NYS 2016

COMMUNITY HEALTH IMPROVEMENT PLAN

AND COMMUNITY SERVICE PLAN

Cover Page

County covered:

TOMPKINS COUNTY, N.Y.

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Plan Author: Tompkins County Health Department

Primary Collaborators: Cayuga Medical Center, Human Services Coalition of Tompkins County, Mental Health Association in Tompkins County, Tompkins County Mental Health Department

Submitted:

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Executive Summary

Priorities and Disparities

Continuing with the Prevention Agenda choices made in 2013, Tompkins County is focusing on Preventing Chronic Disease, and Promoting Mental Health and Preventing Substance Abuse as its two Prevention Agenda priorities for 2016–2018.

With populations and key employers located in and just outside the City and Town of Ithaca garnering so much of the county focus, we recognize that deliberate attention must be paid to the rural populations due to their high potential for isolation from services. Thus, the rural population has been identified as our primary disparity group. In addition, health improvement initiatives will be targeting communities of color within the City of Ithaca, and more broadly, individuals who are of low socio-economic status (SES).

Changes since 2013

Focus areas, goals, and objectives within the priority to Prevent Chronic Disease remain largely unchanged from those established in 2013: diabetes prevention, Chronic Obstructive Pulmonary Disease (COPD) and asthma action education, and tobacco use. We are not totally static though, and a couple of additions have been included: a goal has been added to build up worksite wellness initiatives within the county, as has a goal to reduce youth tobacco use.

The structure of efforts for the priority to Promote Mental Health and Prevent Substance Abuse however, has expanded from that outlined in 2013. The new initiatives include comprehensive efforts to move interventions away from clinical settings and out to families and to schools, allowing whole child and whole family systems of care to act as a preventive measure. To accomplish this, our collaborative pool has grown to include agencies whose specialty is working with children, families, and schools.

While the opioid epidemic that has swept the state and the country has also gained a footing in Tompkins County, we are deferring to the *Ithaca Plan*, released in February 2016, which provides a substantial blueprint for addressing this issue in large part through harm reduction efforts. Instead, we are following the lead established by the Population Health Improvement Program (PHIP) covering Tompkins County, and building our plan around expanding access to mental health services for those individuals and families in crisis.

In addition, measures to reduce the incidence of underage drinking, and the prevalence of tobacco use among individuals with poor mental health have also been included.

Data Review

Much of the information driving the selection/ confirmation of our priorities was gathered through conversations with service providers, and through panels and presentations by peers and providers.

Key data indicators were also reviewed to guide selection decisions. For the Mental Health and Substance Abuse (MHSA) priority, data on hospitalizations related to mental health and substance abuse from NYS SPARCS (page 11), and Medicaid (page 12) showed clear and sometimes steep increases over the last 2–10 years for a variety of diagnoses. NYS vital statistics revealed a frightening increase in opioid deaths from 2003 to 2014 (page 11). The Municipal Drug Policy Committee established by the Mayor of Ithaca also provided a wealth of insight and discussion that added support to the MHSA priority area.

Chronic disease indicators for Tompkins County tend to be within the first or second quartile among counties statewide. Thus it is vital for public health leaders in Tompkins County to spot data trends, respond to community chatter, and expand outreach to the underserved populations in order to maintain a commitment to improving health outcomes for all residents, and encourage long term preventive measures and associated social norms. An example is hospitalization for short-term complications of diabetes. While the Tompkins County rate is below the Prevention Agenda 2018 target, a closer look reveals that it has nearly doubled between 2008 and 2014. Data from the Healthy Neighborhoods Program is also utilized for tracking trends in the wider population.

Partners

Tompkins County Health Department staff has worked closely with staff from a number of major agencies that serve Tompkins County. These include: Alcohol & Drug Council of Tompkins County, Cayuga Center for Healthy Living, Cayuga Medical Center, Collaborative Solutions Network, Family & Children's Services of Tompkins County, Franziska Racker Centers, Human Services Coalition of Tompkins County, Mental Health Association in Tompkins County, Tompkins County Mental Health Department.

Staff for the Population Health Improvement Program (PHIP) conducted fifty-plus interviews with providers across the spectrum of services available in Tompkins County, and both those data and PHIP staff were thoroughly consulted. The broad populace was not engaged for input when preparing the 2016 update; a community survey was conducted for the 2013 Plan.

Evidence-based (EB), Evidence-informed (EI), Best practice (BP) Interventions

In our collaboration with mental health and substance abuse agencies, we sought out EB, EI, or BP programs that had demonstrated success in a pilot run at the agency, or programs that were otherwise ready for introduction or expansion at an agency. As such, we were confident that the service providers were fully prepared to take proven tools into the community for wide use. The EB, EI, and BP programs focus on reaching at-risk individuals at school, or where they live, so that all people and places involved in that individual's emotional or behavioral health may be accounted for in treatment. Programs cited in the CHIP include the Systems of Care framework, School-Based Family Navigator Partnerships, Assertive Community Treatment Teams, Home and Community Based Services, Home-Based Therapy, Health Home Care Management, SafeCare, Wellness Recovery Action Plans, and PROS.

Other EB, EI, and BP interventions identified include Mental Health First Aid, the "5-A's" tobacco dependence treatment, and BASICS alcohol use intervention.

EB, EI, and BP measures to prevent chronic disease include policies and action steps identified by the Bureau of Tobacco Control to reduce youth access to tobacco products and eliminate smoking from multi-unit residences, the National Diabetes Prevention Program, the Health Care Model, and measures to establish and improve worksite wellness programs.

Progress tracking and evaluation

The primary method used to evaluate the intervention over the two years of this Plan will be process metrics. These include tracking cooperation and collaboration among agencies, engagement and contact among staff, staff involvement and referrals, client and patient participation, and patient outcomes. A few interventions call for a policy or resolution to be passed by a governing body.

Report

1: Community

TOMPKINS COUNTY, New York covers 475 square miles at the southern end of Cayuga Lake, the longest of New York's Finger Lakes. Centered in the county and at the lake's tip is Ithaca, the county seat and only city. The U.S. Census Bureau's 2011–2015 American Community Survey (ACS) 5-year population estimates[1] and 2014 NYS Vital Statistics data[2] are used in this section of the report.

Cayuga Medical Center (CMC), a member of Cayuga Health System, is a 212-bed Federally-designated Sole Community Hospital. In 2016, Cayuga Medical Center provided approximately 7,000 inpatient discharges, 5,800 inpatient and outpatient surgeries, 29,000 emergency visits, 44,000 urgent care visits, and 16,000 hematology/ oncology visits. Approximately 60% of CMC's total inpatient discharges were for patients with Medicare or Medicaid; 3% were for patients without insurance. CMC offers a Financial Assistance Policy, which helps to ensure that patients with limited income or no insurance can access health care services.

Tompkins County represents the majority of CMC's primary service area, and is where the majority of the patient population receiving services at the hospital reside.

Population

The 2015 ACS total population estimate for Tompkins County is 103,855, up 2.3% from the 2010 U.S. Census count of 101,564, and a 7.6% increase over the 2000 Census count of 96,501. The City of Ithaca is the population center with 30,565, or 29.4% of the county total.

