Town of Dryden in Tompkins County, May 2026

Community Health Improvement Plan, 2025-2030

TOMPKINS COUNTY, NEW YORK

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PRODUCED BY

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- 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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Executive Summary

The 2025-2030 Tompkins County Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) provide an integrated, equity-centered understanding of community health grounded in the New York State Prevention Agenda and the social drivers of health. Guided by Mobilizing for Action through Planning and Partnerships (MAPP) 2.0, the national 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 the Prevention Agenda domains of 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 and CHIP is its commitment to collaboration. The Steering Committee provided overall direction for the assessment, priority selection, and CHIP development, while the cross-sector Assessment Design Team shaped the Community Health Survey, dissemination plans, and interpretation of findings. Cornell University's Master of Public Health Program supported qualitative design and analysis. Community engagement was woven throughout the process, including a countywide visioning initiative that engaged more than 250 residents and a Community Health Survey completed by more than 1,800 residents. The Community Partner Assessment engaged 76 organizations to identify community strengths, gaps, and opportunities for collective action. Together, these efforts ensured that community voices, lived experiences, and organizational perspectives informed both assessment and planning activities.

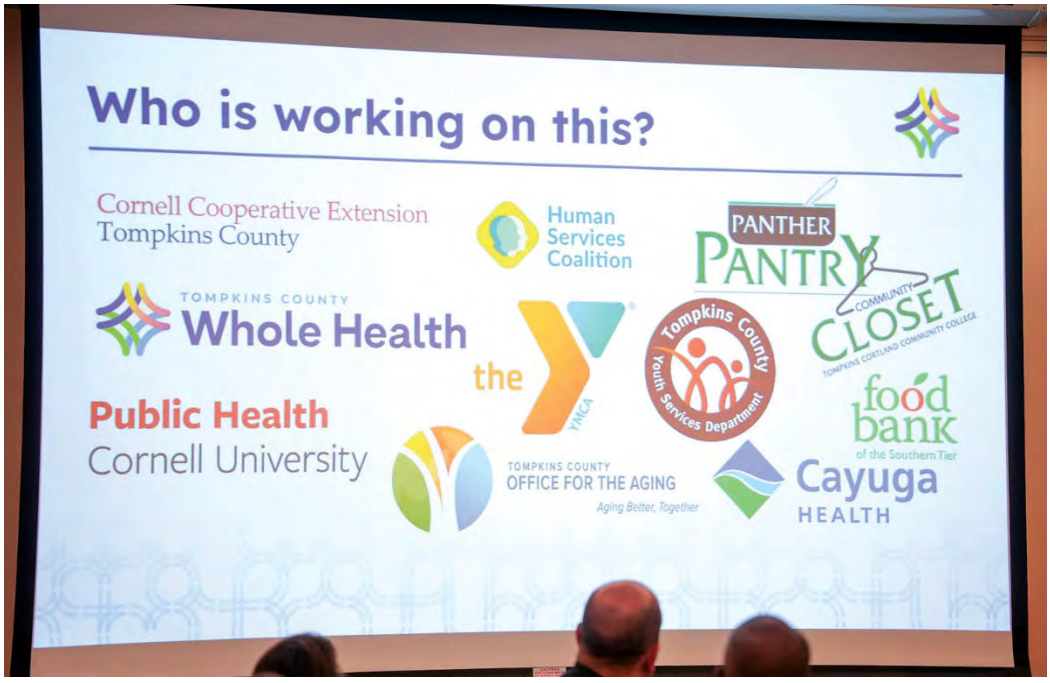

Figure 1: PowerPoint slide from a CHA presentation showing the logo images of Steering Committee community partners

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.

Through a structured prioritization process involving 23 Steering Committee members representing 11 organizations, 5 priorities were selected for the 2025-2030 CHIP: Housing Stability and Affordability; Nutrition Security; Primary Prevention, Substance Misuse, and Overdose Prevention; Chronic Disease Prevention and Control; and Access to and Use of Prenatal Care. These priorities reflect both quantitative evidence and community-identified concerns and acknowledge the persistent disparities experienced by communities facing racism and social injustice, low-income households, and other populations facing barriers to health and well-being.

Across all Prevention Agenda domains, the CHA demonstrates that health in Tompkins County is strongly influenced by social and economic conditions. Challenges related to housing affordability, food insecurity, behavioral health, chronic disease prevention, and access to care are interconnected and shaped by broader structural factors. At the same time, Tompkins County possesses significant assets, including strong academic and healthcare partnerships, a highly engaged nonprofit sector, expanding behavioral health and crisis response systems, and a shared community vision centered on belonging, connection, and equitable opportunity.

The CHIP builds upon these findings by identifying evidence-based interventions and collaborative strategies to address the selected priorities. Planned activities include expanding supportive housing and housing stabilization efforts; expanding screening and closed-loop referrals to increase access to Food as Medicine and produce prescription programs; developing a full-service Crisis Stabilization Center that integrates substance use and mental health services along with establishing a Suicide and Overdose Fatality Review Board; strengthening youth mental health promotion and substance use prevention initiatives; expanding chronic disease screening, referral, and self-management programs; and improving access to prenatal care through outreach, referral, and coordinated maternal health services. Interventions were selected based on Prevention Agenda recommendations, local data, partner expertise, community input, and demonstrated effectiveness in addressing the root causes of health inequities.

Figure 2: CHI Tompkins Timeline for the CHA and CHIP process

Implementation will be guided by cross-sector workgroups and supported through ongoing collaboration among Tompkins County Whole Health, Cayuga Health and the community partners. Progress toward CHIP objectives will be monitored through an evaluation framework that incorporates both process and outcome measures. Population-level data will be monitored using Prevention Agenda indicators and other local, state, and federal surveillance data to measure changes in health status and disparities over time. Process measures will track implementation activities, including program participation, screenings, referrals, service utilization, outreach efforts, and engagement in evidence-based interventions.

Tompkins County Whole Health and Cayuga Health will also facilitate ongoing partner engagement throughout implementation. Priority-specific workgroups will convene regularly to review progress, identify challenges, share successes, and coordinate activities across organizations. Community partners will contribute implementation updates, performance measures, and lessons learned to support continuous quality improvement. Periodic partner surveys and convenings will help to evaluate the effectiveness of the CHIP, identify emerging needs, and inform adjustments to interventions and action steps.

Quarterly reporting of the CHIP will provide opportunities to communicate accomplishments, assess progress toward objectives, and strengthen accountability among participating organizations. Findings from ongoing monitoring, community engagement, and partner feedback will be used to refine implementation strategies, respond to changing community conditions, and ensure that CHIP activities remain aligned with community priorities and health equity goals throughout the 2025-2030 period.

Community Health Improvement Plan, 2025-2030

Overview

The Community Health Improvement Plan represents a shared commitment to improving health and wellbeing across Tompkins County through collaboration, data driven decision making, and meaningful community engagement. Grounded in findings from the Community Health Assessment and shaped by input from residents, partners, and local organizations, this plan identifies priority health needs, underlying social and structural factors, and actionable strategies to advance health equity. It reflects the voices and lived experiences of community members, particularly those from communities facing racism and social injustice, and aligns with the New York State Prevention Agenda and the MAPP 2.0 framework to guide coordinated, measurable action over the coming years. Through this plan, Tompkins County Whole Health and its partners aim to strengthen systems, expand access to care and resources, and create conditions that support healthier outcomes for all who live and work in the community.

Major Community Health Needs

The Community Health Improvement Plan identifies priority health needs based on a comprehensive review of quantitative and qualitative data gathered through the Community Health Assessment, including the Community Status Assessment, Community Partner Assessment, and Community Context Assessment. Findings were triangulated across multiple data sources, including population level indicators, community surveys, qualitative interviews, and stakeholder input, to identify shared concerns, disparities, and opportunities for collective action.

To inform the decision-making process for selecting the 2025-2030 CHIP priorities, the Steering Committee, a group of 23 representatives from 11 partner organizations who guided work through the CHA, drew on their professional expertise, their extensive review of secondary and primary data, and their professional and personal experience as residents of Tompkins County. Throughout the months of August and September 2025, crosscutting themes were identified that reflect how social drivers of health influence access to care, health behaviors, and health outcomes in Tompkins County. Data were collectively reviewed and interpreted to examine patterns across populations, geographic areas, and systems of care. This triangulation of data allowed for a more comprehensive understanding of the issues affecting residents and helped ensure that both quantitative trends and lived experiences were represented.

Based on this analysis, **Issue Statements** were developed in collaboration with the Steering Committee to reflect the most pressing health challenges facing the community. Each Issue

Statement describes who is affected, the magnitude of the issue, contributing factors, and when and where impacts are most pronounced. This approach ensured that priority areas were grounded in evidence, informed by community voice, and aligned with opportunities for coordinated action through the Community Health Improvement Plan.

Figure 3: Registration at a CHI Partner convening, October 2025

Figure 4: CHI Partner convening, October 2025, where CHIP issue statements were presented

Issue Statements

Cross-cutting Themes

Theme: Access to Care

Access To And Use of Prenatal Care

In Tompkins County, access to timely and equitable prenatal care remains a public health concern, with 76% of birthing people receiving prenatal care in the first trimester, falling short of the Healthy People 2030 target of 81%.

Figure 5: Class series presented by the Ithaca-based Child Development Council

Racial disparities are evident, only 65% of Black/African American individuals receive early prenatal care compared to 78% of White individuals. These disparities may contribute to worse outcomes, including higher rates of preterm birth (13% among Black individuals compared to 8% among Whites) and low birth weight (13% for Non-Hispanic Black infants vs. 6% for Non-Hispanic White).

Community interviews highlight limited provider availability, poor continuity of care, and difficulties navigating insurance and payment systems as key barriers. These gaps add stress during a critical time and contribute to unequal maternal and infant health outcomes in the county.

Community partner engagement in this area includes 21% of the 76 surveyed organizations working on prenatal care and maternal health.

Theme: Preventive Services for Chronic Disease Prevention

Cancer

Despite relatively high overall cancer screening rates in Tompkins County, significant disparities persist, particularly among Black/African American women and underserved populations.

In 2021, 83.5% of residents received breast cancer screenings, exceeding the Healthy People 2030 target of 80.3%. However, only 53.1% of Medicaid eligible women aged 50–74 received a mammogram between October 2019 and December 2021, placing the county in the state's "high concern" category. Racial disparities are particularly notable where only 33% of Black/African American women received mammography screenings compared to 46% of White women.

Barriers such as long wait times, limited provider availability, lack of in-network coverage, and the absence of evening or weekend screening hours continue to limit access. These challenges may contribute to delayed detection and poorer outcomes. Late-stage breast cancer incidence rate is 44.9 per 100,000 and is classified as high concern, and the breast cancer mortality rate is 19.6 per 100,000, not meeting the Healthy People 2030 target of 15.3.

Community partner engagement in this area includes 26% of the 76 surveyed organizations working on chronic disease and cancer domain.

Figure 6: Mobile mammogram vehicle operated by Guthrie Lourdes Hospital in Binghamton, N.Y.

Theme: Preventive Services for Chronic Disease Prevention

Cardiometabolic Diseases

Cardiometabolic diseases, including diseases of heart and diabetes remain a major public health concern in Tompkins County, with persistent racial and access-related disparities in both outcomes and prevention.

Although the overall heart disease mortality rate in the county (144.8 per 100,000) is lower than the state average (230.3), Black residents experience higher mortality rates (178.1) compared to White residents (125.4). Diabetes shows similar inequities, where the mortality rate among Black residents (42.8 per 100,000) is more than double that of White residents (20.2), and the overall county rate (27.8) fails to meet the Healthy People 2030 target of 13.7.

Heart disease and diabetes share overlapping risk factors and preventive strategies, as both are strongly tied to metabolic and lifestyle factors. Preventive care efforts are also falling short. Only 63.2% of adults aged 45+ have been tested for high blood sugar in the past three years which is below the state goal of 71.7%. Among Black residents, only 57% have controlled blood sugar, compared to 72% of White adults.

Multiple factors contribute to these outcomes including limited provider availability, restrictive insurance coverage, high costs, and transportation barriers. These are compounded by behavioral factors where 21% of adults report no leisure-time physical activity, and 34% consume no fruits or vegetables daily. While recreational spaces are available, rural and low-income residents often face access challenges due to poor walkability and geographic isolation.

Of the 76 community organizations surveyed, 26% are working on chronic disease prevention activities. Recent federal funding cuts and the absence of chronic disease self-management programs further limit community capacity to address these issues.

