Name of County - Organization(s) Tompkins County Whole Health (formerly Tompkins Health Department) Cayuga Medical Center, a member of Cayuga Health

2023 Workplan

Planning Report Liaison Samantha Hillson and Ted Schiele

E-mail: shillson@tompkins-co.org, tschiele@tompkins-co.org

Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Objectives through 2024	Disparities	Interventions	Family of Measures	Projected Outcomes	Implementation Partner *(Please select one partner from the dropdown list per row)*	Projected Partner Role(s) and Resources	2023 Progress to Date	What partnerships or factors helped you (please provide at least one specific example)	Strengths/Challenges
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.3 Increase food security	1.13: Increase the percentage of adults with perceived food security (among all adults) 1.14: Increase the percentage of adults with perceived food security (among adults with an annual household income of <$25,000)	Poverty - low-income, geographic, racial/ethnic	1.0.5: Increase the availability fruit and vegetable incentive programs	# healthcare providers that receive vouchers to enroll patients in the produce prescription program.	1.0.5.1: A partnership with the Rural Health Network of South Central NY will affect an **increase the availability** of produce prescriptions for Tompkins County residents with food insecurity and diet-related chronic disease by 10%.	Other (please describe partner and role(s) in column D)	Rural Health Network of South Central New York (RHNSCNY) and Cayuga Health Partners: Will work together to increase the availability of produce prescriptions for Tompkins County residents.	RHNSCNY facilitated an increase in health care providers that enroll patients in the produce prescription program to 5 in 2023 from 2 in 2022. **Patients eligible for enrollment increased** to 78 in 2023 from 49 in 2022. Cayuga Health Partners recruits practices and providers to enroll patients in the produce prescription program. Two practices newly enrolled in the program in 2023.	RHNSCNY Cayuga Health System	An increase in enrollment in program is documented. Utilization of produce prescriptions is not documented.
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.3 Increase food security	1.13: Increase the percentage of adults with perceived food security (among all adults) 1.14: Increase the percentage of adults with perceived food security (among adults with an annual household income of <$25,000)	Poverty - low-income, geographic, racial/ethnic	1.0.6: Screen for food insecurity, facilitate and actively support referrals	# organizations that adopt policies and practices to screen for food insecurity and actively support referrals. # of referrals enrolled in nutrition assistance programs and f/v incentive programs.	1.0.6.1: A tool for universal screening for health-related social needs (including food security) will be in **active use at 5+ Cayuga Health practices**, at 2+ programs at Tompkins County Whole Health, and in 1+ programs at the Human Services Coalition of Tompkins County. 1.0.6.2: A system for **tracking closed-loop referrals** for individuals screened as positive for food insecurity will be in active use by 2+ users of the universal screening tool cited above. Referrals will be offered support for accessing/ enrolling in nutrition assistance programs and fruit and vegetable incentive programs (e.g., Produce Prescription Program via health care referrals, Farmers Market Nutrition Program, Senior Farmers Market Nutrition Program, SNAP, and WIC).	Other (please describe partner and role(s) in column D)	Cayuga Health, Human Services Coalition and Tompkins County Whole Health (TCWH): Will implement a tool for universal screening for health-related social needs and track closed-loop referrals. CCE Tompkins, County Office for the Aging, Catholic Charities, Foodnet, and TCWH: Will receive referrals to address food insecurity.	Catholic Charities, REACH, Ithaca Free Clinic, Human Services Coalition, TCWH and Cayuga Health Partners screen for food insecurity. Cayuga Health Partners has **recruited 8 additional** primary care pracitces to screen for food insecurity, to a total of 10. Catholic Charities enrolled people in SNAP. REACH uses case managers to **coordinate nutrition assistance referrals**. CCE coordinates the Student Resource Navigator program, which trains college students to facilitate referrals for food insecurity. Human Services Coalition referred 220 individuals to nutrition assistance so far in 2023. TCWH WIC program received 292 external referrals and 24 internal referrals for nutrition assistance. The CHW program received 21 referrals where food security was listed as the primary concern. COFA has over 500 participants in their Senior Nutrition Program, contracted through Foodnet, providing home delivered meals, congregate meals, and nutrition education and counseling. They also provide Farmer's Market coupons to individuals 60+; they distributed 750 coupons in 2023. CATCHI, an interorganizational working group, meets monthly to plan a system for tracking closed-loop referrals.	Cayuga Health and primary care practices HSC Catholic Charities (could use more data) CCE/Student Resource Navigators WIC TCWH/CHW Program COFA FoodNet CATCHi	TCWH does not have a universal screening process. Health Transformations Grant (HSC and Cayuga Health) enables improvements. Specific numbers regarding SNAP enrollment (Catholic Charities), food insecurity screening (CCE), and referrals for food insecurity (CCE) were not reported.
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	4.1.1 and 4.1.2 Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening, cervical cancer screening based on most recent guidelines 4.1.3 and 4.1.4 Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years); (adults with an annual household income less than $25,000)	Poverty - low-income, geographic, racial/ethnic	4.1.1 Work with health care providers/clinics to put systems in place for patient and provider screening reminders (e.g., letter, postcards, emails, recorded phone messages, electronic health records [EHR] alerts).	# healthcare practices and hospitals that receive cancer screening reminder quality improvement training	4.1.1.1 Implement improvements in patient and provider **screening reminders** at three (3) primary care practices in Tompkins County.	Other (please describe partner and role(s) in column D)	Cayuga Health Partners: Will implement improvements in patient and provider screening reminders at Cayuga Medical Associates primary care practices.	CHP has not yet initiated the reminder systems.	Cayuga Health	Plans for the reminder system are ongoing.
