Community Health Assessment, 2025-2030

TOMPKINS COUNTY, NEW YORK

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PRODUCED BY

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Community Health Improvement (CHI) Steering Committee

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

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Photo 1 View north from downtown Ithaca with Cayuga Lake at the top

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GLOSSARY

Key Collaborators

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

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

CCHEq: Cornell Center for Health Equity

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Acronyms

BIPOC: Black, Indigenous, or People of Color

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

CHI: Community Health Improvement process

CoC: Continuum of Care

ED: Emergency department

EMS: Emergency Medical Services

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

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

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

NYSDOH: New York State Department of Health

OASAS: New York State Office of Addiction Services and Supports

PA: Prevention Agenda

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

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

SDOH: Social Drivers of Health

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

WHO: World Health Organization

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

EXECUTIVE SUMMARY

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

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

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

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

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