Figure 7: Whole Health outreach includes free blood pressure testing at an annual county-wide event, September 2025

Theme: Primary Prevention, Substance Misuse, and Overdose Prevention

Substance overdose continues to impact Tompkins County, with mixed trends across populations and settings. In 2023, the overdose mortality rate involving any drug was 26.1 per 100,000, lower than the New York State rate of 32.3 but failing to meet the NYS 2030 objective of 22.6. Overdose deaths involving opioids specifically were 3.9 per 100,000, below both the statewide rate (8.9) and the 2030 target (14.3).

Emergency department visits tell a broader story where the 2022 rate for all drug overdoses was 167.8 per 100,000 (compared to 191.9 statewide), while opioid-related ED visits were higher than average at 42.5 per 100,000 (vs. 26.1 statewide).

Treatment and response systems remain active. In 2024, 811.5 per 100,000 residents were enrolled in OASAS treatment programs for opioids as their primary substance, compared to 775.5 in 2023. Naloxone access has also expanded, with community kit distribution rising from 1,284 in 2020 to 6,264 in 2024. EMS naloxone administrations, however, have fluctuated over time, peaking in 2021-2022 at 8 per 1,000 dispatches before dropping to 4.7 in 2023. Access to treatment medications has grown, with 587 per 100,000 residents receiving at least one buprenorphine prescription for opioid use disorder, above both the state rate (446) and the NYS 2030 objective (490.6).

Despite these resources, challenges persist. Community survey data indicate that 12% of residents reported using substances more than they would like, while 6% cited barriers to

accessing treatment. Reported barriers include lack of providers, cost, and difficulty making appointments. Community partner engagement in this area includes 28% of the 76 surveyed organizations working on overdose prevention.

At the national level, recent changes in SAMHSA's strategic priorities raise concerns about the future of harm reduction and voluntary, health-led crisis response. Local progress in naloxone distribution, medication-assisted treatment, and community-based prevention may be affected if federal support shifts away from harm reduction strategies toward more abstinence-based or coercive approaches, underscoring the importance of sustaining local investment and cross-sector collaboration.

Theme: Nutrition and Food Security

Food insecurity continues to affect residents across Tompkins County, with rising demand for assistance and widening disparities across populations. In 2023, 13.1% of residents were food insecure, slightly below the state average (15%) but trending upward from 9% in 2021. In 2024, one in eight adults (12.5%) and one in eight children (12.5%) lacked reliable access to nutritious food.

Racial disparities persist with 33% of Black residents and 28% of Latino residents experiencing food insecurity, compared to 12% of White residents.

Local food systems are under increasing strain. Only half of eligible residents receive SNAP benefits, and 5% of residents live in low-income areas without nearby grocery stores. Requests for food assistance grew 21% between 2023 and 2024 and 121% since 2019, highlighting growing reliance on emergency food programs. Older adults are also affected, with 12% reporting challenges having enough to eat.

Figure 8: Foodnet Meals on Wheels hosts state elected officials and county leaders at their senior dining program in Slaterville Springs

Community members and service providers identify persistent barriers including affordability, transportation, stigma, lack of culturally appropriate foods, and income limits that exclude working families from public assistance. About one-third of food-insecure households earn too much to qualify for benefits but still struggle to afford food. Chronic food insecurity contributes to poor health outcomes, higher stress, and reduced educational and employment opportunities.

Of the 76 surveyed organizations and agencies, 55% responded they are working to improve nutrition and food security.

Theme: Housing Stability, Affordability and Homelessness

Housing instability continues to be a challenge in Tompkins County, particularly for those with low income, young adults, single parents, and historically marginalized populations. Nearly one in three households (33%) spend half of their income on housing, higher than both the state (26%) and national (24%) averages. Homelessness affects 12.6 per 10,000 residents, the third highest rate among comparable Continuums of Care (CoC), a communitywide planning approach to promote the goal of ending homelessness, and 54.5 per 10,000 residents use emergency or transitional housing annually. Waitlists for Section 8 vouchers and public housing range from 2-2.5years, while the county's rental vacancy rate remains critically low at 3.2%.

Racial disparities are evident. Within the county's homeless CoC population, BIPOC residents represent 12.4% of the homeless population but make up nearly half of all shelter residents. Among those experiencing homelessness, 38.3% report a mental health disorder, 26.8% a substance use disorder, and 40% identify as survivors of domestic violence. Formerly incarcerated individuals face disproportionately high housing instability. Youth and young adults encounter unique risks: 11% of shelter guests are ages 18-25, youth homelessness has tripled since 2021, and no developmentally appropriate shelter exists locally.

Community members and service providers describe barriers to stable housing, including high rental costs, long waitlists, discrimination, and difficulty navigating fragmented systems. Affordable units are scarce while higher-priced rentals remain vacant, and emergency shelters often cannot accommodate "pets, partners, or possessions." Transportation and communication barriers further limit access to housing assistance.

Of the 76 surveyed organizations and agencies, 49% responded they are working on overdose prevention.

Figure 9: Ribbon cutting at the Northside Apartment Complex in Ithaca, November 2024

Theme: Preventive Services for Chronic Disease Prevention

Oral Health Care

Access to oral health care in Tompkins County is limited, particularly for Medicaid beneficiaries, children, and rural or low-income residents. The county has just one dentist for every 1,660 residents and is well below the state ratio of 1,200:1, contributing to delays and unmet needs. Only 26.8% of Medicaid enrollees had at least one dental visit in 2023, and just 23.6% received preventive care, both tagged as “moderate concern” by New York State.

Barriers are widespread with 60% of residents reporting difficulty accessing dental care due to high costs, lack of insurance or in-network providers, long wait times, and a shortage of local dentists. Nearly half of parents reported traveling over an hour outside the county to find dental services for their children, and there are currently no pediatric dentists available locally. Parents reported only 24.5% of children saw a dentist in the past 12 months.

Workforce shortages are compounded by limited local training opportunities in oral health career pathways. Community partner engagement in this area includes 13% of the 76 surveyed organizations working on oral health care.

Theme: Mental Health Well-being and Substance Use

Depression affects both youth and adults in Tompkins County and is closely linked with substance use and difficulties accessing timely care. On average, 15% of adult residents reported experiencing poor mental health for 14 or more of the past 30 days (compared to 13% statewide and 15% nationally). Among youth, 35.2% of students in grades 7-12 reported feeling depressed most days, and 44.1% reported feeling "I am no good at all." Substance use often overlaps with these challenges, with 72% of students reporting they use substances "to feel better."

Barriers to care contribute to these outcomes. Residents describe shortages of mental health professionals, long wait times, lack of in-network insurance coverage, and stigma around mental health and substance use. Workforce shortages have further reduced access to mental hygiene services, while the limited availability of trauma-informed care creates additional challenges. Community members emphasize that unless individuals are able to pay out of pocket, they often face restricted choices of therapists and long waitlists, particularly for those on Medicaid.

Community partner engagement in this area includes 46% of the 76 surveyed organizations reporting work in the domain of depression.

Theme: Mental Health Well-being and Substance Use

Youth Vaping

Youth vaping is a growing concern in Tompkins County, with use increasing steadily through adolescence and often linked with coping behaviors. In 2023, lifetime nicotine vape use rose from 3% in grade 7 to 22% in grade 12, while lifetime marijuana vape use increased from 1% to 25% across the same grades. Past 30-day use showed similar trends, with 2% of middle school students and 9% of high school students reporting nicotine vaping, and 1% of middle schoolers and 8% of high schoolers reporting marijuana vaping.

Perceptions of harm and social norms shape these behaviors. Among students in grades 7-12, 25.6% perceived little or no risk from nicotine vapes, while peer disapproval was reported at 77% compared to 95% for parental disapproval. Substance use was also tied to coping, with 72% of students reporting they use substances "to feel better."

Qualitative feedback reflects this progression where middle school students often cited curiosity and peer pressure as reasons for vaping, while high school students were more likely to describe vaping as a way to manage stress or cope. Compared to statewide averages, Tompkins County rates remain lower, but the steep increase by grade level highlights growing vulnerability among older youth.

Community engagement in this area includes 17% of the 76 surveyed organizations working in the domain of tobacco and e-cigarette use.

Figure 10: Anti-vaping campaign, "Keep your focus, not your fix. Vaping can make life a blur. Save your breath for the things you love to do." Tobacco Free Tompkins, Tompkins County Whole Health, Ithaca City School District, with funding from NYSDOH Advancing Tobacco Free Communities

Theme: Health and Wellness Promoting Schools

Education Access and Chronic Absenteeism

Chronic absenteeism is a barrier to educational attainment and long-term health in Tompkins County, with disparities noted across student groups. In the 2022-23 school year, the chronic absence rate across all districts was 23%, matching the statewide rate but failing to meet the Healthy People 2030 target of 16.4%. Rates in the Ithaca City School District (ICSD) were especially high in the 2021-22 school year, when 59% of Black students, 53% of economically disadvantaged students, 48% of Hispanic/Latino students, and 45% of students with disabilities were chronically absent, compared to 29% of White students. At Lansing School District, absenteeism among economically disadvantaged students was 31% and students with disabilities was 32%.

Contributing factors are multifaceted and extend beyond the classroom. Families experiencing economic hardship or parental struggles with mental health face greater challenges supporting consistent school attendance. Students often lack a strong sense of connection to school, with some reporting that attention is directed primarily toward elite college applicants or those most at risk, leaving others without needed support. Additional drivers include the COVID-19 pandemic and post-pandemic challenges (e.g. socialization), pressures on first-generation students, and the need for some youth to work to support their families.

Community partner engagement in this area includes 40% of the 76 surveyed organizations working on education access.

Theme: Mental Health Well-being and Substance Use

Suicide

Suicide and self-harm remain elevated concerns in Tompkins County, with outcomes that surpass state averages and fall short of public health targets. From 2020-2022, the county's suicide mortality rate was 10.9 per 100,000, compared to 8 statewide and above the NYS 2030 objective of 6.7.

Emergency department visits for self-harm highlight the burden among youth and young adults: in 2021, rates were 209.8 per 100,000 for ages 10-19 and 293.8 for ages 25-34, compared to much lower rates in older age groups. Drug poisoning and overdose accounted for nearly half of all self-harm cases. Community survey data indicates 8% of respondents reporting thoughts of self-harm or suicide.

Service access challenges contribute to these outcomes. Residents report difficulty finding providers, long wait times, and limited in-network coverage. Workforce shortages have reduced availability of mental hygiene services, and while the 988 crisis line and regional CSIDD were introduced in 2022, local capacity remains limited. As one participant observed: "We don't have enough therapists in this community for the need and… who is able to take insurance versus not… that limits the type [of care provided]."

Community partner engagement in this domain includes 29% of the 76 surveyed organizations reporting work on suicide prevention.

Figure 11: CARE Team, Crisis Alternative Response & Engagement, Tompkins County Sheriff's Office, Ithaca Police Department, Tompkins County Whole Health

Theme: Economic Stability

Poverty

Economic instability remains a core challenge in Tompkins County, where 15.3% of residents live below the poverty level, higher than the New York State average (14.2%) and nearly double the Healthy People 2030 target (8%). Notable racial disparities persist, with 55% of Native Hawaiian and Pacific Islander residents and 37% of Black residents living in poverty, compared to 14% of White residents.

Additionally, 41% of Black youth under 18 live in poverty compared to 8% of White youth. The high cost of living could compound these inequities. On average, households spend 44% of their income on childcare for two children which is well above state (38%) and national (28%) averages. Community survey data show that 40% of residents have difficulty paying for basic needs, and 41% report stress or anxiety related to financial insecurity.

Community members describe how eligibility limits, loss of benefits after gaining employment, and childcare costs make it difficult to achieve financial stability. Local trends also reflect the influence of social support systems where poverty rates fell sharply during 2020 when federal

benefits and safety net programs were expanded, underscoring how robust supports can reduce poverty, while their reduction risks reversing these gains.

Of the 76 surveyed organizations and agencies, 62% responded they are working to address poverty and related economic challenges across the county.

Theme: Injuries and Violence

Safe Neighborhoods

Injuries and violence continue to affect community safety and well-being in Tompkins County, with disparities by race and type of injury. The county's overall index crime rate (1,907 per 100,000) and property crime rate (1,736 per 100,000) both exceed state averages. The domestic violence rate (282.8 per 100,000) is also higher than the New York State average (269.8).

Black residents experience disproportionate harm while comprising only 5% of the adult population, they account for 26% of arrests and 28% of prison sentences, and their age-adjusted unintentional injury mortality rate (132.4 per 100,000) is more than twice that of White residents (51.2).

Contributing factors include poverty, homelessness, substance use, and systemic inequities that shape neighborhood safety and access to resources. Many unintentional injuries stem from falls, motor vehicle crashes, and overdoses, while intentional injuries result from assault and self-harm. Community perceptions reflect these concerns where 4% of survey respondents rated their neighborhoods as "not safe".

Of the 76 surveyed organizations and agencies, 24% responded they are working on injury prevention or safe neighborhoods.

