Table of Contents

HEALTH STATUS OF THE POPULATION AND DISTRIBUTION OF HEALTH ISSUES

Tompkins County Whole Health (TCWH) recognizes that the NYS Prevention Agenda (PA) commonly uses the term social determinants of health to describe the conditions that shape health outcomes. For the purposes of this CHA, we use the term social drivers of health to emphasize the dynamic conditions that influence health and wellbeing, while maintaining alignment with the PA framework. This reflects our commitment to describing the conditions that influence health as actionable and changeable rather than fixed.

In the pursuit of a more community-driven approach, the National Association of County and City Health Officials (NACCHO) published updated guidance for the Mobilizing for Action through Planning and Partnerships framework (MAPP 2.0) in 2023. MAPP 2.0 is designed to align local resources and strengths with the goals and visions of community members, emphasizing engagement at every step– from where data comes from, to how it is interpreted, to how priorities are ultimately set. TCWH developed the latest Community Health Assessment and Community Health Improvement Plan (CHA/CHIP) using this updated framework.

As outlined in NACCHO's 182-page handbook, MAPP 2.0 includes three phases, each intended to strengthen community voice and center health equity:

- Build the Community Health Improvement Foundation: establishes shared values, structures, and relationships needed to guide the process.
- Tell the Community Story: collects and synthesizes information about community health through three assessments.
- Continuously Improve the Community: uses the findings to select priorities, implement strategies, and monitor progress.

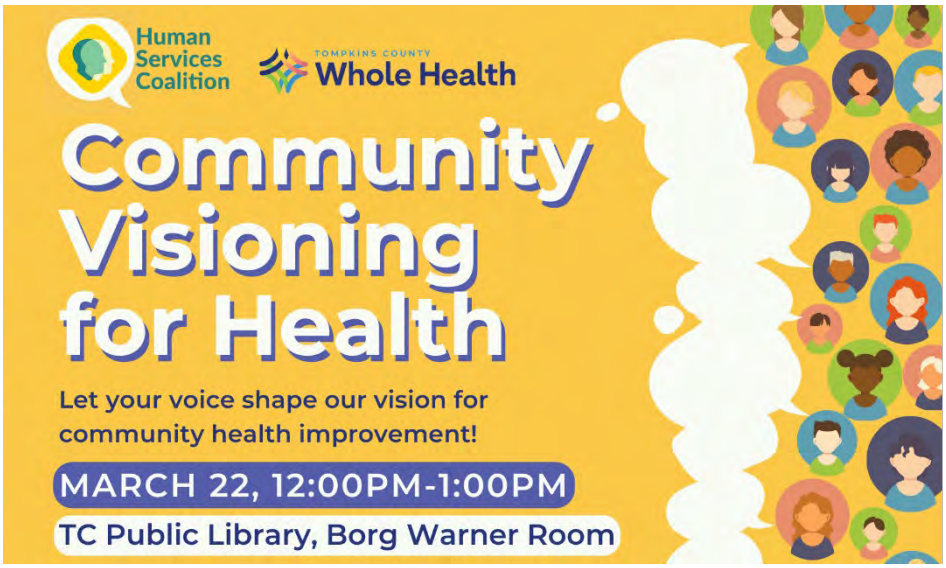

Photo 4 Promotional flier for the MAPP Community Partner Assessment event

Within the “Tell the Community Story” phase, three brief assessments help create a comprehensive understanding of local conditions:

- Community Partner Assessment: explores the capacity, strengths, and priorities of organizations and sectors working in the community.
- Community Status Assessment: examines quantitative health indicators, demographic trends, and socioeconomic conditions.
- Community Context Assessment: gathers lived experiences, qualitative input, and local history to understand the deeper factors shaping health.

Together, these components provide a new scaffold for CHA/CHIP development, one that intentionally centers health equity, community power, and collective action.

The overarching goal of the Community Health Assessment or the CHA is to move the community "upstream" in addressing health inequities by examining not just health behaviors and outcomes, but also the underlying social drivers of health (SDOH) and systems of power, privilege, and oppression that shape them. Through this community-driven process, TCWH sought to understand not only the overall health of the County but also who is experiencing disparities across health, socioeconomic, and environmental outcomes.

