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

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

Focus Area 2: Mental and Substance Use Disorders Prevention

Goal 2.2 Prevent opioid overdose deaths

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

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

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

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

Interventions include:

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

Associated activities include:

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

Performance will be monitored with following measures:

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

Goal 2.3 Prevent and address adverse childhood experiences

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

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

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

Interventions include:

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

Associated activities include:

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

Performance will be monitored with following measures:

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

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

Goal 2.5 Prevent suicides

Zero Suicide Model of Care

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

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

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

Interventions include:

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

Performance will be monitored with following measures:

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

PROMOTE HEALTHY WOMEN, INFANTS, AND CHILDREN

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

Focus Area 2. Perinatal & Infant Health

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

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

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

Goal 2.1: Reduce infant mortality and morbidity.

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

Activities will include the following:

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

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

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

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

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

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

Tompkins CHIP partners will do the following:

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

Performance will be monitored with following measures:

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

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

Additional Activities for Promote Healthy Infants, Women and Children

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

GEOGRAPHIC AREAS OF FOCUS

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

Local Health Department resources to address the need

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

Hospital resources to address the need

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

Maintaining engagement, tracking progress, making corrections.

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

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

Presentation, access, and availability of the CHIP

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

Presentations will be requested at the following venues:

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

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