Tompkins County includes 9 towns and 6 villages. The three largest towns, Dryden, Ithaca, and Lansing, contain about 45% of the county population.

Profile

Tompkins County is home to three institutions of higher education: Cornell University, Ithaca College, and Tompkins Cortland Community College. A total of 29,272 county residents are enrolled in college or graduate school.[3]

Much of the county's demographic profile reflects the weight of the college sector. The median age of Tompkins County residents is 30.2 years, with 17% of residents age 20–24 years. Seniors, age 65 or older, make up 11.8% of the county population.[4]

Tompkins County's population is well educated: 94.2% of residents age 25-plus are high school graduates, 50.8% have a Bachelor degree, and 28.6% a graduate or professional degree.[5]

Close to half (46.3%) of the employed workforce in Tompkins County works in education, healthcare and social assistance. For Ithaca city, the rate is over half (54%).

Tompkins County workers who are employed in manufacturing has decreased from 7.0% in 2000 to 5.8% by the current 5-year estimate.[6]

Unemployment in Tompkins County is often the lowest in the state. The ACS 5-year estimate (2011-2015) shows a 5.9% county unemployment rate and 7.8% in Ithaca city.

The U.S. Census Bureau demonstrates population transience using data on "Residence one year ago" for those age one year-plus, and Tompkins is high in all categories measured: 21.6% lived in a different house the previous year, 6.6% in a different state and 2.6% were living abroad.[7] For Ithaca city, these numbers are 35.2%, 11.7%, and 3.7%, respectively. These numbers are easily attributable to the academic population. The impact of such transience is a lack of population consistency when providing and promoting awareness of public services.

Place of birth shows a similar pattern. Thirty percent of Tompkins' population were born in a state other than New York, and 12.7% were foreign born.[8] Tompkins County's population is 83.4% white, 3.8% Black or African American, 9.0% Asian, and 4.1% Hispanic or Latino (of any race). Proportions in Ithaca city are 72.6%, 6.0%, 15.8%, and 7.6%, respectively.[9] In the county, 13.8% speak a language other than English at home; 19.9% in Ithaca city.

Households

Very close to half (47.3%) of Tompkins County households are non-family households. In Ithaca city, the rate is 70.8%.[10] Consistent with rates of non-family households and transience, a high proportion — 44.5% — of Tompkins County housing is renter-occupied. In Ithaca, the rate is 73.6%, nearly three out of four.

Poverty

The poverty rate — percentage of those whose income in the past 12 months is below the poverty level — reported in the 2011-2015 ACS for all families in Tompkins County is 9.5%, and in Ithaca city it is 18.1%. Of interest, the 2006-2010 ACS recorded just 6.5% of all families in Tompkins County living in poverty, and just 10.6% in Ithaca city.

Of greater concern are families with children. In Tompkins County, 17.1% of families with related children under age 18 have incomes below the poverty level. For Tompkins County families whose children are all under age 5, the rate rises to 23.9%. In the 2006-2010 ACS these rates are 10.2% and 13.2%, respectively. Poverty figures for Ithaca city (2011-2015 ACS) are 29.2% for families with related children under 18, and 42.7% for families with related children all under age 5.

In the cases of single-mother family households with related children under age 18, the poverty rate is 41.0% for Tompkins County, 64.4%% for Ithaca city. Among the civilian, non-institutionalized population in Tompkins County 5.6% have no health insurance coverage. Among those of that population who are under age 18, 3.1% have no

health insurance coverage. In Ithaca city, 9.4% of the under 18 population have no health insurance coverage.

Please refer to the 2013 Community Health Assessment for additional background information and comparative data. A link may be found at www.tompkinscountyny.gov/health/pnc/cha.

2: Data Sources

Sources for Tompkins County data reviewed for this Community Health Improvement Plan (CHIP) included those summarized on the Prevention Agenda (PA) dashboard,[11] NYS SPARCS data,[12] NYS Vital Statistics,[13] NYS Community Health Indicators,[14] the expanded Behavioral Risk Factor Surveillance System survey,[15] and Tompkins County's 2014 Communities That Care® Youth Survey of risk and protective factors.[16] *The Ithaca Plan*: *A Public Health and Safety Approach to Drugs and Drug Policy*,[17] published in 2016 as a result of reports provided by the Mayor's Municipal Drug Policy Committee, was also consulted, as were unpublished Pillar reports.

The PA dashboard was the launching point, with the other sources providing the opportunity for deeper analysis and perspective.

3: Priorities & Goals

A core team of individuals representing Cayuga Medical Center (CMC), the Health Planning Council (HPC), the Mental Health Association in Tompkins County (MHATC), and the Tompkins County Health Department (TCHD), met to consider PA priorities. The team determined that Tompkins County will continue to focus on the PA priorities that were identified in the 2013 CHIP,[18] (1) Prevent Chronic Disease (CD), and (2) Promote Mental Health and Prevent Substance Abuse (MHSA). Furthermore, the team identified the rural population, and in particular those identified as low socio-economic status (SES) as the key, though not exclusive disparity group on which to focus.

What follows is an overview of the Goals that are included in this CHIP 2016 update. Italicized Goal numbers refer to the workplan charts addendum, described under *Section 4: Actions, Measures, and Roles*, on page 9.

Priority Area Chronic Disease

With respect to CD, a number of the interventions identified in the 2013 CHIP have launched and/or more fully developed, and, backed up by data, the team felt it was most appropriate to continue their development to sustainability.

1. Diabetes Prevention: The National Diabetes Prevention Program has successfully launched in Tompkins County, and now has four partners involved in providing

classes. However, there is still much to do in order to have classes available in an ongoing basis. Current SPARCS data shows that the hospitalization rate for short-term complications of diabetes in adults has doubled from 2008–2014 (Figure 1), demonstrating a continued or growing need. *CD Goal #3.3.*

2. Asthma: Growth in the Healthy Neighborhoods Program, landlord and property manager resistance in establishing smoke free policies in low income housing, and continued interest in building COPD awareness, has supported continuation of asthma initiatives in the CHIP update. *CD Goal #2.3, #3.3.*
3. Reducing youth access to tobacco products is both a statewide and county level priority, recommended in 2015 by the Prevention Pillar of the Municipal Drug Policy Committee.[19] *CD Goal #2.1.*
4. All team participants agreed that ongoing efforts to promote worksite wellness is a valuable community strategy for building a culture that supports responsible lifestyle choices. *CD Goal #1.4.*

Mental Health and Substance Abuse Priority Area

While a key MHSA intervention specified in the 2013 CHIP, to increase collaboration among service providers, is well underway, the goal to promote SBIRT (Screening, Brief Intervention, and Referral to Treatment) through a specifically identified grant[20] was not successful, and thus dropped from the 2016 update.