Figure 12: Ithaca's Northside neighborhood

Prioritization Methods

Description of the Prioritization Process

Priority areas for the 2025-2030 Community Health Improvement Plan were identified through a structured and collaborative prioritization process informed by findings from the Community Health Assessment. Data from the Community Status Assessment, Community Partner Assessment, and Community Context Assessment were synthesized to identify key health challenges, disparities, and system level gaps across Tompkins County.

Following development of Issue Statements for each identified health need, a multivoting technique was used to determine priority areas for action. Multivoting is a consensus based method designed to narrow a broad list of issues into a smaller number of shared priorities by identifying areas of strongest collective agreement. This approach allows issues that may not be the top concern of any single participant, but are widely supported across stakeholders, to rise to the top.

Multi-Voting Technique

The multivoting technique was conducted with the Steering Committee using an electronic polling platform, Menti poll, and consisted of two rounds.

In the first round, Steering Committee members reviewed the full list of issue statements and voted for all health issues they believed should be prioritized. This round was intended to capture broad agreement and ensure that issues with strong overall support were retained. Issues receiving votes from at least half of participants advanced to the second round.

In the second round, participants voted on the condensed list of issues. At this stage, participants were asked to consider factors such as the severity of the problem, the size of the population affected, existing disparities, feasibility of intervention, and the capacity of community partners to support implementation. This round was used to narrow the list to a final set of priorities for the five year planning period.

Through this two round multivoting process, consensus was reached on five priority areas for the 2025-2030 Community Health Improvement Plan. These priorities reflect areas where disparities are most pronounced and where community partners identified the greatest opportunity to support meaningful and sustainable improvement.

Final Priority Areas for 2025-2030

The following five priority areas were selected for the 2025-2030 Community Health Improvement Plan:

1. Housing Stability and Affordability
2. Nutrition Security
3. Primary Prevention, Substance Misuse, and Overdose Prevention
4. Preventive Services for Chronic Disease Prevention and Control, with a focus on Cancer and Cardiometabolic Conditions
5. Access to and Use of Prenatal Care

These priorities reflect both the urgency of need and the opportunity for collaborative action to improve health outcomes and advance health equity across the county. The priorities are included across three areas of social drivers of health domains: Economic Stability, Social and Community Context, and Health Care Access and Quality.

Community Engagement In the Prioritization Process

The prioritization process was driven by strong community engagement and occurred throughout the assessment and planning phases. Input gathered from residents, community based organizations, service providers, and cross sector partners through surveys, interviews, and Steering Committee participation informed the decisions.

The Issue Statements were informed by both quantitative indicators and qualitative input describing lived experiences, service gaps, and barriers to care. Community partners provided insight into where inequities were most pronounced and where interventions could be most effective.

The multi voting process was conducted with the Steering Committee, which includes representatives from public health, healthcare, social services, education, housing, and community based organizations. This ensured that final priorities reflected a shared understanding of community needs, feasibility of implementation, and alignment with existing initiatives.

The final selected priorities thus reflected on areas where disparities were greatest and where partners indicated readiness and capacity to support implementation through systems or programmatic change.

Justification for Unaddressed Health Needs

Several health needs identified through the Community Health Assessment were not selected as primary focus areas for the 2025-2030 CHIP. These include oral health, suicide prevention, injury prevention, and education related outcomes.

While these issues remain important, they were not selected as CHIP priorities for one or more of the following reasons:

- Some are currently being addressed through existing initiatives, coalitions, or funding streams, reducing the need for duplication within the CHIP framework.
- Other issues were identified as areas where local capacity, funding, or infrastructure is currently limited, making large-scale impact less feasible within the current planning period.
- Several topics also overlap with selected priority areas and will continue to be addressed indirectly through strategies related to housing stability, economic security, behavioral health, and access to care.

The decision not to prioritize certain health needs does not reflect a lack of importance. Rather, it represents a strategic focus on areas where coordinated action, partner engagement, and measurable progress are most achievable during the 2025-2030 planning period. These needs will continue to be monitored and trends reviewed through ongoing data collection, community engagement, and future planning cycles.

Developing Goals, Strategies, and Action Plan

Alignment with Prevention Agenda

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

1. Housing Stability and Affordability
    a. Objective 1: Increase the number of people living in subsidized housing in Tompkins County from 4,284 to 4,735 (increase of 10.5%/500 people)
2. Nutrition Security
    a. Objective 2:Objective 2: Decrease consistent household food insecurity from 13% to 12% (decrease of 10%).
3. Primary Prevention, Substance Misuse, and Overdose Prevention
    a. Objective 3: Reduce the crude rate of overdose deaths involving drugs, per 100,000 population from 26.1 to 18.3 (30% change).
    b. Objective 4: Reduce the percentage of youth reporting any current (past 30-days) substance use from 19.7% to 16.7% (decrease of 15%).
    c. Objective 5: Reduce the percentage of youth reporting feeling depressed most days in the past year from 35.4% to 30% (decrease of 15%).
4. Preventive Services for Chronic Disease Prevention and Control
    a. Objective 6: Increase the percentage of younger adults aged 35-44 who had a test for high blood sugar in the past year from 40% to 42% (increase of 5%).
    b. Objective 7: Increase the percentage of adults aged 18 years and older with hypertension who are currently taking medication to manage their high blood pressure from 32% to 34% (increase of 6%).
    c. Objective 8: Increase the percentage of women aged 40-74 who have had a biennial mammogram from 46% to 51.4% (increase of 11.7%).
5. Access to and Use of Prenatal Care
    a. Objective 9: Increase the percentage of birthing persons who receive prenatal care during the first trimester from 81.3% to 83.6% (increase of 4%).

Action Plan

Priority Area: Housing Stability and Affordability

Domain	Economic Stability
Priority	Housing Stability and Affordability
Objective 1: Increase the number of people living in subsidized housing in Tompkins County from 4,284 to 4,735 (10.5% increase/increase by 500)	
Evidence-Based Interventions	
1.1 Provide standardized screening for unmet Housing Security and Affordability needs to improve overall access and secure stable, safe housing.	
Existing Work	Lead Organization(s)
Health systems are currently assessing patients' social needs and linking them with appropriate support services.	Cayuga Health (primary care practices), HSC (CHR&N)
Local CBOs are screening for health related social needs through the 1115 Medicaid Waiver to enroll Medicaid beneficiaries in enhanced services.	Care Compass, HSC, Village at Ithaca, WOC,
Local CBOs are screening for housing needs through standardized community wide methods such as Coordinated Entry or their own systems	Tompkins Community Action, DSS, Cornell Health, IHA, INHS, Catholic Charities, OAR, HSC, Learning Web
CHIP Work	Collaborator(s)
Connecting households eligible for a OTDA shelter allowance with HUD subsidized housing Process: ● # households screened ● # households determined to be eligible ● # households connected Outcome:	HSC (CHR&N), REACH, Village at Ithaca, NYS Office of Children and Families, Human Service Coalition, NYS HCR, Habitat for Humanity, private developers, municipalities, all the partners of the Community Housing Development Fund listed above, and IAED/IDA/TCDC.

● # or % of connected households that secure subsidized housing	
Continuing to build partnerships and membership for CHR&N to support screening for housing security. Process: ● # organizations participating in CHRN ● # new partners added annually ● # partner organizations implementing housing security screening ● # staff trained on housing security screening and referral pathways ● # housing security screenings completed through CHR&N partners Outcome: ● % increase in countywide screening coverage for housing insecurity ● # positive housing screens resulting in a referral ● # screened households successfully connected to housing resources	HSC (CHR&N)
Support and connect individuals who are housing insecure through increased referrals and knowledge of pathways to CoC for supportive housing Process: ● # supportive housing units and vacancies ● # individuals referred to CoC supportive housing programs ● # individuals receiving housing navigation or case management support Outcome: ● # referred individuals successfully housed	HSC, Tompkins Community Action

• # people experiencing homelessness who remain housed for more than 24 months	
Disparities Being Addressed	
• Low-income • Medicaid beneficiaries • Rural • youth • BIPOC population • Formerly incarcerated residents	
1.2 Collaborate with new and current partners to increase access to safe and affordable housing, especially supportive housing and wraparound services, and protecting/maintaining existing housing.	
Existing Work	Lead Organization(s)
EH works closely with mobile home park operators for regulatory compliance in areas of water, waste management, and refuse. (not really HUD housing?)	TCWH-EH
Through HOME-ARP funding, 15 units in ArtHaus are available to reduce homelessness and housing insecurity, and provide intensive case management or medical respite if needed.	REACH Medical
CHIP Work	Collaborator(s)
Support community wide "housing literacy" through the developments of materials and trainings to foster a stronger understanding of the "housing" sector within human services. Promote thorough understanding of existing programs including OTDA funded temporary housing, Housing Choice Vouchers and other mainstream programs. Promote	HSC, Law NY, Planning Department, TCA, INHS, REACH, TCWH

tenant literacy about rights and responsibilities etc. Process: ● # housing literacy materials developed ● # trainings/workshops conducted ● # organizations attending housing literacy trainings ● # partner organizations disseminating materials Outcome: ● % organizations reporting increased understanding of housing resources, tenant rights, and housing programs ● % increase in referrals to housing assistance programs resulting from housing literacy activities	
Establish and promote an easy to access shared listing of affordable housing options, including ones with supportive set-aside units. Process: ● Y/N centralized housing listing established ● # housing units included ● # outreach activities promoting the resource Outcome: ● % increase in referrals to affordable housing providers from participating agencies	HSC, Planning Department, TCA, INHS
Partner with EH staff to educate/train about resources for mobile home park operators and residents so that information can be shared (eg. HEAP, Medicaid 1115 Waiver enhanced services, HNP, etc.) Process: ● # materials developed/shared	TCWH-EH, HSC, DSS, Manufactured Housing Working Group

● # trainings or information sessions conducted ● # mobile home parks participating Outcome: ● # referrals to HEAP, Medicaid 1115 waiver services, HNP, or other programs ● % participants reporting increased awareness of available resources	
Development of an original community-based play exploring themes of housing and housing insecurity in Tompkins County (production 2027). The research and development phase will involve review of CHA data, conducting interviews and story circles with community members who have lived experience. Arts as mechanism for well-being, as well as everyone deserving equity in decent, safe housing Process: ● Develop a documentation and evaluation plan with Cornell MPH ● # qualitative interviews, story circles, as part of research and development of the housing play ● # community members who participate in the development of the housing play, and for data engagement/collecting ● # audience who attend and engage in dialogue about themes explored in the play. Outcome: ● # community partners engaged in housing discussions or initiatives following performances	Civic Ensemble, TCWH, Cornell MPH, HSC, Tompkins Planning Dept

HOME-ARP units at ArtHaus are expected to be full by Q3 of 2026. This program also offers intensive case management. This program will end in 2028 with the goal to have all participants receive Section 8 vouchers and secure permanent housing. Process: ● # units occupied ● # people who participate in intensive case management or respite ● # participants receiving housing stabilization services ● #wrap around/case management/medical provider on site at housing Outcome: ● # participants who receive Section 8 vouchers ● # participants who secure permanent housing ● # participants remaining stably housed 24 months after placement	REACH Medical
Redevelopment of homeless shelter on State St. in downtown Ithaca to include 10 permanent supportive ESSHI units and 7 Medical Respite units by Q1 of 2028. Process: ● Progress on construction ● Y/ N Permanent supportive housing units created ● Y/N Medical respite units created Outcome: ● # ESSHI units occupied ● # medical respite beds utilized ● Average length of stay for respite beds ● # respite participants discharged to stable housing	REACH Medical, TC Youth Services, HSC CoC, Village at Ithaca, TCA, Learning Web, NYS OCFS, DSS, TCWH

Improve potable drinking water systems by continuing to upgrade the physical structures, facilities, and networks to meet Safe Drinking Water Act regulations. ● The Town of Dryden is working with Hanshaw Village, a local mobile home park, to install a municipal sewage line. TCWH and others are supporting the development of a municipal water line to be installed at the same time as the sewer line. Process ● # of units that could be connected to municipal water ● Status of funding application ● Timeframe to build infrastructure ● Y/N Plans developed (Hanshaw Village) ● Y/N plans reviewed by TCWH and partners Outcome: ● Y/N project completed and operational ● # residential units connected to municipal water	Town of Dryden, TCWH-EH, Planning Department (infrastructure grant), Hanshaw Village
Advocate for policies that allow new housing development and services to meet resident needs in existing housing. Process: ● Define health-related considerations for acquiring and developing property for residential development. ● Y/ N Policy recommendations developed ● # meetings with elected officials, planning boards, and municipal partners ● Y/N Public comments or testimony provided	TC Planning and Sustainability, Housing & Community Development Group, INHS, Habitat for Humanity, IAED/IDA/TCDC, Tompkins Chamber

● Y/N Municipalities engaged in housing policy discussions Outcome: ● Policies or planning actions adopted that support housing development ● # new affordable or supportive housing units approved	
Reestablish the Hoarding Taskforce and identify streams of funding for support services Process: ● Y/N Hoarding Taskforce reestablished ● # funding sources identified ● Y/N countywide data collection plan developed ● Meetings convened quarterly Outcome: ● Taskforce reestablished ● # funding sources secured for hoarding-related support services ● Y/N sustainable countywide response framework established ● # partner agencies utilizing coordinated referral pathways	Landlords Association, Child Development Council, DSS/APS/CPS, TCWH (including mental health), HSC/211, SPCA of Tompkins County, COFA, Mental Health Association, Private Mental Health providers, IHA, DOER, Code enforcement
Educate and provide resources and strategies around older adults staying in their homes and living independently and safely. Process: ● # education material developed ● # workshops, presentations, or information sessions conducted ● # older adults reached through outreach activities ● # referrals made to home safety, housing, or supportive services	COFA, Love Living at Home, Lifelong, FLIC

Outcome: ● # older adults connected to services that support maintenance and independent living	
Disparities Being Addressed	
● Low-income ● Medicaid beneficiaries ● Rural ● youth ● BIPOC population ● Formerly incarcerated residents ● People who have experienced or are currently experiencing housing insecurity/instability	

1.1 Provide standardized screening for unmet Housing Security and Affordability needs to improve overall access and secure stable, safe housing.

