Rural Health Network Development Program
Human Services Coalition Tompkins Health Network Work Plan
RFA#20495
October 1, 2025 – September 30, 2026

Objective	
1	**Strengthening the collaborative leadership of the Tompkins Health Network**

Tasks

1.1 Convene the Advisory Board on a regular basis to set THN policy and direction – The THN Director will convene regular meetings of the Advisory Board throughout the year.

Performance Measures

1.1.1 Record of discussion – Meeting minutes will be available to the board documenting discussion and actions taken.

1.1.2 Board and Network Membership – Report of Board member meeting attendance, membership terms, and compliance with work rules presented to Executive Committee by July 2026. Network membership will be reviewed to ensure representation from the health-related social needs (HRSN) categories of food, housing and transportation sectors.

1.1.3 Network Assessment – Network assessment completed by the Board by November 2025. The outcome is to measure the Board's understanding of THN's role in the community.

1.1.4 Committee Reports- The board members receive at least six committee and work group reports during 2025-2026 reporting period.

1.1.5 Presentations on HRSN issues – At least three presentations on HRSN categories of food, housing and transportation during board meetings. The purpose of the presentations is to educate the board on related work plan topics.

1.1.6 Community member representation-THN Advisory Board will seek input from community members via focus group meetings in rural townships and the city of Ithaca (where the greatest disparities exist).

Tasks

1.2 Create plan for National Rural Health Day in November – THN staff will develop and implement a plan to promote National Rural Health Day in November

Performance Measures

1.2.1 Plan and timetable developed – Plan for promoting National Rural Health Day is drafted and presented to the Advisory Board by fall 2025.

1.2.2 Plan Implemented – National Rural Health Day Promotion is completed by the end of November 2025.

Objective

2 Expand access to health care and address issues of health equity.

Tasks

2.1 Increase access to information resources that can assist to address health care disparities and inequities- THN staff will engage in outreach and information gathering to increase awareness of resources in Tompkins County.

Performance Measures

2.1.1 Number of outreach and media opportunities pursued – From October 1, 2025 to September 30, 2026 at least 5 outreach opportunities (media/presentations/tabling/ other) will be completed by THN staff to promote THN and Human Services Coalition direct service programs (211, health insurance navigator, community health advocate, community health & resource network)

2.1.2 Collaboration with housing- THN staff will identify opportunities to collaborate with housing initiatives in an effort to improve health outcomes.

2.1.3 Share Community Health Advocate (CHA) program information- THN staff will share CHA program information with at least 25% of primary care providers and pharmacies in Tompkins County. CHA assists with health insurance and non-medical health needs.

Tasks

2.2 Reduce the number of people without health insurance – THN Director will ensure that health insurance navigators meet the deliverables for enrolling and re-enrolling individuals and families into plans offered through the NY State of Health Marketplace.

Performance Measures

2.2.1 Annual enrollment targets – At least **744** applications are processed by navigator staff from October 1, 2025-September 30, 2026. Progress will be monitored quarterly and at year end. The impact is to increase enrollment of the uninsured and to help individuals maintain insurance.

2.2.2 Insurance Information presentations – From October 1, 2025-September 30, 2026, THN Staff will provide at least 4 health insurance information sessions to community members, community-based organizations or employers.

Objective	
3	**Support the priorities of the local Community Health Improvement Plan (CHIP) developed from the NYS Prevention Agenda.**

Tasks

3.1 Convene the Community Health Conversations (CHC) forums – The THN Director will support the Community Health Conversations convenings and manage meeting logistics, inviting community members, and coordination of the agenda with the co-chairs. The purpose is to provide educational presentations on emerging issues that impact healthcare access in the local community.

Performance Measures

3.1.1 Community Health Conversations Convened – The forums will be held on a quarterly basis and will bring any relevant CHIP Work Plan priorities and NYHER 1115 waiver services updated to the community.

3.1.2 Status reports – Regular CHC updates are provided to the Board during the reporting period.

3.1.3 Representation on CHIP Steering Committee- THN Director will continue as a member of the Tompkins County CHIP Steering Committee to contribute to the progress of the CHIP implementation.

Tasks

3.2 Assist with carrying out Well-Being and Substance Use Disorders priorities of the local Community Health Improvement Plan (CHIP)- THN Director will work Tompkins County health department to make progress on maternal and perinatal Health, mental health and substance use treatment goals.

Performance Measures

3.2.1 Promote Wellbeing- THN Director will work with Tompkins County Health Department to support maternal and perinatal health priorities of the CHIP.