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	4.1.1 and 4.1.2 Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening, cervical cancer screening based on most recent guidelines 4.1.3 and 4.1.4 Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years); (adults with an annual household income less than $25,000)	Poverty - low-income, geographic, racial/ethnic	4.1.4 Work with clinical providers to assess how many of their patients receive screening services and provide them feedback on their performance.	% primary care physicians who receive report cards for cancer screening performance	4.1.4.1 **Distributed performance report cards** to 100% of primary care physicians in Cayuga Health Partners network to assess the % of patients who are eligible for screening and who have completed their screening.	Other (please describe partner and role(s) in column D)	Cayuga Health Partners: Will distribute performance report cards to clinical providers to assess the % of patients who are eligible for screening who have completed their screening.	CHP distributes report cards to 100% of clinical providers to assess how many of their patients receive screening services and provide them feedback on their performance.	Cayuga Health	This intervention was successfully implemented. Data regarding changes in cancer screening rates prior-post intervention were not reported.

Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	4.1.1 and 4.1.2 Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening, cervical cancer screening based on most recent guidelines 4.1.3 and 4.1.4 Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years); (adults with an annual household income less than $25,000)	Poverty - low-income, geographic, racial/ethnic	4.1.5 Remove structural barriers to cancer screening such as providing flexible clinic hours, offering cancer screening in non-clinical settings (mobile mammo vans, flu clinics), offering on-site translation, transportation, patient navigation and other administrative services.	# mobile mammography van events promoted. # imaging locations with extended clinic hours for mammograms # imaging locations with improved interpretation services.	4.1.5.1 Promoted or hosted 4 **mobile mammography van** locations where the van is parked for clients. 4.1.5.2 Offer **extended clinic hours** for mammograms at one imaging center. 4.1.5.3 Have an **MOU** (or equivalent) with transportation partners to identify options for individuals who need a ride to and from a colonoscopy procedures. 4.1.5.4 Improved **interpretation services and translation** of print materials at Cayuga Health's imaging locations adding at least 5 languages to the print materials most utilized by patients.	Other (please describe partner and role(s) in column D)	Cayuga Health Partners: Will support practices to offer extended clinic hours for cancer screening services. TCWH, Human Services Coalition, Cancer Resource Center, and Cayuga Health Partners: Will promote mobile mammography van opportunities and work with transportation partners to identify transportation options for individuals who need a ride to and from a colonoscopy procedure. Cayuga Health: Will improve interpretation services and translation of materials at Cayuga Health's imaging locations.	Ithaca Free Clinic hosted the Lourdes Mammogram Van on alternating months. These mammograms were provided free of cost, through resources provided by the Cayuga, Cortland and Tompkins Counties Cancer Services Program. TCWH hosted two mammography van events in 2023. CHP offers **Saturday mammogram hours** (3 Saturdays 8 am - 3 pm Sept - Nov). CHP is partnering with the Cancer Services Program to ensure that individuals who are uninsured or underinsured are able to participate. Insurance navigators and Community Health Advocates at the Human Services Coalition **assisted** with overcoming structural barriers to cancer screening, **by helping clients** with transportation and health insurance.	Ithaca Free Clinic TCWH Cayuga Health HSC	Both availability of cancer screening and barriers to cancer screening were considered. Data regarding the utilization of these interventions was not reported.
Prevent Chronic Diseases		Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	4.2.1 Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5% 4.2.2 Increase the percentage of low-income (<$25,000) adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5%	Poverty - low-income, geographic, racial/ethnic	4.2.1 Promote strategies that improve the detection of undiagnosed hypertension in health systems.	# health screening events hosted # community members who receive blood pressure screening at an event # community members who schedule a primary care appointment at an event	4.2.1.1 Coordinated 1+ **community-based health screening event** per month in partnership with Food Bank of the Southern Tier, Latino Civic Association, Calvary Baptist Church, Southside Community Center, Ithaca YMCA, and other community partners. 4.2.2.1 Staff at each health screening event will include: clinical staff (1+) to provide blood pressure screening, point-of-care HbA1c testing, answer medical questions, CBO staff (1+) to provide resources that address health-related social needs, and one Network Access Center staff (1+) to schedule appointments with primary care.	Other (please describe partner and role(s) in column D)	Cayuga Health: Will support and supervise clinical and administrative staff who staff the events, provide educational materials, equipment and supplies for point-of-care HbA1c testing, and support event planning and marketing. TCWH: Will support and supervise community health workers who staff the events, provide educational materials and assistance with WIC enrollment. Human Services Coalition of Tompkins County: Will support and supervise community health advocates who staff the events, provide educational materials and assistance with health insurance enrollment. CCE Tompkins: Will support and supervise nutrition educators who staff the events and provide educational materials and assistance with SNAP and SNAP-Ed enrollment. YMCA: Will support and supervise wellness educators who staff the events and provide assistance with YMCA program enrollment. Food Bank of the Southern Tier: Will provide resources to support food security Human Services Coalition: Will support and supervise Community Health	CHP **hosted 23 health screening events**, with over 600 individual (duplicates included) interactions with staff. **FBST organizes community health outreach events** at partner food distribution sites. They reach out specifically to organizations that perform hypertension screening, to include this resource at these events. The YMCA offers an **evidence-based Blood Pressure Self-Monitoring Program** that promotes regular self-monitoring of ones blood pressure through consultation with one on one coaches. The program also includes nutrition seminars to promote heart health. The YMCA also has staff that regularly attends local events to conduct blood pressure screenings. The YMCA also offers an evidence-informed Weight Loss Program and is in the process of bringing an evidence-based weight maintenance program for youth called Healthy Weight and Your Child. There have been 12 participants YTD in the Blood Pressure Self-Monitoring Program and 14 in the Weight Loss Program. REACH performs regular hypertension screenings of priority populations.	Cayuga Health Food Bank of Southern Tier YMCA	Multiple organizations are hosting hypertension screening events, broadening the pool of potential individuals reached. Data regarding the number of hypertension screenings at FBST outreach events was not reported.