This CHIP intervention focuses on improving the identification of housing insecurity and strengthening connections to housing resources through standardized screening and referral processes. Housing stability is a critical social driver of health that affects physical and mental health, educational attainment, employment, and overall well-being. In Tompkins County, increasing housing costs, limited availability of affordable housing, and challenges navigating multiple systems can make it difficult for many residents to secure stable housing. Low-income households, Medicaid beneficiaries, rural residents, youth, communities affected by structural racism and social injustice, and formerly incarcerated individuals often experience disproportionate barriers to obtaining and maintaining safe and affordable housing.

Tompkins County has established multiple pathways for identifying housing-related needs through healthcare settings, community-based organizations, Coordinated Entry, and the Medicaid 1115 Waiver. Primary care practices affiliated with Cayuga Health and the Community Health and Resource Network (CHR&N), coordinated by the Human Services Coalition of Tompkins County, screen patients for social needs and connect them to resources. Community partners including Care Compass Network, The Village at Ithaca, Women's Opportunity Center, Tompkins Community Action, the Department of Social Services, Cornell Health, the Ithaca Housing Authority, Ithaca Neighborhood Housing Services, Catholic Charities, Opportunities, Alternatives, and Resources (OAR) of Tompkins County, and Learning Web also screen for housing insecurity and provide navigation support. Through the CHIP, partners will expand participation in CHR&N, increase staff training, strengthen referral pathways, and connect households eligible for OTDA shelter allowances and other assistance programs with HUD-

subsidized housing opportunities. Human Services Coalition and Tompkins Community Action will continue coordinating with the Continuum of Care to provide housing navigation, supportive housing referrals, and case management. State agencies, housing organizations, municipalities, developers, Habitat for Humanity, and economic development organizations will support efforts to increase access to housing opportunities and strengthen countywide coordination.

This intervention advances health equity by creating consistent and coordinated approaches to identifying housing needs and connecting residents to resources regardless of where they seek assistance. Standardized screening and closed-loop referrals can reduce barriers and improve access to housing supports for populations that have historically experienced inequitable access to safe and affordable housing. Strengthening partnerships among healthcare providers, housing agencies, and community organizations will help ensure that housing assistance reaches populations most affected by housing instability and its associated health impacts.

1.2 Collaborate with new and current partners to increase access to safe and affordable housing, especially supportive housing and wraparound services, and protecting/maintaining existing housing.

This CHIP intervention adopts a comprehensive approach that recognizes housing as both a health issue and a community-wide responsibility. Anticipated impacts include increased access to affordable and supportive housing, improved housing literacy, stronger community partnerships, expanded wraparound services, safer housing conditions, and increased long-term housing stability.

Community partners will collaborate to improve housing literacy among service providers and residents by increasing awareness of housing programs, tenant rights, temporary housing resources, and Housing Choice Vouchers. Efforts will also establish a centralized and easily accessible listing of affordable housing opportunities, including units with supportive service set-asides, to improve referrals and coordination among agencies. Environmental Health staff and community partners will support mobile home park (MHP) residents and operators by providing information about available assistance programs and improving infrastructure. Ongoing efforts to connect Hanshaw Village MHP to municipal water and sewer systems will help ensure safe and healthy living conditions.

Supportive housing remains an important component of this strategy. HOME-ARP-funded units at ArtHaus (Cherry St., Ithaca) provide intensive case management and medical respite services with the goal of transitioning residents to permanent housing. Additional supportive housing capacity will be created through the redevelopment of the former homeless shelter (618 W State St., Ithaca), which will include Empire State Supportive Housing Initiative units and medical respite beds. Community organizations and service providers will collaborate to provide wraparound services that help residents maintain housing and improve health outcomes.

This intervention also recognizes the importance of community engagement and systems change. Housing literacy efforts, policy advocacy, and collaboration with planning and economic development organizations will support housing development and preservation. Arts-based initiatives, including a community-developed theatrical production informed by residents with lived experience of housing insecurity, will foster dialogue, elevate community voices, and promote housing as a health and equity issue. Additional efforts include reestablishing the Hoarding Taskforce to coordinate responses for individuals whose housing conditions place them at risk and expanding supports that allow older adults to remain safely and independently in their homes.

Collectively, these activities are expected to increase access to affordable and supportive housing, preserve existing housing, improve housing conditions, strengthen cross-sector collaboration, and support long-term housing stability. The intervention prioritizes populations disproportionately affected by housing insecurity, including low-income residents, Medicaid beneficiaries, rural populations, youth, communities facing structural racism and social injustice, formerly incarcerated individuals, older adults, and people with lived experience of housing instability. Through coordinated investments in housing, infrastructure, services, education, and policy, this intervention seeks to create a more equitable housing system that supports health and well-being for all residents.

Figure 13: Habitat for Humanity project in Tompkins County

Priority Area: Nutrition Security

Domain	Economic Stability
Priority	Nutrition Security
Objective 2: Decrease consistent household food insecurity from 13.1% to 12% (decrease by 7%).	
Evidence-Based Interventions	
2.1 Conduct standardized screening of unmet Nutrition Security needs and provide referrals to state, local, and federal benefit programs and community-based, health-related social needs providers to address unmet needs.	
Existing Work	Lead Organization(s)
Health systems are currently assessing patients' social needs and linking them with appropriate support services.	Cayuga Health (primary care practices), HSC (CHRN)
Local CBOs are involved in screening, referrals, and coordination related to food security	Tompkins County Public Library, Tompkins Community Action, Inc., CCE Tompkins, COFA, Foodnet Meals on Wheels
YMCA, CCETC, Human Services Coalition, Village at Ithaca, and OAR provide screening and navigation services for social care needs (housing, transportation, and nutrition) under the 1115 waiver to Tompkins County residents. Some of these organizations are also part of CH&RN.	YMCA of Ithaca and Tompkins County, CCETC, HSC, Village at Ithaca, OAR, Food Bank of the Southern Tier, Friendship Donation Network, Cayuga Health, Fort Baptist Farm.
YMCA directly provides nutrition services (pantry stocking, mobile food van, food prescription meal boxes, and nutrition counseling)	YMCA of Ithaca and Tompkins County, Food Bank of the Southern Tier, Friendship Donation Network, Cayuga Health, Fort Baptist Farm, Human Services Coalition, Loaves and Fishes.
County agencies and CBO collaborators have formed an active workgroup to strategize around new SNAP Able-Bodied Adults Without Dependents (ABAWD) work	Tompkins County DSS, Workforce Development, Human Services Coalition, Cornell Cooperative Extension Tompkins

requirements. To date, this work group has produced a website to provide information and list opportunities for individuals who may be impacted by these new requirements.	County, United Way, Food Bank of the Southern Tier
CHIP Work	Collaborator(s)
Increase the number of health care practices and other organizations that screen for food insecurity Process: ● # organizations screening for food insecurity ● # eligible patients screened for food insecurity ● # eligible patients who screen positive for food insecurity Outcome: ● # referrals that accessed the resources or % food security referrals resolved	Free Clinic, Food Bank, food pantries, Centralus Health, CCETC, Cornell University, YMCA, Rural Health Network of South Central NY
Increase closed-loop referrals to supportive, trauma-informed, dignified, culturally relevant food and nutrition services (e.g., Food as Medicine, Community Dining, school pantries) Process: ● # referrals placed for food security resources Outcome: ● # referrals that accessed the resources or % food security referrals resolved	Free Clinic, Food Bank, food pantries, Centralus Health, CCE Tompkins County, Cornell University, YMCA, Rural Health Network of South Central NY
Increase awareness and education about SNAP applications and volunteer options for SNAP households to meet the new requirements. Process:	Tompkins Community Action, Inc., DSS, HSC, CCE Tompkins, TCWH, food pantries

• # presentations made to educate the service providers and food pantry staff about the new SNAP requirements • # pantries with capacity to provide SNAP application and/or volunteer assistance on a regular schedule Outcome: • % clients successfully completing SNAP application after assistance from participating pantries • % of SNAP eligible households successfully enrolled for SNAP benefits	
Disparities Being Addressed	
• Individuals from communities facing structural racism and social injustice, particularly Black and Hispanic/Latino • Medicaid beneficiaries • Low-income	

2.2 Expand Food as Medicine and fruit and vegetable incentive approaches across the lifespan, especially for populations at a higher risk of nutrition-related health disparities (e.g., medically tailored meals and groceries, produce prescription programs, etc.).	
Existing Work	Lead Organization(s)
Enrollment of participants and referring health care practices in the produce prescription program increased during 2022-2024.	Rural Health Network of South Central NY, CCE Tompkins, Cayuga Health/Cayuga Center for Healthy Living, Cayuga Women's Health, NorthEast Pediatrics and Cayuga Medical Endocrinology, Cornell University
Food as Medicine program launched in March 2026 with Cayuga Health and YMCA to provide free produce and pantry staples at Cayuga Health's Community Cupboard locations.	Cayuga Health, YMCA

Medicaid 1115 waiver nutrition services offer food vouchers, food boxes, and medically tailored meals to eligible Medicaid Managed Care members. These services will be available through the end of the current waiver period (March 31, 2027), and may be extended in some form after that pending federal and state determinations. Many local organizations and health care providers are participating in identifying and supporting Tompkins County residents to access these services.	Care Compass Collaborative (Southern Tier Social Care Network Lead Entity), Cayuga Health, CCE Tompkins, Human Services Coalition, YMCA, Village at Ithaca, Women's Opportunity Center, OAR, Catholic Charities of Tompkins/Tioga, Rural Health Network of South Central NY
Ithaca Farmers Market, Trumansburg Farmers Market, and Greenstar all participate in Double Up Food Bucks to increase the purchasing power of community members using EBT benefits to purchase food.	Ithaca Farmers Market, Trumansburg Farmers Market, Greenstar
CHIP Work	Collaborator(s)
Expand the number of healthcare practices/providers who receive vouchers to enroll patients in the produce prescription program. Process: ● # of healthcare practices enrolled Outcome: ● # of patients referred/who receive food	Rural Health Network of South Central NY, Cayuga Health/Cayuga Center for Healthy Living
Expand Food as Medicine program at Cayuga Health Community Cupboards and sustain funding. Process: ● # materials created to promote the program ● # Community Cupboard locations ● Amount of secured funding to continue program	Cayuga Health, YMCA

Outcome: ● Increased utilization of Food as Medicine services across sites ● Stability of program funding over CHIP period	
Expand awareness of 1115 Medicaid waiver services, as well as nutrition incentive programs available at Farmers Markets and retailers Process: ● # outreach materials developed ● # presentations on on 1115 waiver and nutrition incentive programs Outcome: ● # referrals or warm handoffs made to waiver and incentive programs ● # individuals enrolled in nutrition incentive programs	CCE Tompkins, COFA, HSC, YMCA
Disparities Being Addressed	
● Individuals from communities facing structural racism and social injustice, particularly Black and Hispanic/Latino ● Medicaid beneficiaries ● Low-income ● Geographically isolated	

2.1 Conduct standardized screening of unmet Nutrition Security needs and provide referrals to state, local, and federal benefit programs and community-based, health-related social needs providers to address unmet needs.

