Tompkins County
COMMUNITY MENTAL HEALTH SERVICES BOARD

Tompkins County Whole Health
201 East Green Street
Ithaca, New York 14850-5635

Tompkins County Community Mental Health Services Board
201 East Green Street, Ithaca, NY 14850
Monday, June 1, 2026, 5:30 p.m. Meeting Minutes

Minutes Approved
July 6, 2026

https://www.youtube.com/channel/UCkpJNVbpLLbEbhoDbTIEgSQ

Present: Mary Hutchens; Sheila McEnery; Jan Lynch; Jacob Parker Carver; Sally McConnell-Ginet; Jessica Conner, PsyD; Larry Roberts; Khaki Wunderlich; and Chief Tom Kelly;
Excused: Stu Bergman; Dr. Auguste Duplan; Travis Winter; Nicole Zulu, PhD; and Anna Tamis, PhD;
Legislature:
Guests: Amanda Horner, New York State Association for Rural Health
Staff: Ms. Jennie Sutcliffe, Commissioner; Harmony Ayers-Friedlander, DCS; and Karan Palazzo, LGU Administrative Assistant

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Ms. Hutchens called the meeting to order at 5:30 p.m. Introductions were made. A quorum was not met, and the May 2026 minutes could not be approved.

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Privilege of the Floor & Announcements:

Local Services Planning Updates – Director of Community Services, Harmony Ayers-Friedlander, provided an overview and update on the local services plan. The Tompkins County Local Services Plan is the four-year, state-mandated roadmap that guides how the county plans, funds, and oversees mental health, substance use, and (by statute) developmental disability services under Article 41 of the Mental Hygiene Law. It aligns local priorities with state plans from OMH, OASAS, and OPWDD and is required annually in order for the county to receive state aid. It sets priorities in areas like workforce, housing, crisis services, cross-system coordination, non-clinical supports, ACEs, and transition-age youth, and is updated annually to track progress. In 2027, the focus will shift to evaluating what has actually changed and using that analysis to shape the next plan for 2028–2031.

- Primary legal purpose:
  - Plan local mental health, substance use, and developmental disability services.
  - Align county priorities with state plans (OMH, OASAS, OPWDD).
  - Qualify for state aid – if the plan/review isn't submitted and approved annually, the county risks losing state aid.
- Board powers tied to the plan:
  - Submit the plan annually.
  - Oversee and review OMH/OASAS contracts that flow through the county.

- Request agency presentations and monitor outcomes.
- Establish procedures for executing the plan.

Planning Cycle and Timeline

- Current plan period: 2024–2027 (4-year cycle).
- Each year:
  - County must submit an annual review of the plan (due June 30; Tompkins typically gets a short extension to use the first Monday board meeting).
- Next cycle:
  - 2028–2031 plan will be developed, with preparatory work starting in 2027.
- 2027 is being framed as:
  - First half: Finish remaining objectives from the 2024–2027 plan; revisit early-year objectives that might merit a "second pass."
  - Second half: Evaluate how well the plan worked and prepare data, feedback, and priorities for the 2028–2031 cycle.

Main Goal Areas (2024–2027)

The current goal area:

- **Workforce**
- **Housing**
- **Crisis services**
- **Cross-system services**
- **Non-clinical/community supports**
- **Adverse Childhood Experiences (ACEs)**
- **Transition-age youth services**

The county has:

- Done substantial front-loading of work in the early years of the plan period.
- Identified the need to move more intentionally into outcomes evaluation:
  - Not just inputs/outputs ("we did X trainings, launched Y programs")
  - But whether those actions "moved the needle" on the above goal areas.

Key 2024 Changes and New Requirements

Several important shifts were highlighted:

1. **Four-year plan cycle**
   - Moved from annual full plans to a four-year plan plus annual reviews.
2. **Care coordination & HIPAA clarification**
   - OMH issued detailed guidance clarifying:
     - Information sharing for treatment and care coordination is permitted and required, even when providers are over-restrictive out of HIPAA fears.
     - Some prior practices were actually violating the 21st Century Cures Act by withholding needed information.
   - Local services plan must now include a published list of OMH providers and key mental health partners, creating a "nexus" that supports appropriate information-sharing for care coordination.
3. **Jail-based addiction services financial plan**
   - There is now an "addiction services jail-based supports county financial plan" that:
     - Must be submitted through the LGU.
     - Must be submitted at the same time as the local services plan.