5. Due to its acute nature (see Figure 2 through Figure 6, below), measures to address the severe increase in drug use and its associated social, behavioral, medical, and institutional impacts are already being planned and implemented by a number of agencies. Furthermore, The *Ithaca Plan*[21] has already directed considerable attention to this problem. Thus, the CHIP team focused elsewhere for a majority of its goals, objectives, and strategies.
6. A key part of our community engagement process to identify MHSA goals, objectives, and strategies was through open discussion among service providers who work with the emotional health of families and children, and who are engaged with the Collaborative Solutions Network (CSN). The CSN, "… initiates and supports positive collaborative work within and between individuals, schools, human service agencies, communities and other working groups."[22] In these discussions we learned of a number of emerging evidence based interventions that were being pilot tested, were operational on a limited basis, or were showing promise for closing identified gaps in services. The team agreed that our Community Improvement Plan should take advantage of the efforts to develop improved and tested infrastructure that are already being undertaken by our providers; efforts that had been selected as able to fill identified gaps in service,

and create efficiencies in moving services away from clinical settings and into family and school communities. *[MHSA Goal #1.1, #2.2, #3.1.]*

7. In 2015, Cayuga Medical Center applied for New York State capital funding through the Capital and Restructuring Financing Program (CRFP) to complete a renovation and expansion of its existing Behavioral Services Unit (BSU). In March 2016, CMC was notified that they would receive up to $2.47 million in capital funding to support this project. This funding, along with the local DSRIP project supporting Crisis Stabilization for individuals with behavioral health and/or substance abuse concerns, will dramatically improve care and outcomes for some of the most vulnerable people in Tompkins County. Along with the facility improvements and DSRIP efforts, CMC has committed to more proactive collaboration with Tompkins County Mental Health Services, to ensure that care is coordinated, and patients requiring intensive hospital-based services have appropriate linkages to community resources upon discharge. *[MHSA Goal #2.2, #3.1.]*
8. The process for developing The *Ithaca Plan* began with the formation of the Municipal Drug Policy Committee (MDPC) in 2014. Each of four "Pillars" of the MDPC submitted their recommendations to the Ithaca Mayor in April 2015.[23] Among the recommendations submitted by the Prevention Pillar, but not included in the final *Ithaca Plan*, were strategies to reduce youth access to tobacco products (see #3 above), and to prevent underage drinking. Currently active measures to prevent underage drinking among both secondary school and college age individuals that will benefit from more widespread deployment have been included in this priority area of the CHIP. *[MHSA Goal #2.1.]*
9. Evidence based strategies to reduce tobacco use among individuals with poor mental or emotional health are steadily being incorporated into mental health provider systems, and will continue with support of this CHIP. *[MHSA Goal #2.4.]*

4: Actions, Measures, and Roles

For each of the two Priority Areas identified in this CHIP, goals and outcome objectives have been identified based on the discussions outlined in *Section 3: Priorities & Goals*, starting on page 7. The goals and outcome objectives were derived from two of the New York State Department of Health's (NYSDOH) Prevention Agenda 2013–2018 Action Plans: Preventing Chronic Disease Action Plan,[24] and Promote Mental Health and Prevent Substance Abuse (MHSA) Action Plan.[25]

The workplan chart addendum follows the template proposed in the NYSDOH CHIP guidance,[26] and includes the following fields for each goal and outcome objective:

Interventions/ Strategies/ Activities, Process Measures, Partner Role, Partner Resources, By When, Will Action Address Disparity. The workplan chart follows the Endnotes (page 13) in this document.

5: Ongoing Engagement

The value of this plan is greatly diminished if partner engagement is not maintained, process measures updated, and open discussion continued.

For the MHSA priority, many of the strategies were identified through the Collaborative Solutions Network (CSN).[27] The CSN was engaged in part because it provided a ready setting through which to maintain connection and track progress.

More broadly in the MHSA priority, *Goal #3.1, Outcome Objective 3.1.1* specifies establishment of a working group that will, "support both the progress and updating of this plan."

Some strategies for the CD priority are defined by the actions of an established board, committee, or collaborative partnership (*Goal #1.4, Goal #3.3*), which by their existence will track progress. Further, though not specified as a CD strategy in the same manner as with MHSA Outcome Objective 3.1.1, a coalition of partners identified as contributing Roles or Resources will be formalized with regular meetings and staff from the LHD.

6: Public Access

The 2016–2018 Community Health Improvement Plan (CHIP) will be housed with easy access on the Tompkins County Health Department (LHD) website, along with references, links to partners and programs, and the executive summary. Cayuga Medical Center (CMC) will provide a link on their website to the CHIP. A press release will be drafted, reviewed with key partners, and a plan for release developed that will allow agencies to garner their own earned media or be recognized in a broader release from the LHD and the hospital.

Figures

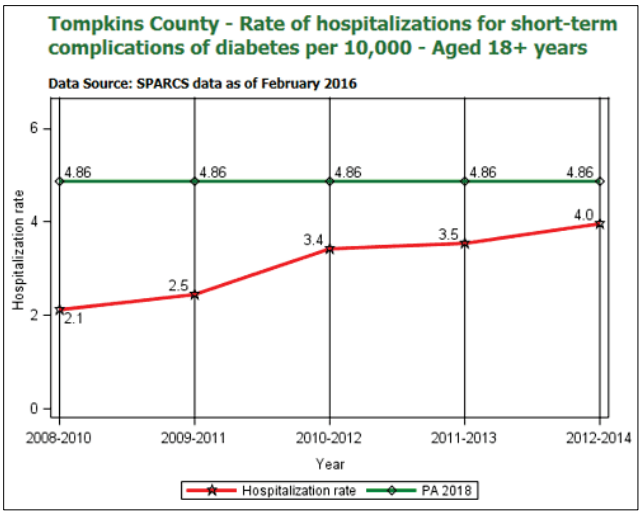

Figure 1

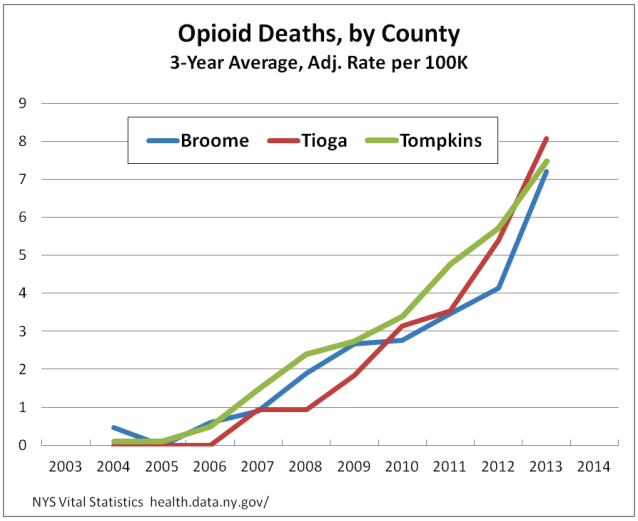

Figure 2 [28]