This CHIP intervention focuses on improving nutrition security by expanding standardized screening for food insecurity and strengthening connections to federal, state, local, and community-based nutrition resources. Through increased screening and closed-loop referrals, healthcare providers and community organizations will connect residents with supportive, trauma-informed, dignified, and culturally relevant food and nutrition services, including Food as Medicine programs, community dining, school pantries, and SNAP benefits. Additional efforts will increase awareness of changes to SNAP Able-Bodied Adults Without Dependents (ABAWD) requirements and strengthen the ability of service providers and food pantries to assist with SNAP applications and volunteer options. These activities are expected to improve access to healthy foods, increase successful enrollment in nutrition assistance programs,

strengthen coordination among organizations, and reduce consistent household food insecurity in Tompkins County.

Tompkins County has established a strong network of healthcare providers and community-based organizations engaged in screening, referrals, and nutrition support. Cayuga Health primary care practices and the Community Health and Resource Network (CHRN) conduct social needs screening and connect patients to appropriate services. Community organizations including Tompkins Community Action, Cornell Cooperative Extension Tompkins County, the Tompkins County Public Library, Foodnet Meals on Wheels, the YMCA of Ithaca and Tompkins County, Human Services Coalition, Village at Ithaca, Opportunities, Alternatives, and Resources (OAR), the Food Bank of the Southern Tier, and Loaves and Fishes provide screening, navigation, direct food assistance, and nutrition services. Several organizations participate in the Medicaid 1115 Waiver and provide enhanced nutrition-related services to eligible residents. County agencies, Workforce Development, United Way, and community partners have also collaborated to educate service providers and residents about changing SNAP requirements and available resources. Through the CHIP, healthcare providers, food pantries, academic institutions, and community organizations will expand screening efforts and strengthen referral pathways to ensure residents can access available food resources.

This intervention addresses disparities in nutrition security experienced by low-income households, Medicaid beneficiaries, and communities facing structural racism and social injustice, particularly Black and Hispanic/Latino residents. Standardized screening and closed-loop referrals help ensure that residents are connected to resources regardless of where they enter the system. Emphasis on culturally relevant, trauma-informed, and dignified approaches to food assistance seeks to reduce barriers and improve equitable access to healthy foods and nutrition services.

2.2 Expand Food as Medicine and fruit and vegetable incentive approaches across the lifespan, especially for populations at a higher risk of nutrition-related health disparities (e.g., medically tailored meals and groceries, produce prescription programs, etc.).

This CHIP intervention focuses on expanding Food as Medicine and fruit and vegetable incentive approaches across the lifespan, particularly among populations at increased risk of nutrition-related health disparities. Healthcare providers and community organizations will increase participation in produce prescription programs, expand Food as Medicine programs, and improve awareness of Medicaid 1115 Waiver nutrition services and nutrition incentive programs available through farmers markets and retailers. These efforts seek to strengthen connections between healthcare and nutrition supports and increase access to nutritious foods that help prevent and manage chronic diseases. Anticipated impacts include increased participation in produce prescription and Food as Medicine programs, improved access to healthy foods, enhanced management of nutrition-related conditions, and reductions in nutrition insecurity.

Figure 14: A volunteer serves a community member at the Foodnet senior dining program in Slaterville Springs, August 2025

Tompkins County has developed several innovative partnerships that integrate healthcare and nutrition supports. The Rural Health Network of South Central New York, Cornell Cooperative Extension Tompkins County, Cayuga Health, and clinical partners have expanded produce prescription programs across healthcare practices. Cayuga Health and the YMCA launched a Food as Medicine initiative through Community Cupboards that provide free produce and pantry staples. Through the Medicaid 1115 Waiver, Care Compass Collaborative and numerous community organizations, including the Human Services Coalition, YMCA, Village at Ithaca, Women's Opportunity Center, OAR, Catholic Charities, and the Rural Health Network of South Central New York, help eligible residents access food vouchers, food boxes, and medically tailored meals. The Ithaca Farmers Market, Trumansburg Farmers Market, and GreenStar Food Co-op participate in Double Up Food Bucks, which increases the purchasing power of SNAP benefits. Through the CHIP, healthcare providers, community organizations, and aging services partners will continue expanding referral networks, outreach, and program awareness to ensure residents are connected to available nutrition supports.

This intervention addresses inequities in access to healthy foods experienced by low-income households, Medicaid beneficiaries, geographically isolated residents, and communities facing structural racism and social injustice, particularly Black and Hispanic/Latino residents. Integrating nutrition services with healthcare, expanding access to produce prescriptions and Food as Medicine programs, and increasing awareness of nutrition incentives can help reduce barriers to obtaining healthy foods and support equitable opportunities for lifelong health and well-being.

Priority Area: Primary Prevention, Substance Misuse, and Overdose Prevention

Domain	Social & Community Context
Priority	Primary Prevention, Substance Misuse, and Overdose Prevention
Objective 3: Reduce the crude rate of overdose deaths involving drugs, per 100,000 population from 26.1 to 18.3 (30% change).	
Evidence-Based Interventions	
3.1 Operate a full service crisis stabilization center in Tompkins County - integrate Substance Use Disorder (SUD) treatment and mental health support.	
Existing Work	Lead Organization(s)
Crisis Stabilization Center under construction, with planned opening in second half of 2027; planning informed by Emergency Department utilization data	Cayuga Health and Cayuga Addiction Recovery Services (CARS),
Ongoing coordination with Legislature and OASAS for licensing, funding, and compliance (including bonding and financial stabilization)	CARS, State Agencies, County Legislature
Workforce and operations development underway, including hiring (medical director, ~55 staff), peer support expansion, and collaboration with REACH Medical for referrals	CARS, REACH
CHIP Work	Collaborator(s)
Develop referral pathways and coordination between Crisis Stabilization Center and community partners and agencies. Process: ● Define referral pathway matrix ● # community meetings to develop and coordinate referral process Outcome: ● Y/N Referral pathway developed	CARS, REACH Medical, TCWH Mental Health Clinic, CBOs

Implement partner education initiatives on Crisis Stabilization Center role, appropriate referrals, and crisis response options Process: ● # agencies identified as strong referrals partners and who could support warm hand off ● # presentations to provider agencies and community partners, e.g., how to know when to go to ER or crisis stabilization center Outcome: ● # appropriate referrals placed to the Crisis Stabilization Center from community partners	Cayuga Health, TCWH, Human Service Coalition
Expand peer support services and train staff in co-occurring mental health and substance use care Process: ● # staff trained in integrated mental health and SUD treatment (co-occurring disorders) Outcome: ● % patients receiving integrated mental health and substance use support services	Cayuga Health, TC3, MHA
Disparities Being Addressed	
● Low Income ● Youth ● Young Adults ● Residents experiencing homelessness ● Formerly incarcerated residents	

3.2 Convene and implement a Suicide and Overdose Fatality Review Board (SOFR) and strengthen non-fatal post-overdose follow-up.	
Existing Work	Lead Organization(s)/Collaborators
TCWH reviews Medical Examiner data, 911 data, and NYS Opioid Overdose Quarterly Reports, and maintains public data about fatal overdose.	Substance Use Subcommittee, TCWH, Medical Examiner, 911 Call Center
Narcan Distribution - through outreach workers, providers, patients and stocking of local vending machines and boxes, OOPP sites distribute thousands of NARCAN monthly.	Cornell Health, Ithaca Health Alliance, TCWH, REACH Medical, RHI
Narcan Training: REACH offers NARCAN training by request, many CPR classes include NARCAN	Tompkins County Public Library, REACH Medical, Tompkins Cortland Community College (TC3)
CHIP Work	Collaborator(s)
Convene partners and develop structure, purpose for SOFR Process: ● Assign a coordinator (TCWH) ● Determine key partners (# of partners) ● Develop a charter ● Identify and execute necessary data sharing agreements ● Conduct a simulated SOFR team meeting Outcome: ● Establishment of an operational SOFR ● # overdose and suicide cases reviewed quarterly through the SOFR	TCWH, Substance Use Subcommittee, Opioid Settlement County Funds
Law enforcement referrals to peer partners and treatment options Process:	Ithaca Police Department, OAR of Tompkins County, Cayuga Addiction Recovery Services, REACH Medical/LEAD

• Work with key partners to develop and establish policy for law enforcement referrals • # referrals placed Outcome: • # referrals that successfully connect to peer support, treatment, or recovery services • % decrease in repeat nonfatal overdoses	
Disparities Being Addressed	
• Low Income • Youth • Young Adults • Residents experiencing homelessness • Formerly incarcerated residents	

3.1 Operate a full service crisis stabilization center in Tompkins County - integrate Substance Use Disorder (SUD) treatment and mental health support.

This CHIP intervention seeks to establish a full-service Crisis Stabilization Center that provides integrated mental health and substance use treatment in a less restrictive, community-based setting. The Crisis Stabilization Center will serve as one component of a broader crisis continuum built around the "three-legged stool" approach: someone to call (988), someone to come (mobile crisis response), and somewhere to go (crisis stabilization). Anticipated impacts include increased access to integrated behavioral health services, reduced reliance on emergency departments, improved coordination across crisis systems, and enhanced continuity of care and recovery support.

Current work includes site retro-fitting construction of the Crisis Stabilization Center (2353 N Triphammer Rd. Ithaca), which is expected to open in the second half of 2027. Planning efforts led by Cayuga Addiction Recovery Services and Cayuga Health have been informed by emergency department utilization data and are supported through ongoing coordination with state agencies and the County Legislature related to licensing, funding, and compliance. Workforce development efforts include hiring approximately 55 staff, expanding peer support capacity, and strengthening referral relationships with REACH Medical. Through the CHIP, partners including TCWH Mental Health Services, the Human Services Coalition, community-based organizations, the Mental Health Association in Tompkins County, and Tompkins Cortland Community College will collaborate to establish referral pathways, conduct

community education, support warm handoffs, and train staff in integrated treatment for co-occurring mental health and substance use disorders. Community organizations will also play a critical role in discharge planning and transitions to housing, treatment, peer support, and recovery services.

This intervention advances health equity by improving access to person-centered and integrated behavioral health services for populations disproportionately affected by substance use disorders and structural barriers to care. Warm handoffs, peer support, and coordinated referral pathways can help reduce fragmentation and increase engagement among individuals who have historically experienced stigma, distrust, or difficulty accessing services. By strengthening the local crisis response continuum and expanding low-barrier access to treatment and recovery supports, this intervention seeks to reduce disparities in overdose-related morbidity and mortality among low-income residents, youth and young adults, individuals experiencing homelessness, and formerly incarcerated residents.

3.2 Convene and implement a Suicide and Overdose Fatality Review Board (SOFR) and strengthen non-fatal post-overdose follow-up.

This CHIP intervention seeks to strengthen overdose prevention and deaths of despair prevention efforts by establishing a Suicide and Overdose Fatality Review (SOFR) process and improving systematic post-overdose follow-up. The SOFR will provide a multidisciplinary mechanism to review suicide and overdose deaths, identify missed opportunities for prevention, and inform systems-level improvements. In parallel, partners will strengthen referral pathways following nonfatal overdoses and develop approaches that prioritize trust, relationship-building, and peer engagement. These actions are expected to improve coordination across agencies, increase successful connections to treatment and recovery supports, and reduce future overdose deaths and suicides through data-informed prevention strategies.

Tompkins County Whole Health, the Substance Use Subcommittee of the Community Services Board (CSB), the Medical Examiner, and the 911 Call Center currently monitor overdose trends and maintain public data on fatal overdoses. Community partners, including Cornell Health, Ithaca Health Alliance, REACH Medical, and Rural Health Institute, support widespread naloxone distribution, while REACH Medical, Tompkins Cortland Community College, and the Tompkins County Public Library provide overdose prevention and naloxone training. Through the CHIP, TCWH will coordinate development of the SOFR structure, establish data-sharing agreements, and convene multidisciplinary partners with support from Opioid Settlement Funds. Ithaca Police Department, OAR of Tompkins County, Cayuga Addiction Recovery Services, REACH Medical, and Law Enforcement Assisted Diversion (LEAD) partners will collaborate to establish referral policies that prioritize peer support and treatment engagement. Recognizing that some individuals may be reluctant to engage with law enforcement following an overdose, partners will explore approaches that leverage existing

relationships, including outreach by peer specialists, Crisis Alternative Response & Engagement (CARE) team members, and trusted providers, to create more effective and person-centered pathways to recovery.

This intervention advances health equity by promoting coordinated, data-informed, and trauma-informed responses to overdose and suicide prevention. The SOFR process will provide opportunities to identify structural and systemic barriers contributing to preventable deaths and inform strategies that better serve populations disproportionately affected by overdose, including low-income residents, youth and young adults, individuals experiencing homelessness, and formerly incarcerated individuals. Strengthening peer support, improving follow-up after non-fatal overdoses, and emphasizing trust-based engagement can help reduce stigma and increase access to treatment and recovery resources. Collectively, these efforts seek to prevent future deaths and create a more equitable and responsive behavioral health system across Tompkins County.