Prevent Chronic Diseases		Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	4.2.1 Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5% 4.2.2 Increase the percentage of low-income (<$25,000) adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5%	Poverty - low-income, geographic, racial/ethnic	4.2.2 Promote testing for prediabetes and risk for future diabetes in asymptomatic people in adults of any age with obesity and overweight and who have one or more additional risk factors for diabetes.	# health screening events hosted # community members who receive HbA1c testing at an event # community members who schedule a primary care appointment at an event	4.2.1.1 Coordinated 1+ community-based health screening event per month in partnership with Food Bank of the Southern Tier, Latino Civic Association, Calvary Baptist Church, Southside Community Center, Ithaca YMCA, and other community partners. 4.2.2.1 Staff at each health screening event will include: clinical staff (1+) to provide blood pressure screening, point-of-care HbA1c testing, answer medical questions, CBO staff (1+) to provide resources that address health-related social needs, and one Network Access Center staff (1+) to schedule appointments with primary care.	Other (please describe partner and role(s) in column D)	Cayuga Health: Will support and supervise clinical and administrative staff who staff the events, provide educational materials, equipment and supplies for point-of-care HbA1c testing, and support event planning and marketing. TCWH: Will support and supervise community health workers who staff the events, provide educational materials and assistance with WIC enrollment. Human Services Coalition of Tompkins County: Will support and supervise community health advocates who staff the events, provide educational materials and assistance with health insurance enrollment. CCE Tompkins: Will support and supervise nutrition educators who staff the events and provide educational materials and assistance with SNAP and SNAP-Ed enrollment. YMCA: Will support and supervise wellness educators who staff the events and provide assistance with YMCA program enrollment. Food Bank of the Southern Tier: Will provide resources to support food security Human Services Coalition: Will support and supervise Community Health Advocates to provide assistance with health insurance and community health navigation.	CHP hosted 23 health screening events, with over 600 individual (duplicates included) interactions with staff. FBST organizes community health outreach events at partner food distribution sites. They reach out specifically to organizations that perform pre-diabetes screening, to include this resource at these events. **CCE supports health screening events**, and facilitates nutrition classes with information and discussion on diabetes. The YMCA has been a host site of a **plethora** of screening events that focus on chronic disease screenings including cardiovascular disease, cancer, and prediabetes.	Cayuga Health Food Bank of Southern Tier CCE YMCA	The outreach events promoting prediabetes screening are often the same as those promoting hypertension screening, leading to a lack of clear data.

Name of County - Organization(s) Tompkins County Whole Health (formerly Tompkins Health Department)
2023 Workplan Cayuga Medical Center, a member of Cayuga Health

Planning Report Liaison Samantha Hillson and Ted Schiele
E-mail: shillson@tompkins-co.org, tschiele@tompkins-co.org

Priority	Focus Area	Goal	Objectives through 2024	Disparities	Interventions	Family of Measures	Projected Outcomes	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources	2023 Progress to Date	What partnerships or factors helped you (please provide at least one specific example)	Strengths/Challenges
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	1.1.2 Reduce the age-adjusted percentage of adult New Yorkers reporting frequent mental distress during the past month by 10% to no more than 10.7%)	Poverty, low- income, geography; Race and ethnicity, age	1.1.2 Support housing improvement, affordability and stability through approaches such as housing improvement, community land trusts and using a "whole person" approach in medical care.	1.1.2 # of OPWDD beds # of working groups for CoC, # of people housed # of successful discharge plans to beds at least one collaborative activity with the Youth Homeless Demonstration Project	1.1.2 Completed a **restoration of OPWDD residential beds** lost during COVID. **Documenting information** about local housing, including residential supports available to advocate for additional emergency and supportive housing solutions, is **accessible to all partners** through shared docs or on a website. *Coordinated with the Continuum of Care to participate in a working group and support initiatives to increase safe, affordable housing for those unhoused or unstably housed in our community, and have a model for continued support services to meet health-related social needs. *Completed an activity with the Youth Homeless Demonstration Project, an initiative that involves youth in the decision-making project. *Reviewed TC Housing Plan and the CoC Homeless Needs Assessment and Plan to better understand goals and objectives.	Community-based organizations	COFA, Human Services Coalition, TC Whole Health, TC Planning Department, Foodnet, Village at Ithaca, Learning Web, community members, Visiting Nurse Services, SNFs, Bang's Ambulance, ADC	The Learning Web has ongoing collaboration with the Youth Homeless Demonstration Project. They also host a social worker from REACH once a week to **facilitate coordinated care**. ADC assists patients with housing as part of their substance ~~mis~~use treatment. The Village operates a crisis **transitional housing program**, which includes a house with 9 beds and staff who provide supportive services to youth and young adults experiencing homelessness and housing instability. Village at Ithaca has been supporting unaccompanied YYA experiencing homelessness or housing instability through our educational advocacy services for almost twenty years. The Village has been providing focused and intensive case management support in addition to educational advocacy since Fall 2019 and have significantly increased this support with the onset of the COVID-19 pandemic in 2020. **HSC CoC workgroups**: Governance, System Evaluation/Ranking, Home, Together, Housing First, Youth Homelessness, Health and Housing, ESSHI - property managers, human service staff, and developers related to ESSHI funded projects.	Learning Web Village at Ithaca Alcohol and Drug Council HSC CoC	We would like to have more involvement with the CoC - get input from HSC and any other orgs who help navigate supportive housing. (TCA, Village at Ithaca)