- There's interest in having jail representatives present to the Board on:
    - What jail-based addiction services look like.
    - How those dollars are being used.

Relationship to Other County and Community Plans

The local services plan is increasingly being integrated with other planning tools:

- It informs:
    - **Community Health Assessment / Community Health Improvement Plan (CHA/CHIP)**.
    - **Department annual goals**.
    - **Human Services Coalition (HSC) / legislative human services budgeting**:
        - CHHA/CHIP priorities (especially housing) are being used as guiding priorities for funding decisions.
        - Applicants are asked to state how their work supports CHA/CHIP priorities.
- Intent: avoid "four different playbooks" and instead coordinate:
    - Local services plan
    - CHA/CHIP
    - Department goals
    - Funding/prioritization frameworks

Regional work (Amanda/NYSARH) is also being used to:

- Compare Tompkins' priorities to neighboring rural counties.
- Draw on evidence-based practice toolkits and local-level data tools for planning and advocacy.

Process and Governance Going Forward (2026–2027)

- Working group for 2027 review:
    - Mix of subcommittee chairs, board leadership, and additional members.
    - Tasked with:
        - Reviewing 2027 objectives and confirming what's still a priority.
        - "Operationalizing" objectives into concrete, measurable actions.
        - Identifying which earlier-year goal areas should be revisited or expanded.
- **Community voice and equity:**
    - 2027 is meant to include stronger community input, especially:
        - People who use services.
        - Underrepresented or marginalized groups.
    - Options under consideration:
        - Surveys (building on prior mental health surveys and CHA tools).
        - Focus groups via trusted partners to reach those who may be wary of government processes.
- **Data and evaluation improvements:**
    - Use more regional tools (e.g., NYSARH diversity dashboard).
    - Improve tracking beyond "referrals made" to "did people actually connect and benefit?"
    - Better integration of hospital plans and other external data as feasible.

NYS Association on Rural Health Initiatives: Amanda Horner, Project Coordinator for Rural Mental Health Initiatives at the New York State Association for Rural Health, presented findings and tools from NYSARH's statewide work on rural behavioral health.

Core Project: SARNA (Statewide Aggregate Rural Health Needs Assessment)

- NYSARH compiled and analyzed Community Health Assessments (CHAs) and Local Services Plans (LSPs) from 44 rural NY counties (including Tompkins), plus supplemental data (County Health Rankings, CDC, DOH, OMH).
- Method: Qualitative analysis of all mental/behavioral-health related text in those plans to identify common themes and needs across rural New York.
- Two main buckets of findings:
    1. Health outcomes (organized by the NYS Prevention Agenda):
        - Anxiety and depression
        - Suicide
        - Drug use and overdose
        - Alcohol, tobacco, and vaping
        - Trauma and ACEs
        - Nutrition and mental health
    2. Access and infrastructure:
        - Workforce shortages
        - Service gaps (e.g., inpatient, crisis)
        - Transportation barriers
        - Broadband and digital access gaps

Key Findings Relevant to Tompkins and Rural NY

- **Suicide & overdose:**
    - Many rural counties have suicide and overdose rates above the state average.
    - Counties are prioritizing suicide prevention (public awareness, school programs, MHFA/ASIST trainings, lethal means reduction, crisis access).
    - Overdose deaths remain widespread; harm reduction is expanding (naloxone, disposal, peer programs), but treatment infrastructure is often insufficient, especially for medication-assisted treatment and integrated care.
- **Workforce:**
    - Severe shortages of mental health and health professionals, including psychiatrists, clinicians, direct support, peer staff, and home care workers.
    - OMH maps show Tompkins County with a high level of mental health professional shortage (highest need category on the map).
    - Impacts: long waits, capped capacity, recruitment/retention problems, program instability, and fragmented care—especially for co-occurring conditions.
- **Services and infrastructure:**
    - Inpatient access is limited; many counties have no psychiatric beds, and youth beds are particularly scarce.
    - Transportation is a major barrier (missed appointments, delayed care, gaps in treatment in rural areas lacking reliable transit).
    - Broadband is a "super-determinant" of access: without it, telehealth and online navigation tools cannot compensate for geographic barriers.
- **Equity and local variation:**
    - County-level averages can obscure local hot spots; e.g., some zip codes within a "good" county have much higher mental distress.
    - Emphasis on demographic equity: disparities by race/ethnicity, income, age, and other historically marginalized identities.