By drawing on primary (survey) data, secondary data, as well as qualitative data, the CHA aims to provide a holistic picture of community health and identify areas that require deeper exploration or intervention.

Photo 5 CHI partners gather in October 2025 to review data collected over the past year

Aggregated Data and Data Collection Methods

A significant amount of data for health indicators is available in databases maintained by the New York State Department of Health (NYSDOH). These include the Community Health Indicator Reports

(CHIRS), County Health Indicators by Race and Ethnicity (CHIRE) and the PA. Because these are core indicators that are pulled from many data sources and tracked consistently over years and across the state, they are the predominant source for data cited in this report. Apart from these, data has also been pulled from various local data sources and needs assessment reports.

The 2025-2030 PA takes a comprehensive approach, focusing on the wide range of factors that impact health beyond traditional medical care, disease prevention, and public health systems. It identifies 24 key priorities aimed at improving health outcomes and tackling underlying social issues such as poverty, education, housing, and access to quality healthcare which are all essential to reducing health inequities.

These 24 priorities are organized into five domains, aligned with the Healthy People 2030 framework for Social Drivers of Health:

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

Most secondary data for the Community Health Assessment came from federal (U.S.) and state (NYS) sources.

- U.S. Census Bureau American Community Survey 2016-2020 5-year estimates.
- New York State Department of Health (NYSDOH)
    - Community Health Indicator Reports (CHIRS) is close to 350 data points organized into 15 categories, including cancer, cardiovascular disease, child and adolescent health, injury, occupational health, health status, and tobacco, alcohol, and other substance abuse. Most of the CHIRS data available for this CHA is from years 2017 through 2019.
    - County Health Indicators by Race and Ethnicity (CHIRE)
    - PA dashboard.
    - Data for both the PA and the CHIRS are pulled from a variety of NYS databases, including Vital Records, the Behavioral Risk Factor Surveillance Survey (BRFSS), Statewide Perinatal Data System (SPDS), and the Statewide Planning and Research Cooperative Systems (SPARCS).
- Robert Wood Johnson Foundation (RWJF) collaborates with the University of Wisconsin to publish annual County Health Rankings, a comparison of proprietary indicators across every U.S. County.
- Cornell University MPH professor and students, assisted with qualitative data collection and data coding.

Comparing data with state and national averages is a common practice for understanding health status and setting realistic health goals. Often, these comparisons are made with a statewide number. In NYS, statewide data are typically provided for “Entire State” and /or for “NYS Except NYC.” The latter, also referred to as the “Rest of State” or ROS, is a common point of comparison in this CHA.

Alongside these state-level data systems, local data sources were essential in contextualizing health trends and identifying community-specific inequities. Local data points for this assessment include:

- TCWH Community Health Survey and Program Reports including the Community Health Survey (2025) and Oral Health Report (2024) which provide locally collected quantitative data on health status, access to care, and service use.
- The Community Context Assessment (CCA): Experiences of Birthing Parents in Tompkins County (referred to as the Maternal and Child Health Report, 2025), which offers in-depth qualitative insights into birthing residents' health experiences, barriers to care, and lived experiences across systems.
- The Horn Research and Consulting Needs Assessment (2022) and Tompkins County Planning and Development Reports contributed housing, economic stability, and homelessness indicators.
- Health system data were drawn from the Cayuga Health Partners Health Equity Dashboard (2023).
- Local Services Plan (for mental health, substance use, and developmental disability services) supplied service access/utilization metrics and race-disaggregated outcome data.
- Additional locally grounded sources included Cornell Cooperative Extension and Village at Ithaca's Youth Mental Health Report (2025), the Tompkins County Office for the Aging Senior Survey (2023), and Tompkins Food Future (2022), which provided community-level perspectives on food security, behavioral health, and education outcomes.

Together, these local datasets complement state surveillance systems by providing community-grounded insights that reflect lived experience, service system realities, and context-specific inequities.