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	1.1.2 Reduce the age-adjusted percentage of adult New Yorkers reporting frequent mental distress during the past month by 10% to no more than 10.7%)	Poverty, low- income, geography; Race and ethnicity, age	1.1.4 Support programs that establish caring and trusting relationships with older people.	1.1.4 **# of participants** in the Senior Planet tablet program.	1.1.4 The **Senior Planet tablet program** is focused on individuals who are low-income, rural, socially isolated, and do not understand how to use a computer and other technology. * Matched **20 clients** with friendly visitors to engage and teach the participant how to engage with the program. *Maintained regular **capacity-building** meetings between Cayuga Medical Center and key partners including community skilled nursing and other facilities, Visiting Nurse Service, transportation providers. Meetings **focusing on** upcoming **discharge planning** needs, **barriers to transition** between hospital and facilities, and **situational awareness** of each partner's capabilities and challenges at that point in time. *Extended planning to **longer-term partnerships** including workforce, communications, and system efficiencies and improvements. *The **social engagement subcommittee** of the Long-term care committee disseminated an informational brochure throughout the County to build awareness about social opportunities in the County.	Community-based organizations	**COFA**, Human Services Coalition, TC Whole Health, TC Planning Department, **Foodnet**, Village at Ithaca, Learning Web, community members, Visiting Nurse Services, SNFs, Bang's Ambulance	**COFA** subcontracts with the local Senior Center to provide health promotion and social programming. COFA began to act as a hub for NYS CRC to launch a respite program for caregivers. There are current three trained volunteers, with the goal creating a registry of trained respite providers. There are currently 6 participants in the Senior Planet tablet program. Originally, 20 tablets were distributed, along with an internet stipend. Foodnet hosted **congregate/community meals every weekday**, along with periodic events intended to foster community building among elders. In 11/23, there were 1080 meals served to 67 participants. Foodnet and COFA organized a new congregate meal location (TBD), to be opening 2/24. The **YMCA** offers a variety of senior-centric programs and services including a **Senior Savings Day each Thursday** to increase socialization and physical activity in the senior community. We also offer an **evidence-based walking and socialization** program for seniors who may suffer with arthritis called **Walk with Ease**, which had **70** attendees YTD. The Y also offers an evidence-based fall prevention program for seniors called **A Matter of Balance**, which had **21** attendees, YTD.	COFA Foodnet YMCA	The pilot of the Senior Planet program will not be renewed; existing users can remain in the program as long as they wish.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages	1.2.2 Increase New York State's Community Scores by 7% to 61.3%	Poverty, low- income, geography; Race and ethnicity	1.2.1 Implement evidence-based home visiting programs	1.2.1 # home visits. PICHC (50), SafeCare (84), MOMs Plus (50), COFA Home Health Aide (35 unduplicated clients)	1.2.1 Conducted: * 60 Home **visits per month** and 25 **clients** per **CHW**, for pregnant people and implementation of elements of **Stress-Free Zones** to support people to make informed choices about their pregnancy. * 84 **SafeCare** home visits and education modules for families enrolled in the program through Family Treatment Court. * 80 **MOMS Plus** home visits **per month**, about 70 clients for the year, for pregnant people and those with infants. * 35 Home visits provided by a Home Health Aide funded by Tompkins County Office for the Aging (COFA) to serve clients on a waiting list due to lack of agency aides (started in Nov 2021). This program serves individuals with low-income and minority target populations.	Community-based organizations	Cayuga Health, Cayuga Health Partners, TC Whole Health, Human Services Coalition, Mental Health Association, COFA, Alcohol and Drug Council	COFA also houses the Project CARE Friendly Visiting program and the Caregivers Resource Center. Project CARE has 16 participants receiving weekly visits as of 12/23. COFA completed also home visits through EISEP Case Management (90 clients), TCARE Caregiver Assessments (2 participants), and CAP Home Safety Evaluations (18 as of 11/23) to promote aging in place. There were **437 MOMS** home visits, and **20 PICHC** home visits YTD .	COFA TCWH	Need to adjust projections and think about most meaningful measures going forward.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages	1.2.2 Increase New York State's Community Scores by 7% to 61.3%	Poverty, low- income, geography; Race and ethnicity	1.2.2 Implement Mental Health First Aid	1.2.2 # trainings offered, # of people trained, # of organizations where all or a majority of staff have completed the training course.	