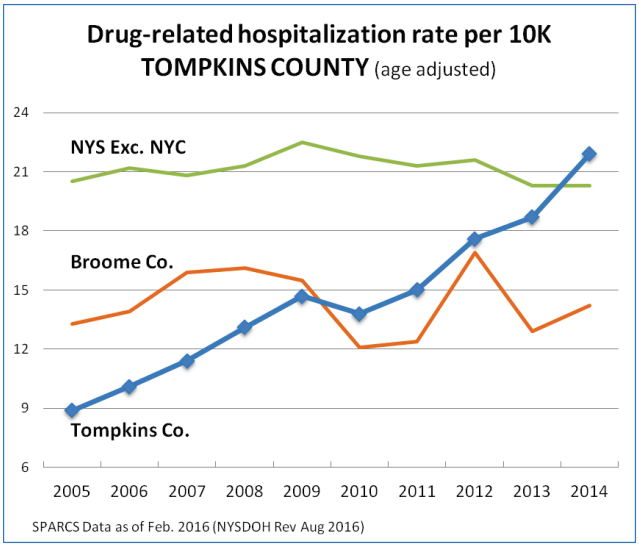

Figure 3

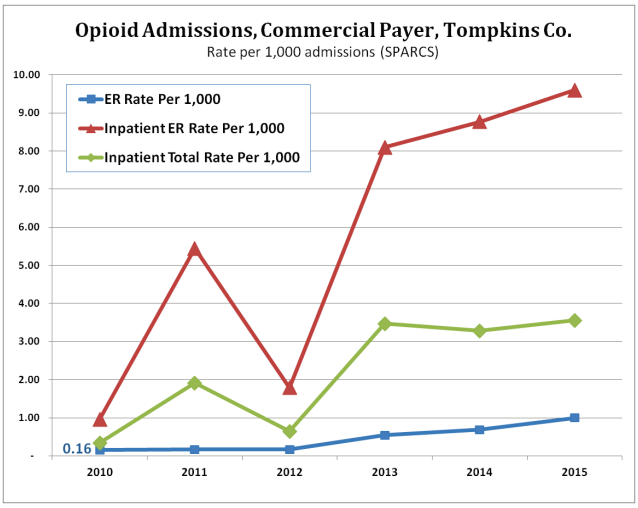

Figure 4

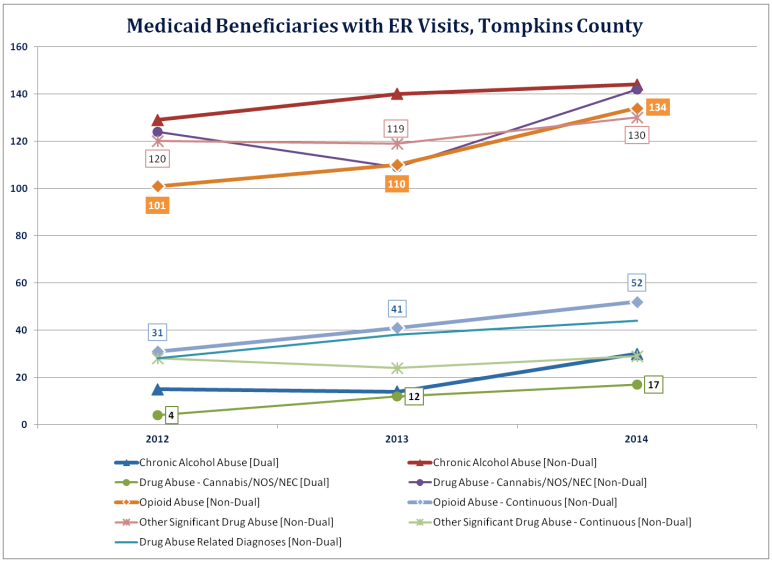

Figure 5 [29]

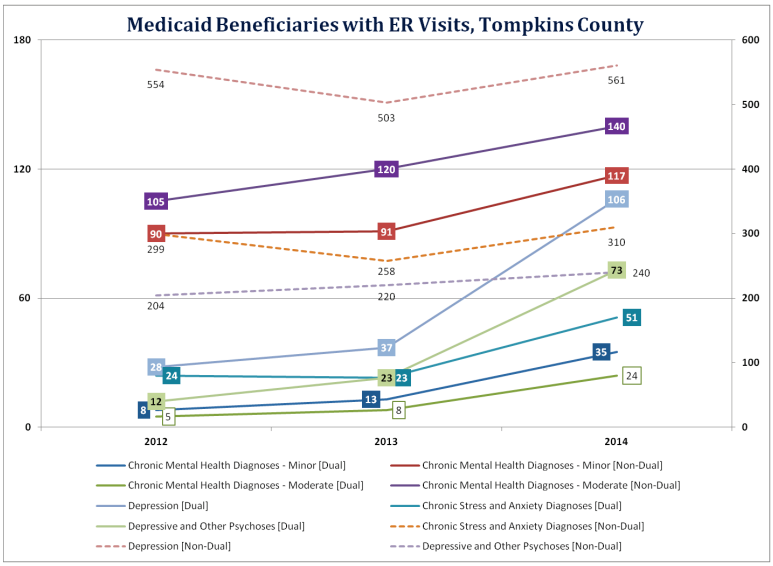

Figure 6 [30]

Endnotes

[1] http://www.census.gov/acs/www/data/data-tables-and-tools/data-profiles/2015/

[2] https://www.health.ny.gov/statistics/vital_statistics/2014/

[3] 2011-2015 ACS DP02

[4] U.S. Census, DP05: 2011–2015 American Community Survey 5-year estimates.

[5] U.S. Census, DP02: 2011–2015 American Community Survey 5-year estimates.

[6] U.S. Census, DP03: 2011–2015 American Community Survey 5-year estimates.

[7] DP02: 2011–2015 5-year

[8] DP02: 2011–2015 5-year

[9] DP05: 2011–2015 5-year

[10] DP02: 2011–2015 5-year

[11] Prevention Agenda Dashboard for Tompkins County. Accessed 11/14/16. https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=50

[12] https://www.health.ny.gov/statistics/sparcs/

[13] https://www.health.ny.gov/statistics/vital_statistics/

[14] https://www.health.ny.gov/statistics/chac/indicators/

[15] https://www.health.ny.gov/statistics/brfss/expanded/

[16] http://www.healthyyouth.org/publications.php, http://www.healthyyouth.org/documents/2014summaryofhighlights_000.pdf

[17] The *Ithaca Plan*: A Public Health and Safety Approach to Drugs and Drug Policy. February 2016. http://www.cityofithaca.org/documentcenter/view/4224 (5MB download)

[18] http://www.tompkinscountyny.gov/files/health/pnc/cha/CHIP-Tomp-2013-2017.pdf

[19] The *Ithaca Plan*. February 2016. Pp. 10–12.

[20] http://www.tompkinscountyny.gov/files/health/pnc/cha/CHIP-Tomp-2013-2017.pdf, page 11.

[21] The *Ithaca Plan*: A Public Health and Safety Approach to Drugs and Drug Policy. February 2016. http://www.cityofithaca.org/documentcenter/view/4224 (5MB download)

[22] http://www.collaborativesolutionsnetwork.org/

[23] The *Ithaca Plan*. February 2016. Pp. 10–12

[24] https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/chronic_diseases/. Download complete printable PDF at https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/prevent_chronic_diseases.pdf. Accessed December 2016.

[25] https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/. Download complete printable PDF at https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/mental_health_prevent_substance_abuse.pdf. Accessed December 2016.

[26] Letter and Community Health Planning Template for 2016-2018, PDF document. Direct download link: https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/letter_community_planning_guidance_2016_18.pdf. Accessed December 2016 at https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/resources_for_communities.htm.

[27] http://www.collaborativesolutionsnetwork.org/.

[28] NYS Vital Statistics: Opioid-Related Deaths by County: Beginning 2003. https://health.data.ny.gov/Health/Vital-Statistics-Opioid-Related-Deaths-by-County-B/sn5m-dv52. Accessed December 2016.