Priority Area: Youth Mental Health and Substance Use

Domain	Social & Community Context
Priority	Primary Prevention, Substance Misuse, and Overdose Prevention - Youth Mental Health and Substance Use
Objective 4: Reduce the percentage of youth reporting any current (past 30-days) substance use from 19.7% to 16.7% (decrease of 15%).	
Evidence-Based Interventions	
4.1 Implement a county-wide environmental change strategy (e.g. campaign) to increase the perception of harm from underage substance use and link with mental health.	
Existing Work	Lead Organization(s)
Substance Use education, screening and referrals	Cornell Health, Cayuga Medical, Advancing Tobacco Free Communities & Reality Check (ATFC/RC)
Prevention curriculum (K-12) and mental health screenings	TST BOCES, CCHY, RHI
Recreation and afterschool programming as early intervention/prevention	Tompkins County Youth Services, ATFC/RC
Distribution of Narcan and safe youth programming	Tompkins County Public Library
School visits (high schools/ youth shelters) and guest speakers on safety	Ithaca Police Department
CHIP Work	Collaborator(s)
Develop and expand multi-disciplinary campaign to educate about and prevent youth vaping (eg. Keep Your Focus, Not Your Fix) Process: ● Develop and administer RFP for JUUL Settlement Funds	TCWH, CCHY, TST BOCES, ATFC/Reality Check, TC Youth Services,

• Contract with an organization to support development and expansion of campaign • Y/N create a countywide youth-driven messaging campaign • # prevention messages developed • # presentations • # outlets for disseminating messages and information • # youth attending presentations • # of schools, youth programs, community sites participating • # of impressions/analytics of campaign materials Outcome: • % youth reporting past 30 day vaping • % youth reporting that regular vaping or substance use poses moderate or great risk	
Disparities Being Addressed	
• Youth experiencing homelessness • Low Income Youth • Rural Youth • LGBTQIA+ Youth	

4.1 Implement a county-wide environmental change strategy (e.g., campaign) to increase the perception of harm from underage substance use and link with mental health.

This CHIP intervention focuses on implementing a countywide environmental change strategy to increase awareness of the risks associated with youth vaping and substance use and strengthen the connection between substance use prevention and mental health promotion. Through youth-centered messaging that incorporates diverse voices and experiences and coordinated community education efforts, the initiative seeks to shift social norms and increase perceptions of harm associated with underage substance use. Anticipated impacts include reduced rates of youth vaping and substance use, increased awareness of the health risks associated with nicotine and other substances, and improved understanding of the relationship between substance use and mental health.

This work builds upon existing prevention, education, and early intervention efforts across Tompkins County. Current activities include substance use education, screening, and referrals provided by Cornell Health, Cayuga Health, and NYS Advancing Tobacco-Free Communities and Reality Check. Educational partners including Tompkins-Seneca-Tioga BOCES, the Center for Children's and Youth Services, and the Rural Health Institute provide prevention curricula and mental health screening programs, while Tompkins County Youth Services supports recreation and afterschool programs that promote positive youth development. The Tompkins County Public Library provides safe youth programming and overdose prevention resources, and the Ithaca Police Department conducts school visits and safety education. Through the CHIP, Tompkins County Whole Health, the Center for Children's and Youth Services, TST BOCES, Reality Check, and Tompkins County Youth Services will collaborate to develop and implement a youth-driven campaign supported through JUUL Settlement Funds. Partners will support campaign development, outreach, presentations, and dissemination of prevention messages through schools, youth-serving organizations, and community channels.

This intervention advances health equity by prioritizing populations disproportionately affected by social, economic, and structural factors that increase vulnerability to substance use and limit access to prevention resources. A youth-centered approach that incorporates diverse voices and experiences can help ensure that prevention messages are culturally responsive, relevant, and accessible. Delivering education and awareness activities through schools, youth programs, and trusted community settings can improve reach among youth experiencing homelessness, low-income youth, rural youth, and LGBTQIA+ youth. By strengthening protective factors, promoting healthy coping strategies, and increasing awareness of the risks associated with vaping and substance use, this intervention seeks to reduce disparities and support healthier outcomes for young people across Tompkins County.

Objective 5: Reduce the percentage of youth reporting feeling depressed most days in the past year from 35.4% to 30% (decrease of 15%).	
Evidence-Based Interventions	
5.1 Improve the utilization and availability of age-appropriate mental health well-being programs throughout Pre-K to 12th grade through partnerships with mental health service providers.	
Existing Work	Lead Organization(s)
CARE Team support to Ithaca City School District Staff	Ithaca City Police Department, Tompkins County Whole Health

Screenings and referrals for depression	TST BOCES, School PCPs
After-school program and summer programs for the youth to have a safe place to hang out and engage with their peers.	Tompkins County Youth Services, Tompkins County Public Library, Groton Public Library
4-H Youth Development Program which has four core content areas: STEM (science, technology, engineering and math); healthy living; civic engagement; and food systems/sustainable agriculture.	CCE Tompkins
Teen Intervene- if students don't need CARS level support they are linked to counseling	TST BOCES, School PCPs
TCWH Children and Youth Team provide mental health treatment for anyone 25 and under. Services are provided in clinic locations, school-based sites, and off-site locations.	TCWH, Schools, Southside CC, The Village at Ithaca, GIAC
CHIP Work	Collaborator(s)
Expand Crisis Alternative Response & Engagement (CARE) program to include a clinician for an afternoon shift. Process: ● # CARE team staff ● # youth served by the program ● # referrals made Outcome: ● % youth successfully connected to ongoing mental health services after CARE response ● % youth reporting depressive symptoms or % decrease in youth reporting feeling depressed most days in the past year	Ithaca City Police Department, Tompkins County Whole Health
Implement a navigator program and build a universal referral system	Cornell Cooperative Extension- Tompkins, TCWH School-based MH Services

Process: ● # trained navigators ● # youth connected to services Outcome: ● # referrals that successfully accessed the services	
Expand/implement Mental Health First Aid trainings among staff members of schools/libraries/orgs and youth Process: ● # staff trained ● # orgs with trained staff ● # of youth trained as peers Outcome: ● # youth connected to supportive services following staff intervention	Finger Lakes Library System, School Districts, TST BOCES, TC Youth Services
Increase protective factors by using a Positive Youth Development (PYD) strategy vs. traditional substance use or mental health specific focused programs Process: ● # staff trained in PYD ● # staff trained in trauma-informed care ● # youth participating Outcome: ● % reduction in youth reporting depressive symptoms or persistent sadness ● #/% youth reporting feeling connected to school ● #/% youth reporting feeling connected to community	TC Youth Services, School districts, TST BOCES, TCWH School-based MH Services, School-based MH Services
Build a universal referral system for mental health services in schools Process: ● # referrals placed	TST BOCES, TCWH School-based MH Services, TC Youth Services

Outcome: ● # referrals that accessed the services ● % reduction in unmet mental health needs among referred students	
TCWH Children and Youth Team provides group-based therapy including DBT (mindfulness, emotion regulation, interpersonal communication) Process: ● # group sessions ● # youth participants Outcome: ● # youth completing the full group therapy series ● % reduction in depressive symptoms among participating youth	TCWH
Disparities Being Addressed ● Youth experiencing homelessness ● Low Income Youth ● Rural Youth ● LGBTQIA+ Youth	

5.1 Improve the utilization and availability of age-appropriate mental health well-being programs throughout Pre-K to 12th grade through partnerships with mental health service providers.

This CHIP intervention focuses on improving the availability and utilization of age-appropriate mental health and well-being programs throughout Pre-K through 12th grade by strengthening partnerships among schools, behavioral health providers, youth-serving organizations, and community partners. In addition to increasing access to services, the intervention seeks to strengthen protective factors, the conditions and experiences that promote resilience and reduce the likelihood of poor mental health outcomes. Protective factors include positive relationships with caring adults and peers, social connectedness, school engagement, opportunities for skill-building and leadership, safe and supportive environments, and access to trusted sources of support. Anticipated impacts include earlier identification of mental health concerns, improved access to behavioral health services, increased social connectedness and resilience, reductions in depressive symptoms, and stronger protective factors that support positive youth development and emotional well-being.

This work builds on a strong network of existing programs and partnerships across Tompkins County. The Crisis Alternative Response & Engagement (CARE) program, led by Tompkins County Whole Health and the Ithaca City Police Department, currently supports Ithaca City School District staff and students and will be expanded to include an afternoon clinician to increase responsiveness and continuity of care. Educational partners, including Tompkins-Seneca-Tioga BOCES and school-based primary care providers, provide depression screening, referrals, and Teen Intervene counseling services. Youth-serving organizations, including Tompkins County Youth Services, the Tompkins County Public Library, and Groton Public Library, provide afterschool and summer programs that offer safe spaces and opportunities for meaningful engagement and peer connection. Cornell Cooperative Extension Tompkins County supports positive youth development through its 4-H Youth Development Program and will help implement navigator programs and referral systems. Additional partners, including the Southside Community Center, The Village at Ithaca, the Greater Ithaca Activities Center, school districts, the Finger Lakes Library System, and TCWH Children and Youth Services, provide school-based mental health services, group-based dialectical behavior therapy (DBT), Mental Health First Aid training, and trauma-informed programming. Collectively, partners will strengthen referral pathways, expand youth and staff training, and implement Positive Youth Development approaches that intentionally build protective factors by fostering connectedness, leadership opportunities, self-efficacy, emotional regulation skills, and supportive relationships with peers and adults.

This intervention advances health equity by prioritizing populations that experience disproportionately high rates of mental health challenges and barriers to care. Expanding school- and community-based services, increasing Mental Health First Aid capacity, strengthening navigation and referral systems, and implementing Positive Youth Development and trauma-informed approaches can help ensure that youth receive timely and culturally responsive support in trusted settings. By strengthening protective factors and increasing feelings of belonging and connectedness to schools and communities, these efforts aim not only to reduce depressive symptoms but also to create environments that support long-term mental health and resilience among youth experiencing homelessness, low-income youth, rural youth, and LGBTQIA+ youth throughout Tompkins County.

Priority Area: Preventative Services for Chronic Disease Prevention and Control

Domain	Healthcare Access and Quality
Priority	Preventative Services for Chronic Disease Prevention and Control
Objective 6: Increase the percentage of younger adults aged 35-44 who had a test for high blood sugar in the past two years from 40% to 42% (increase of 5%).	
Evidence-Based Interventions	
6.1 Integrate chronic disease prevention and self-management resource navigation into existing health-related social needs navigation.	
Existing Work	Lead Organization(s)
NY Connects: Navigation and support for Medicare and other health-related programs	COFA's NY Connects
Refer participants to the Ithaca Free Clinic and community health navigators if they express a desire for assistance with chronic diseases such as diabetes.	Tompkins Learning Partners
Refer to Catholic Charities Immigrant Services Program when translation assistance is needed or when assistance with applications for EPIC or other programs is necessary.	Tompkins Learning Partners
The Community Health & Resource Network started in 2024 and expanded to a second cohort of community based organizations in 2025. The network was created to create a platform for referrals between CBOs, including the health system.	Cayuga Health, HSC, 20+ CBOs
CHIP Work	Collaborator(s)
Co-develop question prompts for navigators (trained community workers who guide individuals through the complex healthcare system) to assess community member	Cayuga Health Partners, YMCA of Ithaca & Tompkins County, Cornell Cooperative Extension Tompkins County, and the Human Services Coalition of Tompkins County, Tompkins County Office for the Aging

eligibility for chronic disease prevention and self-management programs Process: ● # question prompts approved by the Community Health & Resource Network Outcome: ● # referrals to chronic disease prevention and self-management programs after implementation of standardized prompts	
Provide training for navigators to assess eligibility and offer navigation for chronic disease prevention and self-management programs. Process: ● # navigators trained Outcome: ● # successful referrals to prevention and self-management programs made by trained navigators	Cayuga Health Partners, YMCA of Ithaca & Tompkins County, Cornell Cooperative Extension Tompkins County, Human Services Coalition of Tompkins County, County Office for the Aging, OAR, Reach Medical
Assess feasibility of electronic health record (EHR) referrals from primary care to the YMCA's chronic disease prevention and self-management programs Process: ● Y/N Feasibility assessed ● Y/N Proposal presented ● Status of proposal approval Outcome: ● Y/N Establishment of an EHR referral workflow between primary care and YMCA programs ● # PCPs sending referrals to the YMCA via Epic	Centralus Health, Guthrie, YMCA of Ithaca & Tompkins County
Increase the availability of navigators by onboarding undergraduate students as Social Resource Navigators	Cayuga Health Partners, CCE Tompkins

Process: ● # students trained Outcome: ● # clients connected to chronic disease prevention or self-management resources through student navigators	
Track referrals to chronic disease prevention and self-management resources created by the Community Health & Resource Network via the Community Health App and other referral programs Process: ● # referrals sent to chronic disease - prevention and self-management resources Outcome: ● # referred individuals who enroll in or complete a chronic disease prevention/self-management program	Cayuga Health Partners, Human Services Coalition
Disparities Being Addressed	
● Individuals from communities facing structural racism and social injustice, particularly Black and Hispanic/Latino ● Medicaid beneficiaries ● Low-income	

6.1 Integrate chronic disease prevention and self-management resource navigation into existing health-related social needs navigation.