1.2.2 Training for employees and community members. Work to create a registry of local organizations, programs and departments where all or the majority of staff have completed the training course. Goals: offer 12 trainings, train 135 people, train all or most staff in 1 organization.	Community-based organizations	Cayuga Health, Cayuga Health Partners, TC Whole Health, Human Services Coalition, Mental Health Association, COFA, Alcohol and Drug Council	Learning Web promoted Mental Health First Aid training for their staff; the majority of their staff have completed the training. The Ithaca Free Clinic has trained 100% of staff in Mental Health First Aid. 100% of TCWH CHWs have been trained in Mental Health First Aid.	Mental Health Association	Need coordinated tracking/data sharing with MHA. We would also like to demonstrate the impact of MHFA on the community, rather than just the number of people trained.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages	1.2.2 Increase New York State's Community Scores by 7% to 61.3%	Poverty, low- income, geography; Race and ethnicity	1.2.3 Policy and program interventions that promote inclusion, integration and competence.	1.2.3 PICHC: # of people with lived experience who participate in the advisory group. # of peer supports with lived experience # of DEI trainings offered # of Resilience to Thriving community trainings	1.2.3 Developed and held first organizational meeting of a **working group that engages people with lived experience** in program development and decision-making for the Perinatal and Infant Community Health Collaboratives (**PICHC**) Initiative in Tompkins County. The group will establish a quarterly meeting. 1.2.3 In alignment with the Mental Health Local Services Plan (**LSP**), implement non-clinical supports, including the work of peers with lived experience, to address social determinants of health (access to medical dental, optical care) and promote health equity for minoritized communities, to support recovery and quality of life. 1.2.3 Completed training for Whole Health (**LHD**) staff (~120 people) as part of a comprehensive Diversity, Equity, and Inclusion framework (eg. motivational interviewing, trauma-informed care, health literacy, cultural humility and SDOH). 1.2.3 Completed at least 5 trainings **in the community** of the evidence-based OWLS organizational workplace and wellness program - Resilience to Thriving and Ripple Effect. Training of 1-2 more staff to facilitate this program. Coordinated by the **Alcohol and Drug Council**.	Community-based organizations	Cayuga Health, Cayuga Health Partners, TC Whole Health, Human Services Coalition, Mental Health Association, COFA, Alcohol and Drug Council	COFA hosted trainings and resources to promote inclusivity such as SAGE, etc. Five employees trained in mental health first aid. The majority of staff have been trained in CPR in Narcan administration. The Ithaca Free Clinic has regular training for all volunteers to receive guidance regarding inclusivity. HSC is helping to facilitate multiple supports for organizations through our capacity building initiatives. They are facilitating the **Leaders of Color initiative** that provides support and development for approximately a dozen local leaders of color. Workshops were offered addressing the following issues: understanding and managing personalities in a workplace, creating LGBTQ inclusive workplace, creating trauma informed organizations for leaders, conflict management and sexual harassment prevention training. A total of **135** people attended these workshops. HSC's Director of Leadership and Development infuses trauma-informed care into many of the capacity training offerings. **TCWH WIC** held 12 DEI trainings, with an average of 3 staff attending per training. **TCWH CHWs** held 3 DEI trainings, with 3 CHWs attending two trainings and 4 CHWs attending the third. The PICHC **Community Advisory Board** has been initiated to improve the PICHC program, provide input from lived experience, focus on advocacy, policy change, and community building, with the first meeting being held on 10/16. The CAB planning group met 10 times prior to the first convening of the CAB. The CAB has 4 people with lived experience participating.	COFA HSC TCWH WIC TCWH PICHC	No data provided for the TCWH Mental Health peer non-clinical supports.

Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance Use Disorders	Goal 2.2 Prevent opioid overdose deaths	2.2.2. Increase the age adjusted rate of patients who received at least one Buprenorphine prescription for opioid use disorder by 20% to 415.6 per 100,000	Poverty, low- income, geography, race, ethnicity, age	2.2.1 Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine;	2.2.1. Overdose death rates (outcome measure) 2.2.4. # of ED visits for overdose (process) 2.2.4. ED visits for overdose demographics (process) 2.2.1. Overdose death demographics (process)	2.2.1 Established baseline data for buprenorphine prescriptions, with data accessible to active partners 2.2.4. Convened cross-sectional stakeholders as part of Opioid Taskforce. Developed community-wide goals using baseline database described above. 2.2.6. Completed a needs assessment strategic plan to improve collaboration between sectors' tracking and reporting mechanisms	Community-based organizations	Opioid Task Force initiated in 2022 to coordinate countywide efforts; REACH, ADC, CARS, TCMH, STAP, Cayuga Medical Center (CMC) REACH and CMC collaborating via RHETC to increase number of providers waivered to prescribe buprenorphine.	ADC provides services to people who need substance use treatment, regardless of their circumstances, which **increases access to MAT**. REACH **offers medications for opioid use disorder** (MOUD) at every patient visit; they have 1,800 patients diagnosed with substance use disorder.	ADC REACH	Data regarding MAT utilization was not reported in a comprehensive manner.