[29] Based on Medicaid Chronic Conditions, Inpatient Admissions, and Emergency Room Visits by County, Beginning 2012. https://health.data.ny.gov/Health/Medicaid-Chronic-Mental-SA/he2p-cpwa.

[30] Ibid.

THE Prevention Agenda 2013-2018 is the blueprint for state and local action to improve the health of New Yorkers in five priority areas and to reduce health disparities for racial, ethnic, disability, and low socioeconomic groups, as well as other populations who experience them. (Source)

The Community Health Improvement Plan (CHIP) is a local-level, community-informed outline for addressing the two most salient Prevention Agenda priorities in our county, Prevent Chronic Disease, and Promote Mental Health and Prevent Substance Abuse.

PRIORITY AREA: PREVENT CHRONIC DISEASES

Focus Area 1: Reduce Obesity in Children and Adults

Goal #1.4: Expand the role of public and private employers in obesity prevention.

Objective 1.4.1: Increase the percentage of small to medium worksites that offer a comprehensive worksite wellness program for all employees and that is fully accessible to people with disabilities.

Interventions /Strategies /Activities	*Process Measures*	*Partner Role*	*Partner Resources*	*By When*	*Addresses disparity?*
Promote Wellness activities to member municipalities (employers) of the Greater Tompkins County Municipal Health Insurance Consortium (Consortium) through the Owning Your Own Health (OYOH) Committee.	○ # of employer representatives attending OYOH Committee meetings ○ # employers whose employees are involved in a worksite wellness initiative ○ # of employers who have identified an employee wellness champion or wellness committee chair ○ Draft & submit a resolution to the Consortium Board of Directors that encourages employers to follow practices aligned with NYS Labor Law to support breastfeeding at work.	○ *TCHD:* OYOH Chair is on TCHD staff. ○ *OYOH Committee members:* all are on staff at member municipalities ○ *Consortium Executive Director:* Liaison with all other committees, the BOD, and all member municipalities.	○ Staff time for OYOH Chair and committee members ○ Consortium staff time and resources related to outreach to all member municipalities.	Dec. 31, 2017	○ Rural populations ○ Small employers ○ Nursing moms

CCHL=Cayuga Center for Healthy Living; CCN=Care Compass Network; CMC=Cayuga Medical Center at Ithaca; HSC=Human Services Coalition of Tompkins County; TCHD=Tompkins Co. Health Department; YMCA=YMCA of Ithaca & Tompkins Co.;

Interventions /Strategies /Activities	*Process Measures*	*Partner Role*	*Partner Resources*	*By When*	*Addresses disparity?*
Build and Strengthen the Tompkins County Worksite Wellness Coalition, a group formed as a sustainability outcome for Tompkins County's Creating Healthy Places to Live, Work, & Play Worksite grant	○ # of attendees at meetings ○ # of outside speakers presenting at meetings ○ # of employers who report to the coalition that they have established outreach or conducted wellness activities	○ *Founding Coalition members* TCHD, Cornell University, Ithaca College, City of Ithaca, Hospicare, HSC, CCHL, Consortium: Leadership for the Coalition ○ *TCHD:* staff for the Coalition	○ Staff time for planning meetings and grant writing ○ TCHD: Meeting space, admin. support, maintain Coalition records and list	Dec. 31, 2018	○ Small employers with limited resources to initiate a wellness program

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Focus Area 2: Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure

GOAL #2.1: Prevent initiation of tobacco use by New York youth and young adults, especially among low socioeconomic status (SES) populations.

Objective 2.1.1: *Decrease the prevalence of any tobacco use (cigarettes, cigars, smokeless tobacco) by high school age students*
Objective 2.1.2: *Decrease the prevalence of cigarette smoking by adults ages 18-24 years*
Objective 2.1.3: *Increase the number of municipalities that restrict tobacco marketing (including limiting the density of tobacco vendors and their proximity to schools)*

Interventions /Strategies /Activities	*Process Measures*	*Partner Role*	*Partner Resources*	*By When*	*Addresses disparity?*
Encourage municipalities to implement policies that protect youth from tobacco marketing in the retail environment, also known as the point-of-sale (POS).	○ Number of municipalities that reduce youth access to tobacco marketing and tobacco products, including: Limiting the number, type, and location of licensed tobacco retailers, and/or Prohibiting the use of coupons and multi-pack discounts.	○ *TCHD:* Advancing Tobacco Free Communities (ATFC) subcontractor ○ *Cortland County Health Department (CCHD):* Reality Check program lead for Tompkins Co. ○ *Community Coalition for Healthy Youth (CCHY):* partner in substance use reduction advocacy and programming ○ *Ithaca City School District, Trumansburg School District:* Schools that are hosting a Reality Check program 2016-17, providing youth action, voice, & activities	○ TCHD: Staff & in-kind support for ATFC ○ CCHD: Reality Check staffing, travel, gear & supplies ○ CCHY: Coalition member time and support ○ Schools: Support teacher time, classroom use, related materials ○ CCHL: Quit support group facilitation	Dec. 31, 2018	○ Youth ○ Tobacco users with multiple unsuccessful quit attempts

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Goal #2.3: Eliminate exposure to secondhand smoke.

Objective 2.3.2: *Increase the number of local housing authorities that adopt a tobacco-free policy for all housing units*
Objective 2.3.2.1: *Increase the number of worksites with a tobacco-free property policy.*
Objective 2.3.2.2: *Increase the number of colleges that have set an implementation date for a tobacco-free campus.*

Interventions /Strategies /Activities	*Process Measures*	*Partner Role*	*Partner Resources*	*By When*	*Addresses disparity?*
Promote smoke-free policies in multi-unit housing, including apartment complexes, condominiums and co-ops, especially those that house low-SES residents.	○ # of tenant surveys conducted ○ # of tenant town hall meetings held ○ # of low SES units that are in a smoke-free building ○ # of new construction units that are on a smoke-free property ○ At least one social media channel	○ *TCHD:* Advancing Tobacco Free Communities (ATFC) subcontractor ○ Tenant advocates ○ Property manager and owner advocates ○ Community & family advocates	○ TCHD: Staff & in-kind support for ATFC ○ Advocates: Personal time, transportation, materials	Dec. 31, 2018	○ Low SES ○ Tenants with chronic disease or allergies ○ Tobacco users with multiple unsuccessful quit attempts
Promote tobacco-free property policies at worksites	○ # of outreach mailers to local employers ○ # of meetings with worksite wellness coordinators or champions ○ # of resolutions of support from business & employer groups or associations. ○ At least one social media channel	○ *TCHD:* Advancing Tobacco Free Communities (ATFC) subcontractor ○ *Worksite wellness champions:* Internal advocacy	○ TCHD: Staff & in-kind support for ATFC ○ Champions: staff &/or volunteer time and materials	Dec. 31, 2018	○ Employees with chronic disease or allergies ○ Tobacco users with multiple unsuccessful quit attempts

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Interventions /Strategies /Activities	*Process Measures*	*Partner Role*	*Partner Resources*	*By When*	*Addresses disparity?*
Promote tobacco-free campus policies at local colleges and universities	○ # meetings with student champions ○ # meetings with faculty/ staff champions ○ # meetings with administrators &/or institutional governing bodies such as a Faculty Council or University Assembly, or Student Government	○ *TCHD:* Advancing Tobacco Free Communities (ATFC) subcontractor ○ *Student/ Faculty/ staff Champions:* Internal advocacy	○ TCHD: Staff & in-kind support for ATFC ○ Champions: personal time and materials	Dec. 31, 2018	○ Students, faculty, staff with chronic disease or allergies ○ Tobacco users with multiple unsuccessful quit attempts

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Focus Area 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

Goal #3.2: Promote use of evidence-based care to manage chronic diseases.