Community Health Survey

Photo 6 Promotional theme for the 2025 Community Health Survey

As a part of the Community Status Assessment (CSA) from MAPP 2.0 (Telling the Community Story), TCWH launched its Community Health Survey on January 23, 2025, which remained open until

February 28, 2025. The goal of the survey was to collect comprehensive data on various health indicators and social drivers of health (SDOH) within the community.

A well-coordinated promotional campaign supported the survey, leveraging multiple channels such as printed flyers and social media posts to increase participation. The promotional material was specifically adapted for different platforms, ensuring broad outreach across various community groups. Additionally, a dissemination plan was set in motion, where key stakeholders and collaborators (mentioned in detail in the next section) were tasked with taking ownership of at least five locations or agencies to help distribute the survey and encourage participation. This community-centered approach ensured that the survey reached diverse populations in order to maximize representation across all demographics.

To further encourage engagement and accessibility, the survey was made available in multiple languages. The online version was offered via SurveyMonkey in English and Spanish, while the paper version was available in Chinese (Traditional and Simple), French, Spanish, Russian, and Karen. The paper version was available for download on the TCWH website or by request through email or phone. A telephone survey option was also promoted, particularly through partnerships with 2-1-1 and the County Office For the Aging (COFA). These outreach efforts were further supported by targeted email communications, press releases, and social and print media, encouraging both organizations and individuals to participate and spread the word about the survey. Those age 18 or over and living in Tompkins County were eligible to participate in this survey.

Survey Data Results

- Survey Goals and Demographic Distribution of the Respondents:
- Target Response Goal: 1,200 - 1,500 Respondents
    - Achieved: 2,266 opened survey/answered #1; more than 1,800 completed all or a majority of survey
- Zip Code Representation: 66% of the responses are from 14850
- Age Distribution: Over 60% of the responses from younger populations (Under 65); 38% are from 65+
- Race & Ethnicity Representation: White: 83%, Black: 2%, Asian: 2%, Other: 6%
- Gender Balance: 71% women; 23% men; 3% non-binary
- Education: 24% attended some college or less, 27% have a Bachelor's degree and 46% have a graduate or professional degree.

Compared to County demographics, the survey responses were skewed toward older adults and women.

Following the completion of the Community Health Survey, a comprehensive and methodical data analysis process was undertaken to extract meaningful insights that would inform the CHA and ultimately shape the CHIP. Individual survey questions were analyzed, and cross-tabulation was used to explore intersections between multiple variables. A focus was placed on disaggregating the data by key demographic and socioeconomic variables, including age, race, geographic location, income

level, and other factors that influence health equity. This step allowed the analysis to surface patterns of health disparities across populations. By exploring these intersections, the analysis revealed deeper insights into the relationship between health outcomes, social drivers, and lived experiences.

The survey asked residents to identify the three most important factors that contribute to a healthy community, a recurring question across previous assessments to support trend analysis. Among the 2,017 respondents, affordable healthcare (57%), affordable, safe housing (49%), and a clean environment (36%) emerged as the top three priorities, closely mirroring the findings from the 2022 and 2019 Community Health Assessments. Other frequently selected factors included preventative health services (30%), safe neighborhoods (24%), and mental health supports (24%). These selections provide important context for interpreting community needs and expectations related to wellbeing, access, and environmental quality. *(Figure 11)*

Following the completion of the survey data analysis, clear, accessible visualizations and presentation materials were produced. To ensure a diversity of perspectives in interpreting the results the ADT and the Steering Committee members engaged in structured analysis discussions. In these sessions, participants broke into smaller groups, each focusing on specific domains of the SDOH framework. Within these groups, the survey findings were reviewed using a set of guiding questions:

- What patterns and unexpected results emerge from the data?
- Do the findings align with the original goals and guiding questions of the Community Status Assignment from the MAPP 2.0 process?
- Are the results presented in a clear and accessible manner for both stakeholders and the general public?
- Where do data gaps exist, and what additional qualitative or secondary data might be needed to strengthen the interpretation?
- How can the survey results be shared back with the community in a transparent and engaging way?