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance Use Disorders	Goal 2.2 Prevent opioid overdose deaths	2.2.1 Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.3 per 100,000 population;	Poverty, low- income, geography, race, ethnicity, age	2.2.2 Increase availability of/access to overdose reversal (Naloxone) training to prescribers, pharmacists, and consumers	2.2.1. Overdose death rates (outcome measure) 2.2.4. # of ED visits for overdose (process) 2.2.1. # of community Narcan trainings	2.2.2. Naloxone will be accessible in all Cayuga Health and Whole Health (LHD, LGU) healthcare settings and 25% of staff will be trained in its use, with assurance that at least one trained staff is always available within emergency reach of each Naloxone depository.	Community-based organizations	Opioid Task Force initiated in 2022 to coordinate countywide efforts; REACH, ADC, CARS, TCMH, STAP, Cayuga Medical Center (CMC) Alcohol and Drug Council conducts virtual community Narcan trainings once a month, all clients are offered training to receive a Narcan kit. (Addiction Medicine Consult Service) providing services including Naloxone access/harm reduction.	REACH performs an average of 5 **community Narcan trainings** per month. REACH also offers Narcan to patients at every visit. The Learning Web has trained 100% of staff on **Narcan administration**. Alcohol and Drug Council conducts **virtual community Narcan trainings** once a month, all clients are offered training to receive a Narcan kit. The Ithaca Free Clinic has Narcan available in every treatment room and office. HSC hosted a Narcan training which was attended by 12 individuals. **As of March 2023**, naloxone had been administered 23 times by EMS, 3 times by law enforcement, and 36 times by the COOP program. TCWH hosted two Narcan trainings, 20 staff attended. All mental health service providers are trained in Narcan training and administration. Mental Health clinic is a registered OOPP (opioid overdose prevention program).	REACH ADC TCWH	Data regarding exact numbers of narcan distribution and training is not centralized. We would like to engage more with STAP, so that their data can be included in future updates. We would like to differentiate between organizations that are registered OOPPs and train/distribute Narcan, and agencies who voluntarily train staff.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance Use Disorders	Goal 2.2 Prevent opioid overdose deaths	2.2.1 Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.3 per 100,000 population;	Poverty, low- income, geography, race, ethnicity, age	2.2.4. Build support systems to care for opioid users or at risk of an overdose	2.2.1. Overdose death rates (outcome measure) 2.2.4. # of ED visits for overdose (process) 2.2.4. ED visits for overdose demographics (process) 2.2.1. Overdose death demographics (process) 2.2.1. # of community Narcan trainings	2.2.4. Established baseline data for opioid deaths, naloxone trainings and distribution, and trauma-informed care trainings for behavioral health and healthcare providers, with data accessible to active partners 2.2.4. Convened cross-sectional stakeholders as part of Opioid Taskforce. **Developed community-wide goals** using baseline database described above.	Community-based organizations	Opioid Task Force initiated in 2022 to coordinate countywide efforts; REACH, ADC, CARS, TCMH, STAP, Cayuga Medical Center (CMC)	ADC is an Opioid Overdose Prevention Center; they perform **ongoing community trainings and treatment**. STAP hosts a **syringe exchange**, facilitates referrals to a wide range of programs, and has an Opioid Overdose Prevention Program. TCWH Mental Health clinic is a **registered OOPP** (opioid overdose prevention program).	ADC STAP TCWH - Mental Health Clinic	There are multiple OOPC/OOPP in the county.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance Use Disorders	Goal 2.2 Prevent opioid overdose deaths	2.2.1 Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.3 per 100,000 population;	Poverty, low- income, geography, race, ethnicity, age	2.2.6. Integrate trauma-informed approaches in training staff and implementing program and policy	2.2.1. Overdose death rates (outcome measure) 2.2.4. # of ED visits for overdose (process) 2.2.4. ED visits for overdose demographics (process) 2.2.1. Overdose death demographics (process)	2.2.4. Convened cross-sectional stakeholders as part of Opioid Taskforce. **Developed community-wide goals** using baseline database described above. 2.2.6. Completed a **needs assessment strategic plan** to improve collaboration between sectors' tracking and reporting mechanisms	Community-based organizations	Opioid Task Force initiated in 2022 to coordinate countywide efforts; REACH, ADC, CARS, TCMH, STAP, Cayuga Medical Center (CMC)	REACH, the Village, and Learning Web **trains all staff** in trauma-informed care and utilize a trauma-informed approach. TCWH held a **five part all staff training series** focused on trauma informed care. Training was facilitated by Deana Bodnar from DSS. HSC offers trauma-informed **training for local organizations**; it was attended by 21 people in 2023 YTD.	DSS	We would like to differentiate between agencies who train others and agencies who have staff trained.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance Use Disorders	Goal 2.3 Prevent and address adverse childhood experiences	2.3.3 Increase communities reached by opportunities to build resilience by at least 10 percent	Poverty- low income, geography; race and ethnicity	2.3.1 Integrate principles of trauma-informed approach in governance and leadership, policy, physical environment, engagement and involvement, cross sector collaboration, screening, assessment and treatment services, training and workforce development, progress monitoring and quality assurance, financing and evaluation.	# trainings offered including principles of trauma-informed approach # organizations with staff participating in trauma-informed approach trainings	2.3.1. Established a **Community Health Integration Work Group** with a cross-sector partners to develop a **countywide strategy** to increase Community Health Worker professional development opportunities, including training on trauma-informed approach. 