Objective 3.2.8: *Reduce the rate of hospitalizations for short-term complications of diabetes per 10,000, aged 18+ years, by 15%, from 4.0 (2012-2014) to 3.6 (2010-2012) (SPARCS data as of Feb. 2016)*

Interventions /Strategies /Activities	*Process Measures*	*Partner Role*	*Partner Resources*	*By When*	*Addresses disparity?*
In accordance with DSRIP project 2biv, Care Transitions, implement the Health Coach model, to ensure patients admitted to the medical-surgical unit make contact prior to discharge, and receive a home visit post discharge, to support improved continuity of care and a reduction in avoidable hospital use.	○ # of Medicaid patients receiving a visit from the Health Coach while in the hospital and # of home visits received post discharge. ○ # of patients that received Health Coach services who were not readmitted within 30 days of being discharged.	○ *CMC*: Employ Health Coach. Track outcomes. ○ *Care Compass Network* (CCN, local Performing Provider System): Provide training; reimburse CMC for Health Coach efforts. ○ *CCHL, TCHD*: Support Health Coach.	○ *CMC*: Staffing, facilities ○ *TCHD, CCHL*: Staffing ○ *CCN*: reimbursement funds	Dec. 31, 2018	○ Persons subject to readmission due to unsuccessful community re-entry

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Goal #3.3: Promote culturally relevant chronic disease self-management education.

Objective 3.3.1: *Increase the percentage of adults with asthma or diabetes who have taken a course or class to learn how to manage their condition.*

Interventions /Strategies /Activities	*Process Measures*	*Partner Role*	*Partner Resources*	*By When*	*Addresses disparity?*
Promote the National Diabetes Prevention Program (NDPP) by expanding class availability, and by strengthening ties and collaboration among NDPP providers	○ # of trained Lifestyle Coaches ○ # of planning meetings among DPP providers ○ # classes offered ○ # of rural locations where classes are offered ○ Establish at least one social media channel	○ *CCHL:* program provider ○ *HSC:* program provider, master trainer ○ *TCHD:* program provider ○ *YMCA:* program provider ○ *Primary Health Care Providers:* referral source	○ All program providers contribute staff time, class materials, meeting rooms, Coach certification maintenance, promotional time & materials	Dec. 31, 2018	○ Rural populations ○ Other underserved pops., especially persons of color
Increase coverage for the Diabetes Prevention Program by working with self-insured employers	○ # self-insured employers with DPP as a covered benefit. ○ # of employees with access to DPP as a covered benefit through their self-insured employer ○ # of worksites that promote DPP through their wellness programs or other health information outlet ○ # of employers that include DPP as eligible for an in-house wellness reimbursement benefit	○ *CCHL:* program provider ○ *HSC:* program provider ○ *TCHD:* program provider ○ *YMCA:* program provider ○ *CMC:* diabetes education provider ○ *Worksite Wellness champions:* Internal advocacy	○ All program providers contribute staff time toward developing an outreach plan to employers, health benefit providers, and elected officials ○ Worksite wellness champions: advocate for coverage with their HR, union, or employee association	Dec. 31, 2018	○ Low SES populations

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Interventions /Strategies /Activities	*Process Measures*	*Partner Role*	*Partner Resources*	*By When*	*Addresses disparity?*
Increase awareness of basic asthma management steps that adults can take to lessen the daily impact of their disease.	○ # member organizations in Healthy Lungs for Tompkins County (HLTC) ○ # of HLTC meetings held ○ # of outreach targets contacted (Primary Care Providers, worksite wellness programs, faith-based orgs, senior living centers) ○ # of Healthy Neighborhoods Program (HNP) homes with fewer triggers found during home revisit ○ At least one social media channel	○ *CMC:* HLTC leadership ○ *TCHD:* HLTC leadership, Healthy Neighborhoods Program (HNP) contractor	○ CMC: staff, meeting location, materials, printing services ○ TCHD: staff, meeting location, HNP materials	Dec. 31, 2016	○ Low SES populations ○ Rural populations ○ Persons living in old or poorly maintained rental housing

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PRIORITY AREA: PROMOTE MENTAL HEALTH & PREVENT SUBSTANCE ABUSE

Focus Area 1: Promote Mental, Emotional, and Behavioral Well-Being

GOAL #1.1: Promote mental, emotional, and behavioral well-being in communities.

Outcome Objective 1.1.1: *Increase the use of evidence-informed policies and evidence-based programs which are grounded on healthy development of children, youth and adults.*

Interventions /Strategies /Activities	*Process Measures*	*Partner Role*	*Partner Resources*	*By When*	*Addresses disparity?*
Expand Mental Health First Aid training to target at-risk families, rural populations, law enforcement, first responders, and schools.	○ # of training options at venues familiar and/ or convenient to people of color within the City of Ithaca. ○ # of training options in rural towns and school districts. ○ # of training options at times and places convenient to families.	○ *MHATC*: certified MH First Aid instructors	○ *MHATC*: plans, promotes, administers, teaches	Dec. 31, 2018	○ Rural pop. ○ Families at risk ○ Incarcerated population ○ People in crisis ○ Youth ○ School teachers

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Interventions /Strategies /Activities	*Process Measures*	*Partner Role*	*Partner Resources*	*By When*	*Addresses disparity?*
Create partnerships among families, schools, service & health care providers, and community to: - promote and support early recognition through universal social & emotional screening, - increase student success through peer support to families, and - normalize conversations about emotional health.	○ # schools with School-Based Family Navigator Partnership navigator assigned. ○ # of trained Family Navigator peer counselors. ○ # of school districts exploring use of the Universal Kindergarten Assessment (UKA) ○ # of school districts where UKA has been implemented	○ *FRC*: administers Family Navigator Partnership; promotes universal screening ○ *Local school districts*: partner in Family Navigator initiative; partner in Universal Kindergarten Assessment ○ *Pediatricians and Primary Care Providers*: implements universal screening during all well visits	○ *FRC*: trains & supervises Family Navigators, interface with schools ○ *FRC*: Provides Navigator training manual ○ *Schools*: staff involvement in Family Navigator Partnership; ○ *Health Care Providers*: integrates universal screening into their electronic records system ○ *Mental & Emotional Health Services Providers*: supports primary care providers' referral to treatment	Dec. 31, 2018	○ Rural schools and rural school districts ○ Families in crisis
Expand awareness of the Systems of Care framework, and access to the CARE Team process for youth and families in need of mental and emotional health services and support.	○ # of agencies, parents, families, youth involved in the Collaborative Solutions Network (CSN) ○ # family & youth services agencies with a trained CARE team facilitator ○ # families participating in a CARE team process ○ # CANS Assessments	○ *CSN Agencies*: CSN Hub Group: sets guidelines and agenda for CSN meetings ○ *FRC*: CSN staffing, CSN founders, training teams, training organizers; CARE team training ○ *SPOA team members*	*FRC*: Staff support, CARE Team facilitator training staff & materials, SPOA administration	Dec. 31, 2018	○ Families in crisis ○ Schools

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Focus Area 2: Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders

GOAL #2.1: Prevent underage drinking, non-medical use of prescription pain relievers [and other opioids] by youth, and excessive alcohol consumption by adults.