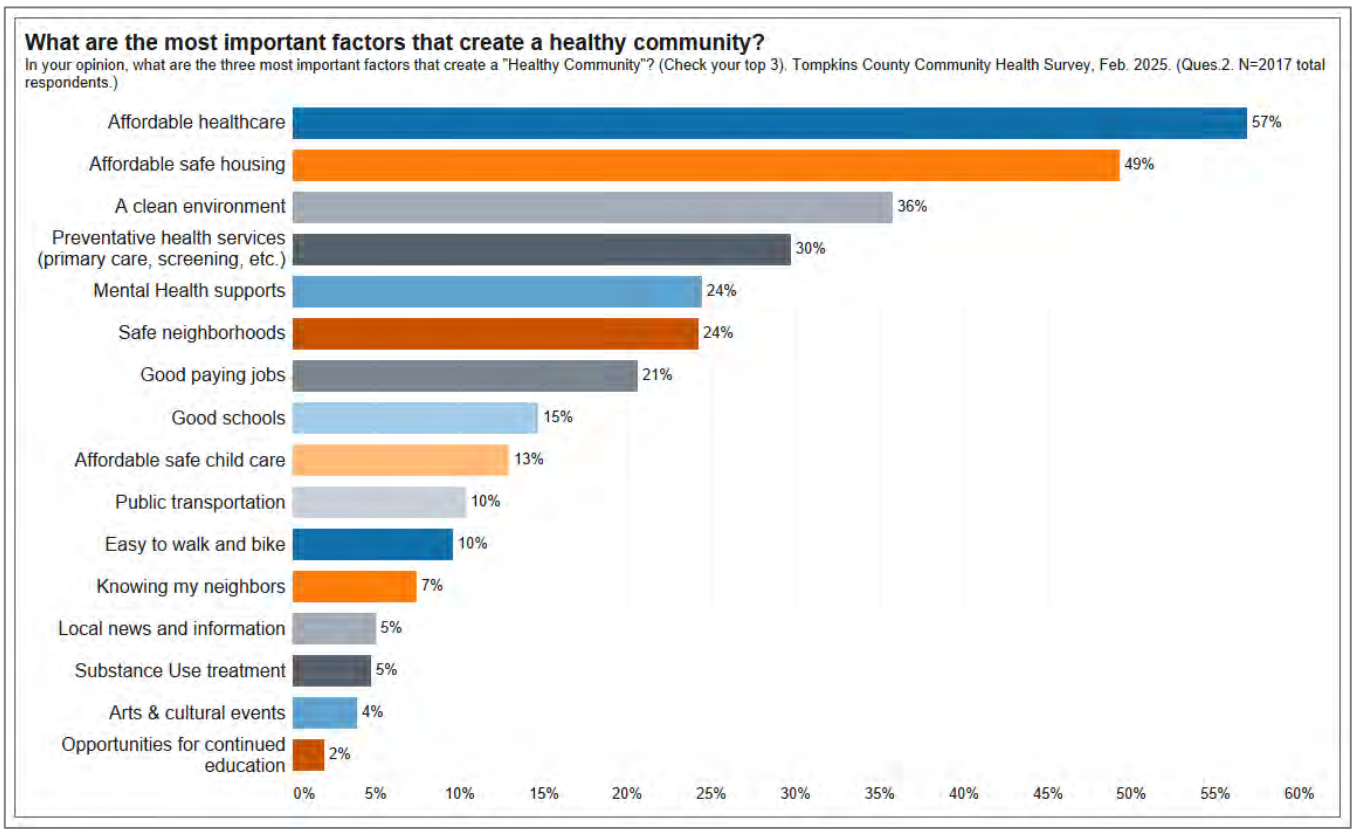

Figure 11 Factors that create a healthy community

COMMUNITY ENGAGEMENT

TCWH collaborated with a broad network of community partners, academic institutions, and advisory bodies to plan and conduct the 2025 Community Health Assessment (CHA). Guided by the MAPP 2.0 framework, the community engagement process was designed to center health equity, ensure diverse representation, and build long-term capacity for shared decision-making.