2.3.1. Piloted and documented **3+ workflows**, including person-centered resource navigation services following screening in health care settings.	Other (please describe partner and role(s) in column D)	Community Health Integration Work Group (with representatives from Cayuga Health Partners, TCWH, Human Services Coalition, Cornell Cooperative Extension Tompkins County, and REACH Medical): develop countywide strategy for Community Health Worker professional development.	CATCHI, an **interorganizational working group**, meets monthly to address community health workforce development and collaboration, with efforts to integrate a trauma-informed approach.	Cayuga Health TCWH CCE HSC	CATCHI is not strictly focused on integration of a trauma-informed approach. Include CDC and ECDC, pediatric offices, and other agencies/programs. ID measures, repetitive with goal above.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance Use Disorders	Goal 2.3 Prevent and address adverse childhood experiences	2.3.3 Increase communities reached by opportunities to build resilience by at least 10 percent	Poverty- low income, geography; race and ethnicity	2.3.3 Grow resilient communities through education, engagement, activation/mobilization and celebration.	**# health care practices** linking patients to **person-centered resource navigation services**	2.3.3. Direct education and engagement opportunities scheduled for **families** to build and celebrate resilience skills, including 7 **parenting education workshop series** through Cornell Cooperative Extension Tompkins County.	Other (please describe partner and role(s) in column D)	Cayuga Health Partners, CCE-Tompkins, and Human Services Coalition: offer person-centered resource navigation services following social needs screening in health care settings.	Although REACH does not see pediatric patients, they do screen all patients with children for child's safety needs and provided education regarding safe medication storage. Many of ADC's patients have experienced ACE(s); by providing treatment and recovery services, ADC **helps to facilitate** a more resilient community. **CCE and the Village** provide **person-centered resource navigation services**. **HSC's** Community Health Advocates also provide person-centered resource navigation services, accepting social needs **referrals from four (4) primary care practices** in the county.	CCE The Village HSC	Specific information (frequency, attendance) on the parenting education workshop series was not reported.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance Use Disorders	Goal 2.3 Prevent and address adverse childhood experiences	2.3.3 Increase communities reached by opportunities to build resilience by at least 10 percent	Poverty- low income, geography; race and ethnicity	2.3.4 Implement evidence-based Home visiting programs: These programs provide structured visits by trained professionals and paraprofessionals to pregnant women and families, particularly those considered at-risk, necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn.	# educational workshops and home visits to **build parenting and resilience skills**	2.3.4.1 Tompkins County Whole Health Moms PLUS+ Program conducted 80 nursing home visits per month, about 70 clients for the year, with pregnant and postpartum families using the evidence-based Survivor Mom's Companion curriculum for expectant and new parents who have experienced trauma.	Other (please describe partner and role(s) in column D)	Tompkins County Whole Health Moms PLUS+ program, CCE-Tompkins: complete home visits and offer direct education workshops around resources and skills that build resilience (other partners offering home visits, direct education, and engagement opportunities for families include Child Development Council, Tompkins Community Action, Learning Web, and Advocacy Center)	**CCE provides parenting classes** to teach resilience to families, along with communication skills. Parenting workshops address adverse childhood experiences and build resilience skills. In 2023 YTD TCWH community nurses conducted **14 Safecare** home visits.	CCE	Data regarding attendance and frequency of parenting classes was not reported. The parenting classes are also a repeat of the previous row.
Promote Well-Being and Prevent Mental and Substance Use Disorders		Goal 2.5 Prevent suicides	2.5.2 Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000.		2.5.2 Strengthen access and delivery of suicide care --Zero Suicide	2.5.2. Number of actions by the Tompkins County Zero Suicide Steering Committee	2.5.2 Held 4 quarterly meetings of the <u>TC Zero Suicide Steering Committee</u>	Community-based organizations	TC Suicide Prevention Coalition, Sophie Fund. TC Whole Health's Community Health Workers (CHWs), 911 Call Center at the TC Dept of Emergency Response The Tompkins County Zero Suicide Steering Committee. Goal: "To promote meaningful cooperation and coordination among healthcare leaders around suicide prevention using the Zero Suicide model." Purpose: "To advance tangible implementation of the Zero Suicide Model by caregivers and across healthcare systems."	In September 2023, the Zero Suicide Coalition hosted a community event with a panel of experts, to discuss opportunities for suicide prevention in TC. The Zero Suicide Coalition met monthly through out 2023. 211, a member organization of the coalition, collaborates with and connects individuals to Suicide Prevention Crisis Services. 211 creates educational materials and presentations regarding the different helpline numbers. The TC Director of Communications collaborates with 211 on producing and distributing some of these materials. In 2023 YTD, 211 has referred 31 calls to crisis line services.	Suicide Prevention Coalition/Zero Suicide Sophie Fund	The membership and goals of the Suicide Coalition were not clearly reported.