***Outcome Objective 2.1.1*:** *Reduce the percentage of youth in grades 9-12 reporting the use of alcohol on at least one day for the past 30 days (Baseline: 26 per 100, 2014-15 Tompkins County CTC Survey, Table 7.43, pg. 110).*

Interventions /Strategies /Activities	*Process Measures*	Partner Role	*Partner Resources*	*By When*	*Addresses disparity?*
Build awareness of underage drinking prevalence and focus on social norms that intervene in incidences of underage drinking	○ Alcohol related risk & protective factors in bi-annual high school & middle school survey. ○ Related college data: Cornell Alcohol & Social Life Surveys. ○ TC3 social media campaigns ○ Collaborative media & social media campaigns targeting M&HS students, their parents, and college students. ○ Passage of county-wide social host liability law.	○ *ADC*: provides preventive services & education outreach ○ *TST-BOCES*: administers bi-annual youth survey ○ *Cornell University*, Skorton Center for Health Initiatives: Awareness campaigns ○ *Ithaca College* Hammond Health Center: ○ *TC3*: STOP Act Grant (thru 9/30/17) social norms campaign on campus ○ *CCHY*: STOP Act Grant ○ *Trumansburg & Dryden Central School Districts*: STOP Act grant student collaborations with TC3	○ *ADC*: prevention education staff & staff support, training materials ○ *TST-BOCES*: interfaces with school districts, distributes & collects survey instrument, delivers completed surveys to survey contractor, collates and delivers survey results to school districts ○ *Colleges*: Health promotion staff and outreach programming	Dec. 31, 2018	○ Not specifically targeted
Improve access to early intervention programs for underage drinking	○ Increase # trained in BASICS ○ Increase # BASICS referral agencies	○ *ADC*: Provides BASICS programming to Cornell students	○ *ADC*: Prevention staff & staff support	Dec. 31, 2018	○ Not specifically targeted

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Goal #2.2: Prevent and reduce occurrence of mental, emotional and behavioral disorders among youth and adults.

Outcome Objective 2.2.1: *Reduce the percentage of adult Tompkins County residents reporting 14 or more days with poor mental health in the last month by 10% to no more than 6.2% (Baseline: 6.9%, 2013-14 eBRFSS, Tompkins County, age-adjusted).*

Interventions /Strategies /Activities	*Process Measures*	Partner Role	*Partner Resources*	*By When*	*Addresses disparity?*
Assess feasibility, support, and implementation of outpatient treatment programs for patients with behavioral health needs, including Assertive Community Treatment (ACT) Teams to help reduce avoidable hospital utilization and readmissions..	○ Implement a focus group to establish the work plan for identifying appropriate outpatient programs. ○ # of rural communities where ACT Team referrals are accepted/ available ○ # of referrals to ACT Teams	○ *CMC*: redesigned inpatient unit and addition of ED flex space (completed Nov 2015) ○ *TCMH*: partnering with EPC to bring ACT to Tompkins County ○ *EPC*: administers ACT program ○ *MHATC, SPCS*: transition support for hospitalized patients	○ *CMC*: Redesign and renovation of inpatient behavioral health unit; hospitalization and emergency services provider ○ *TCMH*: is the LGU ○ *MHATC*: maintains Jenkins Center, a peer-run drop-in center ○ *SPCS*: 30-day follow-ups for CMC discharges	Dec. 31, 2018	○ Pops. with mental illness ○ Rural pops.
Introduce Home and Community Based Services (HCBS), programs that seek to fill service gaps by partnering with non-licensed service provider agencies	○ Identify service gaps that may appropriately be filled by HCBS ○ Identify HCBS services for which there are currently appropriately trained staff ○ # HCBS services provided	○ *TCMH*: Service plan administrator and eligibility evaluator ○ *F&CS*: staff clinical satellite offices in rural communities ○ *CCTT*: employment training ○ *Challenge*: employment training ○ *MHATC*	○ Staffing ○ Training ○ *F&CS*: Clinical staff, supervision, insurance billing staff	Dec. 31, 2018	○ Adults for whom service gaps challenge their ability to successfully re-enter the community

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Interventions /Strategies /Activities	*Process Measures*	Partner Role	*Partner Resources*	*By When*	*Addresses disparity?*
Utilize the PHIP Toolkit Project to generate interest in mental health anti-stigma messaging among identified target audiences within Tompkins County	○ track local earned media related to messaging or a campaign ○ track social media involvement related to anti-stigma messaging	○ *PHIP*: developing toolkit ○ *CMC*: marketing & social media channels ○ *MHATC*: outreach & education networking ○ *TCHD*: outreach to providers, web & social media channels ○ *TCMH*: outreach to providers	○ *CMC*: marketing and outreach staff time & expertise ○ *MHATC*: education staff time	Dec. 31, 2018	○ Not specifically targeted
In accordance with DSRIP project 2biv, Care Transitions, implement the Health Coach model, to ensure patients admitted to the inpatient behavioral health unit make contact prior to discharge, and receive a home visit post discharge, to support improved continuity of care and a reduction in avoidable hospital use.	○ # of Medicaid patients receiving a visit from the Health Coach while in the hospital and # of home visits received post discharge. ○ # of patients that received Health Coach services who were not readmitted within 30 days of being discharged.	○ *CMC*: Employ Health Coach. Track outcomes. ○ *Care Compass Network* (CCN, local Performing Provider System): Provide training; reimburse CMC for Health Coach efforts. ○ *TCMH*: Support Health Coach.	○ *CMC*: Staffing, facilities ○ *TCMH*: Staffing ○ *CCN*: reimbursement funds	Dec. 31, 2018	○ Persons subject to readmission due to unsuccessful community re-entry

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Outcome Objective 2.2.2: *By December 31, 2018, reduce the number of youth grades 9-12 who felt sad or hopeless by 10% to no more than 28.5% (Baseline: 31.7%, 2014-15 Tompkins County CTC Survey, Table 7.95, pg. 134, total YES! + yes).*

Interventions /Strategies /Activities	*Process Measures*	*Partner Role*	*Partner Resources*	*By When*	*Addresses disparity?*
Utilize Home-Based Therapy program to reduce barriers to enrolling families in ongoing care for MH , especially for cases where family dynamics plays a big role or are at the core.	○ # of meetings held to educate referral sources to build awareness of the Home-Based care program, and encourage self-referral ○ # of families enrolled in the program. ○ # of CCOS (Children's Crisis Outreach Services) families who receive extended therapy through the home-based care program	○ *F&CS*: program administrator ○ *Rural schools, CBOs, & providers*: referral sources	○ *F&CS*: provider staff, staff support, supervisory staff	Dec. 31, 2018	○ Families in crisis
Promote Health Home youth care management for youth under age 18, and for transitional youth under age 25.	○ # of enrollments	○ *FRC*: Health Home Care Management provider ○ *TCMH*: same ○ *EPC*: same	○ Screening and assessment services for clients	Dec. 31, 2018	○ Youth with multiple diagnoses
Introduce State Plan Amendment (SPA) services for youth	○ Identify service gaps that may appropriately be filled by SPA ○ Identify SPA services for which there are currently appropriately trained staff ○ # SPA services provided	○ *TCMH*: SPA services provider	○ *TCMH*: staffing, program resources	Dec. 31, 2018	○ Youth who are subjected to service gaps