3.2.2 Mental Health and Substance Use Disorders Integration- THN Director will continue to represent THN on the local Community Services Board for Tompkins County and report progress of local services plan to THN.

3.2.3 Reporting- The THN Director will share the progress of the CHIP priorities identified in performance measure 3.2.1-3.2.2 with the THN Advisory Board on a quarterly basis. The Board will be knowledgeable about the CHIP interventions and their relation to THN.

Objective	
4	**Support healthy aging through the Long-Term Care Committee**
Tasks	
4.1	Maintain the Long-Term Care Committee (LTCC) and ensure broad representation from multiple sectors of the community – The THN Director will support the LTCC and manage meeting logistics, communicating with members, and coordination of the agenda with the chair. Performance Measures 4.1.1 Partnership with NY Connects – A contract will be executed with the local Office for the Aging to staff the advisory group known as the Long-Term Care Committee. The outcome is to identify issues in the Long-Term Support Services System. 4.1.2 Broad representation – Combined meeting attendance records will indicate participation from at least 15 organizations/ community sectors. Attendance sheets will be reviewed to confirm this measure is being met. Committee memberships will be reviewed and expanded for broad inclusion of nontraditional sectors. 4.1.3 Formation of work groups - Work groups on emerging problems are established as needed, with specific objectives identified. Activities are reported to the Long-Term Care Committee.
Tasks	
4.2	Increase access and awareness to resources available in Tompkins County to support healthy aging- THN staff will identify and compile Tompkins County resources for hoarding, long-term care services, and caregiver support resources. Performance Measures 4.2.1 Hoarding resources dissemination- THN Director will work with LTCC to identify hoarding resources available in Tompkins County to share with local community based organizations that serve older adults and/or address mental health wellbeing.

4.2.2 Long Term Care Services resources dissemination - THN Director will work with LTCC to identify long-term care services available in Tompkins County to share with community-based organizations in rural areas and/or that serve marginalized populations.

4.2.3 Caregiver support resources dissemination- THN Director will work with LTCC to identify caregiver support resources available in Tompkins County and share with community-based organizations in rural areas and/or that serve marginalized populations.

Objective	
5	**Maintain a community health network to connect health and social care providers**

Tasks	
5.1	Maintain the Community Health & Resource Network (CH&RN) – THN staff will continue the growth and improvements of a closed loop referral platform that connects users, including health and social care providers, to ease burden on community members of navigating community care silos. Performance Measures 5.1.1 Regular network meetings- THN staff will coordinate regular network meetings to support current community-based organizations (CBOs) in the CH&RN 5.1.2 Support network platform changes- Monitor network platform improvement requests on behalf of CBOs and work with healthcare system staff to implement platform changes. 5.1.3 Expansion of network- THN staff will add community-based organizations in waves on a regular basis to the network over the course of the reporting period.

Tasks	
5.2	Support expansion of Health-Related Social Needs (HRSN) services accessible to Tompkins County residents- THN staff will work with Tompkins County community-based organizations to optimize participation in NYHER 1115 Waiver and the CH&RN. Performance Measures 5.2.1 Local HRSN inclusion into the CH&RN -THN staff will continue to identify services providers for HRSNs areas that are included in the NYHER 1115 screening tool to be included in the CH&RN. 5.2.2 NYHER 1115 Integration with the CH&RN- THN staff will continue to identify integration opportunities with NYHER 1115 waiver to inform network development.

Objective	
6	**Strengthen data and information sharing among providers and community-based organizations to improve coordination**
Tasks	
6.1	Support development of data-driven collaborations – THN staff will participate in collaborations to address development of community data among organizations providing social determinant of health services. Multiple regional/ local initiatives are emerging around information exchanges and referral systems to prepare for healthcare delivery system transformation. The impact of this task is to strengthen social care organizations in positioning value-based arrangements. Performance Measures 6.1.1 Representation in regional and local collaborations – Attendance at meetings (web conference, phone, or in-person) around emerging data partnerships. Report quarterly. 6.1.2 211 participation in the Community Health & Resource Network (CH&RN)- 211 will provide referral services for community members referred to 211 via the CH&RN.
Tasks	
6.2	Promote use of 2-1-1 for information about social determinant of health services – THN staff in coordination with 2-1-1 Call Center Manager promote usage of 2-1-1- to obtain information about programs that provide social determinant of health services. Performance Measures 6.2.1 Trainings held – At least two training sessions about 2-1-1 resources are documented.

6.2.2 Domain specific developments – At least two 2-1-1 projects completed to respond to service care organizations' needs in a specific domain.