Promote Well-Being and Prevent Mental and Substance Use Disorders		Goal 2.5 Prevent suicides	2.5.2 Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000.		2.5.3 Create protective environments: Reduce access to lethal means among persons at risk of suicide; integrate trauma informed approaches, reduce excessive alcohol use	2.5.3. # gunlocks distributed	2.5.3. In partnership with 10+ community organizations, distributed 200 gunlocks provided by the VA Lethal Means Safety & Suicide Prevention. Coordinated by the Tompkins County Suicide Prevention Coalition, Lethal Means Safety workgroup: Priority Area 3: Increase lethal means safety.	Community-based organizations	TC Suicide Prevention Coalition, Sophie Fund. TC Whole Health's Community Health Workers (CHWs), 911 Call Center at the TC Dept of Emergency Response	CMC is implementing the **Zero Suicide model**, along with other community partners engaged with the Suicide Prevention Coalition. The Lethal Means Workgroup **distributed gunlocks** throughout 2023. FoodNet helps to create protective environments by providing **daily friendly check-ins** and regular assessment visits. REACH helps to create protective environments by administering a **mental health assessment** to every patients and providing them with behavioral health care, based on the level of concern resulting from the screening. ADC also screens their patients for behavioral health concerns.	CMC Lethal Means Workgroup	Data regarding gunlock distribution counts was not reported.

Name of County - Organization(s) Tompkins County Whole Health (formerly Tompkins Health Department)
2023 Workplan Cayuga Medical Center, a member of Cayuga Health

Planning Report Liaison Samantha Hillson and Ted Schiele
E-mail: shillson@tompkins-co.org, tschiele@tompkins-co.org

Priority	Focus Area	Goal	Objectives through 2024	Disparities	Interventions	Family of Measures	By December 2023, we will have completed . . .	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources	2023 Progress to Date	What partnerships or factors helped you (please provide at least one specific example)	Strengths/Challenges
Promote Healthy Women, Infants and Children	Focus Area 2: Perinatal and Infant Health	Goal 2.1 Reduce infant mortality & morbidity	Objective 2.1.2: Decrease the percentage of births that are preterm by 5% to 8.3 percent of live births. (adjust rates as needed)	Poverty - low-income, geographic, racial/ethnic, insurance status	2.1.2: Increase capacity and competencies of local maternal and infant home visiting programs	Participation rates in PICHC and MOMS Plus+, infant mortality and morbidity rates	Finalized a **Perinatal and Infant Working Group** to provide advisory and oversight support for the Perinatal and Infant Community Health Collaboratives (PICHC) Initiative in Tompkins County. Community Health Workers (4 CHWs) provide support through home visits to improve outcomes for perinatal and infant health. Concurrent, ongoing **redesign of the Tompkins County MOMS Plus+** program resulting in increased capacity to deliver maternal child health supportive services to residents of Tompkins County regardless of insurance status, with a focus on providing equitable access to care.	Other (please describe partner and role(s) in column D)	Partners in the working group will include: TCWH, Community Based Organization, Hospital and Healthcare Providers (including maternal and child health providers), School Districts, other Local Government and other stakeholders. Working group will advise and assist Local Health Department in delivering PICHC and MOMS Plus+ services. Leading partners will include TCWH, Human Services Coalition (CBO, working group facilitator), Cornell Cooperative Extension (key CBO partner), Child Development Council, and clinical providers including OBGYN Associates and Planned Parenthood, among others.	Cayuga Birthplace has recently hired a Lactation Education Coordinator that is working to standardize and improve lactation education in the birthplace and after discharge. TCWH and HSC have collaborated on forming a **Community Advisory Board** to evaluate and improve upon the PICHC program. The **Perinatal and Infant Working group** consists of 18 organizations collaborating on oversight for the PICHC Initiative.	TCWH HSC include other partners (CDC,	Reported data does not directly map to the planned intervention. Intervention is about competencies and capacity, specifically. PICHC CAB development is ongoing.
Promote Healthy Women, Infants and Children	Focus Area 4: Cross Cutting Healthy Women, Infants, and Children	Goal 4.1 : Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations	By 2024: Reduce disparities in health care access for maternal and child health populations. Reduce disparities in health outcomes for maternal and child health populations.	Poverty - low-income, geographic, racial/ethnic, insurance status	4.1: Enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families across the life course.	Number of partners with TCWH PICHC and MOMS Plus+ Programs, maternal and child **insurance rates**, **Child Health Plus enrollment rates** as percent of eligibility	Engaged with at least **20 key partners** to emphasize insurance enrollment, supports for birthing families, and parenting skills, among other needs. Established a **baseline for indicators** to measure changes in disparities in maternal and child health outcomes. **Completed "We Ask Because We Care"** campaign, increasing demographic data collection at Cayuga Medical Center and 42 outpatient practices, improving Cayuga Health's ability to identify and address disparities (including in maternal and child health outcomes as cited above).	Community-based organizations	Human Services Coalition - health insurance navigation, Cornell Cooperative Extension - parenting programming, Local School Districts - outreach partners Tompkins Whole Health: Key programs (MOMS Plus+ and PICHC) will convene community partners and those with lived experience to collect and review data to address disparities in maternal and child health outcomes. Cayuga Health: will lead the campaign to increase demographic data collections and improve health system's efforts to identify and address disparities in maternal and child health outcomes.	ADC prioritizes treatment of pregnant people in accessing services. CHP actively works with HSC by **referring patients** to them **for health insurance** enrollment support. The YMCA offers scholarship opportunities for programs and services to ensure that anyone that could benefit from our services can **access** them. These scholarships provide families in Tompkins County access to childcare, summer camp, and youth and family programs. The Village provides resources to combat disparities, including transportation to medical appointments, clothing from community closet, and childcare resources. **HSC facilitates health insurance** enrollment, specifically through Medicaid and Child Health Plus.	ADC Cayuga Health YMCA Village HSC	Include progress with We Ask - TCWH hosted training for staff about better collecting demographic data to understand population served/not served.