From Needs to Action: Tools and Best Practices

Ms. Horner highlighted several NYSARH resources meant to be used by counties and boards:

1. **Evidence-Based Best Practices Guide + Companion**
    - Catalog of **34 program models** that address rural behavioral health access barriers (workforce, transportation, integrated care, etc.).

- Includes: program descriptions, implementation tips, funding and TA resources, and cross-cutting implementation considerations.
- Framed as menu options, not mandates—meant to be tailored to local capacity and needs.

2. **Integrated Care White Paper**
    - Focus on integrated care for anxiety and depression, using SARNA data plus practice models.
    - Synthesizes examples such as:
        - **Collaborative Care Model**
        - **CCBHCs (Certified Community Behavioral Health Clinics)**
        - **Community paramedicine**
        - **Integration between EDs and primary care**
    - Shows how multiple models can be combined into **one local strategy**, depending on what fits the community.
3. **Diversity Dashboard (Local-Level Data Tool)**
    - Publicly available dashboard on NYSARH's site with:
        - Demographic, social, economic, and health metrics at county, census tract, and zip code levels.
        - Rural/suburban/urban classification of sub-county areas (via Common Ground Health methodology).
    - Example metrics shown:
        - Suspected opioid overdoses by EMS in Tompkins, 2021–2024 (county-level trend).
        - Mental health providers (e.g., social workers) per zip code within Tompkins, compared to the county rate.
    - Intended uses: assessment, planning, grant writing, policy, advocacy, and educating stakeholders with place-specific data.

Evaluation and Next Steps

- Ms. Horner stressed that SARNA's first emphasis is needs assessment and planning, but that evaluation is essential to know if initiatives are working.
- NYSARH's guide includes some basic evaluation and data tips, and Amanda pointed to the University of Kansas Community Toolbox as a general, educational resource on evaluating community initiatives.
- Her closing message:
    - These tools are meant as a flexible toolkit counties can adapt:
        - Use SARNA to understand rural patterns.
        - Use local data (dashboard, CHAs, LSPs) to understand your county.
        - Use the best-practices guide and white paper to choose models that fit your context.
    - She offered to share slides and be available for follow-up questions, underscoring that there is no one-size-fits-all solution, but there are many evidence-informed options to draw from.

Substance Use Subcommittee Update: Mr. Jacob Parker Carver shared that the Subcommittee is focusing on how local substance use trends and emerging risks should shape Tompkins County's planning, services, and funding priorities. Recent work includes reviewing the Local Services Plan from a substance-use perspective; getting briefed on new, highly potent synthetic opioids and the DOH drug-checking data; examining youth survey findings showing high levels of distress and self-medicating use, especially via friends under 21 and cannabis vaping; and exploring how to strengthen recovery and peer services (learning from Casa Trinity's recovery centers and supporting local peer initiatives at MHA and REACH). The subcommittee is also preparing to engage with the opioid/overdose task force and to use these findings to inform broader county strategy and oversight.

Asteri Discussion: Asteri was discussed as a supportive/affordable housing project, with the core problem seen as a failure in property management and support, not an inherent flaw in supportive housing. Housing partners urged the Board not to send a formal complaint letter, warning it could make future affordable housing approvals harder. Instead, the Board agreed to treat Asteri as a lesson learned: when housing high-need residents, strong on-site management, clear support

structures, and better planning board questions for developers are essential, and this topic should return to future agendas in a forward-looking, non-punitive way.

The meeting was adjourned at 7:00 p.m.

The Next Community Mental Health Services Board Meeting is Monday, July 6, 2026, at 5:30 pm.