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Interventions /Strategies /Activities	*Process Measures*	*Partner Role*	*Partner Resources*	*By When*	*Addresses disparity?*
Utilize SafeCare, part of the Prevention & Family Recovery program, to provide support to further promote, build and sustain family-based recovery enhancements that enable service providers to integrate information on parenting skills, child development and substance abuse treatment in work with FTC participants.	○ - Increase in # trained. ○ - Increase in # of referring agencies.	○ *TCDSS*: staff certified in SafeCare ○ *TCHD*: staff certified in SafeCare ○ *TC Family Court*: referral agency	○ *TCDSS & TCHD*: enrolled staff in certification training, provide certified staff	Dec. 31, 2018	○ Families in crisis

GOAL #2.4: Reduce tobacco use among adults who report poor mental health.

Outcome Objective 2.4.1: *Reduce the prevalence of cigarette smoking among adults who report poor mental health by 15% (Baseline: xx%).*

Interventions /Strategies /Activities	*Process Measures*	*Partner Role*	*Partner Resources*	*By When*	*Addresses disparity?*
Improve Quality Assurance for utilizing evidence-based models for treating tobacco dependence in line with PHS guidelines, OMH system of care, or OASAS protocol, for organizations that provide mental health and substance abuse services.	○ # of staff trained in the "5 A's" (Ask, Advise, Assess, Assist, Arrange) or other model ○ % clinicians properly utilizing tobacco screening system ○ Involvement by tobacco treatment champion, system administrator, or QA officer	○ *CNY Regional Center for Tobacco Health Systems at St. Joseph's Hospital Health Center (THS)*: administers outreach and support program for MH providers ○ *Lakeview Health Services*	○ *THS*: staff time, training materials, stipend for qualifying MH care organizations	Dec. 31, 2018	○ Persons in treatment for poor mental health who use tobacco

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Focus Area 3: Strengthen Infrastructure

GOAL #3.1: Support collaboration among leaders, professionals and community members working in MEB health promotion, substance abuse and other MEB disorders and chronic disease prevention, treatment and recovery.

Outcome Objective 3.1.1: *Identify and strengthen opportunities for sharing data on access to care, identifying service gaps, studying cost-effectiveness strategies for integration and coordination, and the impact of interventions.*

Interventions /Strategies /Activities	*Process Measures*	*Partner Role*	*Partner Resources*	*By When*	*Addresses disparity?*
Utilize the Health Planning Council, DSRIP Behavioral Health Subcommittee, and the RHIO, to share relevant data and indicators that support both the progress and updating of this plan.	○ - # of participating sectors ○ - # of participating agencies ○ - # of engaged individuals ○ - # of meetings at which this activity is a fully realized agenda item	○ *HPC*: convenes the group ○ *RHIO*: aggregated data ○ *DSRIP BH Subcmte*: ○ *Agencies that form a Steering Committee* that will track the progress of this Prevention Agenda priority	○ TCHD: convenes, staffs, & co-chairs steering committee, maintains CHIP ○ CMC: co-chairs steering committee ○ TCMH: steering committee participant ○ HPC: steering committee participant ○ FRC: participant ○ MHATC: participant ○ F&CS: participant ○ CSN Hub: participant ○ Tompkins County ITS Compliance officer	Dec. 31, 2018	○ Not specifically targeted

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Outcome Objective 3.1.2: *Identify and strengthen opportunities for implementing MEB health promotion and MEB disorder prevention with individuals.*

Interventions /Strategies /Activities	*Process Measures*	*Partner Role*	*Partner Resources*	*By When*	*Addresses disparity?*
Expand Wellness Recovery Action Plan (WRAP) training to support successful reintegration into the community after hospitalization or incarceration.	○ # facilitators trained to deliver WRAP program ○ availability of training manuals ○ # of sites where WRAP is training is provided	○ *MHATC*: WRAP provider ○ *TCMH*: WRAP provider	○ Resources for staff training, staff time and travel to provide services	Dec. 31, 2018	○ Incarcerated persons ○ Persons hospitalized due to a mental health crisis
Expand PROS programming	○ # of people enrolled ○ # successfully transitioned to less intensive services ○ # of opportunities to provide community education on the PROS model ○ Degree of community integration of PROS services	○ *TCMH*: PROS program provider ○ *PROS service providers*, including CCE, CMC, Challenge, MHATC	○ *MHATC*: maintains the Jenkins Center peer managed drop-in center ○ *TCMH*: program administration	Dec. 31, 2018	○ Persons with poor mental health

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Outcome Objective 3.1.4: *Support efforts to integrate MEB disorder screening and treatment into primary care.*

Interventions /Strategies /Activities	*Process Measures*	*Partner Role*	*Partner Resources*	*By When*	*Addresses disparity?*
Integrate behavioral health in the primary care setting, utilizing the parameters defined through DSRIP, to improve early identification for patients with behavioral health or substance abuse concerns.	○ # of patients receiving behavioral health screenings in the primary care setting ○ # of schools & providers who are utilizing standardized MH screening questions. ○ # of primary care practices in Tompkins County that have integrated behavioral health services	○ *Cayuga Medical Associates (CMA)*: Implement DSRIP project 3ai (Integration of Primary Care and Behavioral Health) in one Internal Medicine practice setting.: ○ *TCMH*: provides satellite location services at rural schools	○ *CMA*: staff training, records keeping upgrades ○ *TCMH*: staffing and related resources for satellite locations	Dec. 31, 2018	○ Rural school districts
Develop education & coordination between Primary Care Provider (PCP) and Health Home Care Management (HHCM) program agencies for *screening and referral to treatment* in an integrated model, and to strengthen the care management process.	○ # of HHCM agencies involved ○ # of PCP offices involved ○ # of PCP offices with a plan to integrate screening and referral to treatment	○ *TCMH*: HHCM provider ○ *FRC*: HHCM provider ○ *EPC*: HHCM provider ○ *Southern Tier Care Management*: HHCM provider	○ All: staffing resources for referral and development of the *plan of care* that HHCM is required to provide to PCP	Dec. 31, 2018	○ All persons at risk for MEB disorder

ADC=Alcohol & Drug Council; CCN=Care Compass Network; CCTT=Catholic Charities of Tioga & Tompkins Counties; CMC=Cayuga Medical Center; CSN=Collaborative Solutions Network; EPC=Elmira Psychiatric Center; F&CS=Family & Children's Services; FRC=Franziska Racker Centers; HPC=Health Planning Council; MHATC=Mental Health Assoc. in Tomp. Co.; SPSC=Suicide Prevention & Crisis Service; TCDSS=Tomp. Co. Dept. of Social Services; TCHD= Tomp. Co. Health Dept.; TCMH= Tomp. Co. Mental Health Dept.