Chronic disease prevention refers to policies, programs, services, and individual or community-level actions that aim to reduce the risk of developing long-term health conditions such as diabetes, heart disease, hypertension, cancer, and chronic respiratory diseases, or to delay their progression and complications.

This CHIP intervention focuses on increasing blood sugar screening among adults ages 35 to 44 by integrating chronic disease prevention and self-management navigation into existing health-related social needs support systems. By embedding prevention and referral strategies within community-based navigation programs, the initiative aims to improve awareness of diabetes risk, increase access to preventive screenings and self-management resources such as the

YMCA's Diabetes Prevention Program, and strengthen connections between health care providers and community-based supports. Anticipated impacts include earlier identification of chronic disease risk factors, increased participation in prevention and self-management programs, and improved coordination of care and supportive services.

Figure 15: Program staff at the YMCA of Ithaca & Tompkins County

This work depends on collaboration among health systems, navigators, educational organizations, aging services, and community-based organizations. A navigator is a professional or community health worker who connects individuals with essential non-medical support, such as housing, food, transportation, and financial assistance. They guide individuals through complex social service systems to address social drivers of health and improve overall well-being. Cayuga Health, the Community Health & Resource Network, and more than 20 community-based organizations are working to strengthen closed-loop referral pathways and improve coordination between health care and social care providers. Human Services Coalition of Tompkins County supports community referral infrastructure and resource coordination, while YMCA of Ithaca and Tompkins County provides chronic disease prevention and self-management programming. Cornell Cooperative Extension Tompkins County, the County Office for the Aging, Opportunities, Alternatives, and Resources (OAR) of Tompkins County, and

REACH Medical will support training for navigators and assist with community outreach and navigation services. Educational and literacy organizations, including Tompkins Learning Partners, help connect residents to health care, translation services, and benefits programs, while providers such as Centralus Health and Guthrie are exploring opportunities to streamline electronic referrals to community-based chronic disease prevention programs. The onboarding of undergraduate students as Social Resource Navigators is also intended to expand navigation capacity and strengthen outreach efforts across the county.

The proposed actions are intended to advance health equity by improving access to preventive care and chronic disease resources for populations disproportionately affected by barriers to health care access, including low-income residents, Medicaid beneficiaries, and Black and Hispanic/Latino communities facing structural racism and social injustice. Integrating chronic disease prevention into existing navigation systems may help reduce structural barriers and increase awareness of available services. Community-based navigators and closed-loop referral systems can also improve trust, accessibility, and continuity of care by connecting residents to culturally responsive and locally available resources. Overall, these efforts seek to reduce disparities in chronic disease screening and prevention while supporting healthier outcomes across Tompkins County.

Objective 7: Increase the percentage of adults aged 18 years and older with hypertension who are currently taking medication to manage their high blood pressure from 32% to 34% (increase of 6%).	
Evidence-Based Interventions	
7.1 Implement community screenings to detect and address hypertension (e.g. at community events, in workplaces, wellness programs).	
Existing Work	Lead Organization(s)
Community screenings for blood pressure	TCWH, Cayuga Health
Blood pressure self-monitoring program which helps people make lifestyle changes like taking their antihypertensives, checking their blood pressure regularly and properly, and making smart nutrition choices that benefit their blood pressure.	YMCA

CHIP Work	Collaborator(s)
Train volunteers to provide BP screening in community settings. Process: ● # volunteers who complete training and pass competency assessment ● # community members screened for high blood pressure Outcome: ● # community members screened for high blood pressure	Cayuga Health
Provide community members with actionable information based on their BP screening results including primary care scheduling, health insurance navigation, and the YMCA's blood pressure self-monitoring program. Process: ● # community members screened for high blood pressure who receive actionable information Outcome: ● # individuals with elevated BP who successfully connect to primary care follow-up ● # individuals who enroll in a blood pressure self-monitoring or self-management program after screening	Cayuga Health, TCWH, YMCA of Ithaca & Tompkins County
Identify primary care patients eligible to receive a home blood pressure monitor along with care coordination to support blood pressure control. Process: ● # patients enrolled in program Outcome: ● # patients using home monitoring at least once per week	Cayuga Medical Center’s Internal Medicine Residency

• # patients achieving improved blood pressure control	
Disparities Being Addressed	
• Individuals from communities facing structural racism and social injustice, particularly Black and Hispanic/Latino • Medicaid beneficiaries • Low-income	

7.1 Implement community screenings to detect and address hypertension (e.g. at community events, in workplaces, wellness programs).

This CHIP intervention focuses on increasing the percentage of adults with hypertension who are taking medication to manage their condition through expanded community-based screening, education, navigation, and self-management support efforts. By offering blood pressure screenings in accessible community settings and connecting individuals to follow-up care, insurance assistance, and self-monitoring programs, the initiative aims to increase early identification of hypertension, improve medication adherence and self-management behaviors, and reduce complications associated with uncontrolled high blood pressure.

This work is supported through collaboration among health systems, public health agencies, community organizations, and volunteer networks. Tompkins County Whole Health and Cayuga Health currently conduct community blood pressure screenings and will continue leading outreach and volunteer training efforts. The YMCA of Ithaca and Tompkins County provides a blood pressure self-monitoring program that supports participants in developing healthy lifestyle behaviors, monitoring blood pressure regularly, and improving medication adherence and nutrition practices. Additional collaboration with the Cayuga Medical Center and Weill Cornell Internal Medicine Residency Program will help identify eligible primary care patients who may benefit from home blood pressure monitors and care coordination services. Partners will also help connect community members to primary care providers, insurance navigation assistance, and ongoing chronic disease management resources following screenings. Together, these organizations contribute clinical expertise, educational resources, care coordination, and community outreach capacity to support improved hypertension prevention and management across Tompkins County.

The proposed actions are intended to advance health equity by increasing access to hypertension screening, treatment, and self-management resources for populations disproportionately affected by chronic disease and barriers to care. Community-based screenings in trusted and accessible locations may help reach individuals who are less connected to routine health care services or who experience transportation, cost, language, or

insurance-related barriers. Providing actionable follow-up information, navigation support, and home monitoring resources can also help reduce disparities in diagnosis, treatment adherence, and chronic disease outcomes among Black and Hispanic/Latino residents, Medicaid beneficiaries, and low-income populations. Overall, these efforts seek to improve long-term cardiovascular health outcomes and strengthen equitable access to preventive and chronic disease care throughout the county.

<table>
<tr><td colspan="2">Objective 8: Increase the percentage of women aged 40-74 who have had a biennial mammogram from 46% to 51.4% (increase of 11.7%).</td></tr>
<tr><td colspan="2">Evidence-Based Interventions</td></tr>
<tr><td colspan="2">8.1 Develop a pilot allowing mammogram scheduling without a primary care visit.</td></tr>
<tr><td>Existing Work</td><td>Lead Organization(s)</td></tr>
<tr><td>Primary care practices outreach eligible patients who have not had at least one mammogram to screen for breast cancer in the past two years.</td><td>Cayuga Health</td></tr>
<tr><td>CHIP Work</td><td>Collaborator(s)</td></tr>
<tr><td>Assess the feasibility of implementing a self-referral pilot program for mammography appointments at Centralus Health
Process:
● Y/N Proposal presented to senior leadership
● Status of proposal approval
Outcome:
● Approval of self-referral workflow for mammography scheduling</td><td>Cayuga Health Partners, Centralus Health, Cornell Public Health, NYS Cancer Services Program, Cancer Resource Center of the Finger Lakes, Tompkins County Whole Health</td></tr>
</table>

If feasible, develop and implement a communications plan for promoting the pilot program. Process: ● Y/N Plan developed ● # messages, advertisements Outcome: ● # mammography appointments self-scheduled	Cayuga Health Partners, Centralus Health, Cornell Public Health, Cancer Services Program, Cancer Resource Center of the Finger Lakes, Tompkins County Whole Health
Implement a public education campaign to remind people to schedule their routine screening (eg. Colorectal Cancer coasters from Essex County) Process: ● Y/N Campaign is defined Outcome: ● Y/N Campaign is executed	TCWH, Cancer Resource Center, Cancer Services Program
Disparities Being Addressed	
● Individuals from communities facing structural racism and social injustice, particularly Black and Hispanic/Latino ● Medicaid beneficiaries ● Low-income	

8.1 Develop a pilot allowing mammogram scheduling without a primary care visit.

This CHIP intervention focuses on increasing biennial mammography rates among women ages 40 to 74 by exploring and implementing strategies that reduce barriers to screening access. The proposed self-referral pilot program would allow eligible individuals to schedule mammograms without first requiring a primary care appointment, while public education campaigns aim to increase awareness and encourage routine preventive screening. Anticipated impacts include increased screening rates, earlier detection of breast cancer, reduced delays in care, and improved access to preventive services across the community.

This work involves collaboration among health systems, public health agencies, academic institutions, and community-based organizations focused on cancer prevention and patient support. Cayuga Health currently conducts outreach to eligible patients who are overdue for breast cancer screening and is working with partners to assess the feasibility of implementing a self-referral mammography pilot. Centralus Health will play a key role in evaluating operational

feasibility and potential implementation of the scheduling model. Additional collaborators, including Cornell Public Health, the New York State Cancer Services Program, the Cancer Resource Center of the Finger Lakes, and Tompkins County Whole Health, contribute expertise in public health outreach, patient education, navigation services, and cancer prevention programming. These organizations will support development of communication strategies, public awareness campaigns, and outreach materials designed to increase community awareness of routine breast cancer screening and available services.

The proposed actions are intended to advance health equity by reducing structural and logistical barriers that may limit access to preventive cancer screenings. Allowing self-referral for mammography appointments may improve access for individuals who do not have an established primary care provider or who face challenges scheduling routine health care visits. Public education and outreach campaigns can also help improve awareness of screening recommendations and available resources among populations disproportionately affected by inequities in health care access and outcomes. By increasing access to timely screening and strengthening community outreach and navigation supports, these efforts aim to reduce disparities in breast cancer detection and improve preventive health outcomes for women across Tompkins County.

Priority Area: Access to and Use of Prenatal Care

Domain	Healthcare Access and Quality
Priority	Access to and Use of Perinatal Care
Objective 9: Increase the percentage of birthing persons who receive prenatal care during the first trimester from 76% to 79% (increase of 4%).	
Evidence-Based Interventions	
9.1 Screen prenatal and postpartum clients for health-related social care needs (especially mental health needs) and strengthen referrals.	
Existing Work	Lead Organization(s)
HIP Tompkins - CHWs support clients to navigate pregnancy and health-related social needs.	TCWH
MOMs PLUS+ - Nursing home visiting for prenatal and postpartum visits.	TCWH
Child Development Council (CDC) provides information to pregnant parents on the importance of early prenatal care and transportation to doctor appointments. Participants are connected with other resources such as WIC, MOMS+, etc based on need and interest. Information related to a healthy pregnancy is provided- nutrition, sleep, dental care, abstaining from substance use, mental health needs, preparing for baby, etc.	CDC
Doula Access Initiative (DAI) matches eligible community members with free doula care in the first trimester. DAI doulas provide referrals to services and providers in the community when appropriate.	Doula Access Initiative
The Community Health and Resource Network provides a platform to send and	HSC, Cayuga Health

receive closed-loop referrals between providers and 24 community-based organizations that provide SDOH services including, but not limited to, food resources, housing access/navigation, transportation, education, childcare and employment.	
REACH Medical has a doula and midwife on staff, the practice is working to offer prenatal services. Through County funding, the practice is purchasing ultrasound equipment to offer services.	REACH Medical
CHIP Work	Collaborator(s)
Increase prenatal engagement and visits through education and partnerships. Process: ● # prenatal visits and connects Outcome: ● # completed prenatal visits among enrolled participants ● % birthing persons entering prenatal care during the first trimester	Ithaca OB-GYN, Cayuga Birthplace, pediatric offices, MOMs PLUS+, HIP Tompkins, doula networks, Guthrie Midwives
Increase screening for mental health needs during prenatal visits: Process: ● # people screened ● # referrals for positively screened Outcome: ● # referrals that accessed the resources ● % increase in follow up care utilization among individuals identified with mental health needs	Ithaca OB-GYN, Cayuga Birthplace, TCWH, REACH, Guthrie
Increase postpartum mental health screenings and connections to mental health resources. Process:	Child Development Council; OB-GYN, TCWH (HiP Tompkins, Moms PLUS+, Mental Health Services), Guthrie