Key Collaborators and Structures

The Steering Committee served as the primary governance body overseeing the CHA/CHIP process. The committee was composed of 23 representatives from 11 organizations representing public health, healthcare, higher education, social services, community-based organizations, and advocacy groups. The Steering Committee worked collaboratively to establish the CHI charter and guiding values.

The Assessment Design Team (ADT), convened in Summer 2024, functioned as a cross-sectoral advisory group of 17 members responsible for reviewing assessment tools and supporting dissemination of the Community Health Survey. Members included representatives from the hospital, local agencies, non-profit organizations, academic institutions, and community stakeholders with experience in data analysis, communication, and engagement. The ADT met monthly to refine the Community Health Survey, advise on data collection strategies, and ensure alignment with the MAPP framework and community priorities.

In partnership with the Cornell University Master of Public Health (MPH) Program, TCWH engaged academic expertise in qualitative research design. Dr. Elizabeth Fox, Professor of Practice in the MPH Program, provided technical leadership in the design and implementation of qualitative data collection. This included the development of semi-structured interview tools, interviewer training, and integration of qualitative findings. Graduate students supported data coding, thematic synthesis, and community interpretation of findings.

Additionally, a team at Cornell MPH program, through a grant from the Cornell Center for Health Equity (CCHEq), provided ongoing consultation and served as a sounding board throughout the initial review and adoption of MAPP 2.0.

Community Engagement and Visioning

To establish a shared vision for health equity, TCWH launched a community visioning process in Spring 2024. Activities included an in-person event, co-hosted with the Human Services Coalition of Tompkins County (HSC), and a virtual session via Zoom. Ten community poster boards were also displayed across local organizations and public spaces, inviting residents to respond to two key prompts:

1. Who is in our community?
2. In five years, if our community achieved health equity, what would be different?

More than 250 community contributions were received through Post-it notes, drawings, and online comments. Responses were coded thematically, and the results were shared with the Steering Committee, which refined the feedback into a Community Vision Statement.

> *"We are a diverse and caring community rooted in belonging and mutual support. We envision a community where everyone, no matter their background, income, or ability, has access to inclusive healthcare, safe environments, and the resources needed to thrive physically, mentally, and socially."*

Sharing Findings and Incorporating Community Input

Preliminary findings and process updates were shared at multiple public convenings and through digital channels to ensure transparency and invite continued feedback.

Photo 7 Community Partner Convening, October 9, 2025

PHASE I KICK-OFF EVENT (JUNE 7, 2024):

TCWH convened approximately 70 community partners and stakeholders to mark the completion of Phase I. The event introduced the vision statement, provided an overview of the MAPP 2.0 framework, and invited feedback on the direction of the three assessments: the Community Partner Assessment, Community Status Assessment, and Community Context Assessment. Participants also engaged in a Spectrum of Engagement activity to reflect on power-sharing and collaborative decision-making in Tompkins County.

ONGOING ENGAGEMENT THROUGH ADT AND STEERING COMMITTEE:

Feedback from the ADT and CCHEq meetings guided revisions to survey instruments, dissemination plans, secondary data analysis, and interview protocols. These groups served as iterative review bodies to ensure that community priorities were reflected in the assessment design and interpretation.

COMMUNITY PARTNER CONVENING (OCTOBER 9, 2025):

At the conclusion of Phase II, TCWH hosted a second partner convening to share preliminary CHA findings. This session focused on presenting key results from the Community Health Survey, secondary data analysis, and insights from qualitative data collected from the Maternal and Child Health Interviews as well as from the existing local data reports. Partners provided reflections on data, contextual factors, and emerging priorities, which are incorporated into the CHA narrative and inform the forthcoming CHIP planning process.

Through these efforts, TCWH ensured that the CHA was both rigorous and deeply grounded in community experience. Each phase intentionally built on the previous one, beginning with shared values and vision, moving through collaborative data collection, and culminating in the collective interpretation of findings that will guide community health improvement actions in Tompkins County.