● # targeted outreach activities by collaborator(s) ● # MH screenings of postpartum individuals ● # referrals for positively screened Outcome: ● # referrals that accessed the resources ● % increase in follow up care utilization among individuals identified with mental health needs	
Disparities Being Addressed	
● Birthing people from communities facing structural racism and social injustice, particularly Black, Hispanic/Latino ● Low-income families	
9.2 Establish policies and practices supporting doula care and services, especially in areas of maternal deserts and historic underinvestment.	
Existing Work	Lead Organization(s)
DAI- provides free doula services to eligible community members; establishes code of ethics and agreements for doulas in community; supports doula services by paying fair wages/fees directly to doulas	Doula Access Initiative
Training of more doulas who are committed to serving Medicaid beneficiaries, low-income, people who identify as BIPOC. (May 2026)	TCWH/HIP Tompkins Community Action Board - Southside Community Center, DAI, Ithaca Doula Collective
CHIP Work	Collaborator(s)
Increase certified doulas and continue to expand access to doula care for low-income, Medicaid beneficiaries, and/or people identifying as BIPOC during the perinatal phase.	Childhood Development Council, Doula Access Initiative (+ Collaborators: local OBGYN and midwifery practices, TCWH/WIC, REACH Medical, Ithaca Doula Collective), TCWH HIP Tompkins CAB

Process: ● # certified doulas contracted with DAI ● # referrals to DAI ● # doulas enrolled in Medicaid billing Outcome: ● % birthing persons receiving doula support during pregnancy, labor, or postpartum ● # successful linkage to prenatal, postpartum, breastfeeding, and behavioral health supports through doula referrals ● % reduction in disparities in prenatal care access and birth outcomes among populations disproportionately impacted by maternal health inequities	
Disparities Being Addressed	
● Birthing people from communities facing structural racism and social injustice, particularly Black, Hispanic/Latino ● Low-income families	
9.3 Develop peer support services for the prevention of perinatal depression and connect birthing persons to peer support services as part of prenatal care. 9.3.1 Increase postpartum follow up visit among birthing people by 5%	
Existing Work	Lead Organization(s)
Connects birthing families to established peer-supported resources in our community and facilitates connections between families.	Doula Access Initiative
Family Reading Partnership (CBO) hosts a Pregnancy Support Group at The Nook, with participation of birthing parents and support persons. Currently, they have participants represented at all three trimester stages and offer direct services in the form of Pregnancy and New Parent support groups, referring	Family Reading Partnership

birthing parents to other services via word of mouth and a community resources bulletin board, and providing early literacy development information and books via OB/Gyn, midwives, and birthing centers.	
Annual Community Baby Shower started in 2025.	TCWH, Fidelis, Healthy Families
CHIP Work	Collaborator(s)
Increase postpartum engagement and visits by 5% through the HIP Tompkins quality improvement initiative. Process: ● # of successful referrals made ● # postpartum visits completed % patients who receive a follow-up visit between 7 and 84 days after delivery. Outcome: ● # postpartum follow-up visits completed	Ithaca OB-GYN, Cayuga Birthplace, pediatric offices, MOMs PLUS+, doula networks, CMC Birthplace
Establish age-specific play/support groups for birthing parents Process: ● Convene collaborator workgroup/ planning team ● Define local needs ● Track group development, implementation, usage ● # support groups ● # participants Outcome: ● % participants reporting increased social support after participation ● % increase in prenatal care engagement among participants	Family Reading Partnership (+ We collaborate with Connected Journeys Counseling (LMHC, LCPC, IMH-E, PMH-C, ATR-BC) to offer support groups, All pediatric primary care and prenatal care providers (OB/Gyn, midwives, and birthing centers), as well as several other agencies offering services to new families (Whole Health, Child Development Council, etc.), Mental Health Association

<table>
<tr><td>Coordinate with partners to increase free community/peer-to-peer resources including Centering Pregnancy and new parent meet ups.
Process:
public health detailing sessions about Centering Pregnancy
of health care practices that adopt group prenatal care models
# of birthing persons enrolled in group prenatal care
child birth sessions facilitated by TCWH
new parents who participate in support groups/meet-ups after birth
Outcome:
providers participating in Centering Pregnancy
% increase in prenatal and postpartum care engagement among participants</td><td>DAI + local OBGYN and midwifery practices, TCWH/HIP/Mental Health Clinic/WIC, REACH Medical, Childhood Development Council, Ithaca Doula Collective</td></tr>
<tr><td>Expand Community Baby Shower to include more community partners and participants.
Process:
Partner with Cornell Veterans program
Identify lead agency who can receive funding
participants
partner agencies
Outcome:
birthing families connected to community resources and supports</td><td>TCWH, Fidelis, Healthy Families, Cornell</td></tr>
<tr><td colspan="2">Disparities Being Addressed</td></tr>
<tr><td colspan="2">Birthing people from communities facing structural racism and social injustice, particularly Black, Hispanic/Latino
Low-income families</td></tr>
</table>

9.1 Screen prenatal and postpartum clients for health-related social care needs (especially mental health needs) and strengthen referrals.

This CHIP intervention focuses on increasing access to first trimester prenatal care and strengthening screening and referral systems for health-related social needs and mental health support. Anticipated impacts include increased prenatal and postpartum engagement, earlier identification of social and mental health needs, improved access to supportive services, and stronger continuity of care throughout pregnancy and the postpartum period.

This work is supported through collaboration among public health agencies, health care providers, doulas, community-based organizations, and social service networks. Tompkins County Whole Health leads programs including HiP Tompkins (NYS Perinatal and Infant Community Health Collaboratives (PICHC) funding)and MOMs PLUS+ (County-funded), which provide community health worker navigation and nursing home visiting services for individuals in the prenatal and postpartum phases. Child Development Council provides education on healthy pregnancy, transportation support, and connections to programs such as WIC and home visiting services. The Doula Access Initiative connects eligible individuals with doulas early in pregnancy and supports referrals to additional community services when needed. REACH Medical is expanding access to prenatal services through doula and midwifery support, while the Community Health and Resource Network, coordinated by Human Services Coalition of Tompkins County and Cayuga Health, strengthens referral coordination across health and social care providers. Additional partners including Ithaca OB-GYN, Cayuga Birthplace, pediatric practices, mental health providers, and doula networks contribute screening, referral, outreach, and care coordination support throughout the perinatal period.

The proposed actions are intended to advance health equity by addressing barriers that disproportionately affect Black and Hispanic/Latino birthing people, low-income families, and communities facing structural racism and social injustice. Strengthening screening and referral systems may help improve access to mental health services, housing support, transportation assistance, nutrition resources, and prenatal care for populations facing systemic inequities in maternal health outcomes. Providing services through trusted community-based programs, home visiting services, and culturally responsive care models may also improve engagement and continuity of care during pregnancy and postpartum recovery. Overall, these efforts seek to improve maternal and infant health outcomes while reducing disparities in access to prenatal and postpartum care across Tompkins County.

9.2 Establish policies and practices supporting doula care and services, especially in areas of maternal deserts and historic underinvestment.

This CHIP intervention seeks to expand access to doula services, strengthen referral systems, and support policies that sustain and grow the doula workforce, particularly in communities affected by maternal care shortages and historic underinvestment. Anticipated impacts include

increased utilization of doula services, improved connections to prenatal and postpartum care, stronger care coordination, and reductions in disparities related to maternal and infant health outcomes.

The Doula Access Initiative serves as the primary lead organization by providing free doula services, coordinating referrals, supporting workforce standards, and ensuring fair compensation for doulas. Tompkins County Whole Health, the HIP Tompkins Community Action Board (part of the NYS PICHC program), Southside Community Center, and the Ithaca Doula Collective support recruitment, training, and professional development opportunities for doulas committed to serving underserved populations. Additional partners, including WIC, the Child Development Council, REACH Medical, local OB-GYN practices, and midwifery providers, contribute referral pathways and client engagement efforts. Future considerations include technical assistance for doulas, enhanced electronic medical record integration, and advocacy for improved Medicaid reimbursement policies.

The proposed actions are intended to advance health equity by increasing access to culturally responsive and community-centered perinatal support for populations disproportionately affected by maternal health disparities. Expanding doula services and strengthening referral pathways may help reduce barriers related to cost, trust, navigation of the health care system, and continuity of care. Recruiting and supporting doulas who reflect the communities they serve can also strengthen culturally affirming care experiences and improve communication and advocacy throughout pregnancy and childbirth. These efforts aim to improve maternal and infant outcomes while addressing inequities in access to supportive perinatal care services across Tompkins County.

9.3 Develop peer support services for the prevention of perinatal depression and connect birthing persons to peer support services as part of prenatal care.

9.3.1 Increase postpartum follow up visit among birthing people by 5%

This CHIP intervention focuses on strengthening peer support opportunities, increasing postpartum follow-up, and expanding community-based resources that promote social connection and emotional well-being. Anticipated impacts include increased postpartum care utilization, stronger social support networks, improved identification of mental health concerns, reduced isolation, and improved maternal mental health outcomes.

Community-based organizations play a central role in implementing this intervention. The Doula Access Initiative connects families to peer support opportunities and community resources throughout pregnancy and the postpartum period. Family Reading Partnership provides pregnancy and new parent support groups, educational programming, and opportunities for peer connection. Tompkins County Whole Health, Fidelis, Healthy Families, and community partners coordinate initiatives such as the Community Baby Shower and support outreach to expectant and new parents. Health care providers, pediatric practices, OB-

GYN providers, midwives, WIC, mental health providers, and community organizations will collaborate to expand support groups, implement group prenatal care models such as Centering Pregnancy, increase postpartum engagement, and strengthen referral pathways to peer and behavioral health services.

The proposed actions are intended to advance health equity by increasing access to social support, mental health resources, and postpartum services for birthing persons disproportionately affected by poverty, systemic inequities, and barriers to care. Community-based and peer-led support models can help reduce stigma, strengthen trust, and improve access to culturally responsive services for Black and Hispanic/Latino families and low-income households. Expanding postpartum engagement and peer support opportunities may also help address isolation, improve continuity of care, and strengthen protective factors for families during the transition to parenthood. Overall, these efforts seek to improve maternal mental health, strengthen family well-being, and reduce disparities in postpartum care and support across Tompkins County.

Figure 16: Certified Lactation Counselor in the WIC program with a new mother

Population and Process

Disparities and Health Equity

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

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

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

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

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

Geographic Areas of Focus

The geographic area of focus for this Community Health Improvement Plan (CHIP) is Tompkins County, New York, including both urban and rural communities across the county. While the CHIP addresses population health needs countywide, special attention is given to communities and neighborhoods experiencing disproportionately poorer health outcomes, barriers to care, and social and economic inequities. This includes residents in historically under-resourced areas, rural communities with limited access to transportation and health services, and populations disproportionately impacted by poverty, housing instability, food insecurity, mental health challenges, and chronic disease. The CHIP prioritizes collaborative strategies that strengthen access to care, prevention services, mental health supports, and community-based resources across all municipalities and service settings in Tompkins County. Efforts are designed to meet residents where they are by leveraging schools, libraries, community centers, health care organizations, social service agencies, and other trusted community-based locations to improve health outcomes and advance health equity throughout the county.

Local Health Department resources to address the need

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

Hospital resources to address the need

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

Maintaining engagement, tracking progress, making corrections

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

course corrections can take place. On a formal basis, the Director of TCWH's Health Promotion Program is the Chair of the CHIP

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

Presentation, access, and availability of the CHIP

Tompkins County Whole Health and Cayuga Health have posted the CHA on the website with an accessible visual version of the Executive Summary and highlights of the CHA/CHIP on the TCWH website and for dissemination to the public in Spring 2026. The link of this entire report is available on the TCWH and Cayuga Health website. Links will be provided to any partner organizations who want to promote on their website or through social media.

Presentations will be requested at the following venues:

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

In addition, a press release will be issued to the TCWH media list. Notification will be posted on the local Human Services listserv, which is the primary accessible channel to the local nonprofit community. Information about the CHA/CHIP will be disseminated through Whole Health's GovDelivery platform with more than 4500 subscribers. These notices will remind the public of access to the CHA/ CHIP online and invite groups to request presentations. TCWH will continue to present the CHA/CHIP process in related courses in the Cornell MPH Program, TC3 and at Ithaca College, as requested. A subset of the CHIP Steering Committee will convene in summer 2026 to develop a detailed communications plan for further dissemination.

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