Rural Health Network Development Program
Performance Measures Report
January 1, 2025– September 30, 2025

Contractor Name: **Human Services Coalition of Tompkins County**

Network Name: **Tompkins Health Network/ Health Planning Council**

Reporting Period: **July 1, 2025 to September 30, 2025**

Provide summary of significant progress achieved during the reporting period:

The health insurance navigators provided enrollment assistance to 207 individuals in this quarter. This represents 37% of the contract-term goal, and across all 3 quarters, 122% completed of this contract term goal.

The Community Health & Resource Network has had 757 referrals sent on the platform in the first three quarters. We have started the recruiting process of Cohort 2 to join the network, and should have an additional 15-20 organizations join the network in the next quarter.

The Long Term Care Committee met this quarter and discussed focusing on issues of discharge planning, hoarding and falls prevention in the coming year.

THN Director and 211 Program Director worked with the Tompkins County Community Health Improvement Steering Committee to help to choose the health priorities from the Prevention Agenda that will be focus of the Community Health Improvement Plan that will be submitted to NYS at the end of the year.

THN Advisory Board met to focus on restructuring current membership to be more intentional of aligning social care and clinical care initiatives in our community.

Rural Health Network Development Program
Human Services Coalition Tompkins Health Network Work Plan
January 1, 2025 – September 30, 2025

Objective

1 Expand access to health care and address issues of health equity

Tasks

1.1 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

1.1.1 Number of outreach and media opportunities pursued – From January 1, 2025 to September 30, 2025 at least 3 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)

Quarter 1 Report:
Outreach was conducted via email notice on the county listserv on a monthly basis in the first quarter. The Tompkins County listserv has 3,000 subscribers. Advertising was also done on Facebook in each month of the first quarter and reached a total of 33,704 individuals online.

Quarter 2 Report:
Outreach was conducted via email notice on the county listserv on a monthly basis in the second quarter. The Tompkins County listserv has 3,000 subscribers. Advertising was also done on Facebook in each month of the second quarter and reached a total of 55,718 individuals online. We also began our public transit advertising in April of this quarter which reaches approximately 60,000 riders each month.

Quarter 3 Report:
Outreach was conducted via email notice on the county listserv on a monthly basis in the third quarter. The Tompkins County listserv has 3,000 subscribers. Advertising was also done on Facebook in each month of the third quarter and

reached a total of 27,124 individuals online. We continued our public transit advertising this quarter which reaches approximately 60,000 riders each month.

1.1.2 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.

Quarter 1 Report:
No activity to report this quarter. Performance measure expected to be completed in the 3rd quarter.

Quarter 2 Report:
No activity to report this quarter. Performance measure expected to be completed in the 3rd quarter.

Quarter 3 Report:
We prepared our outreach material and generated a list of over 100 providers and pharmacies that will receive information about our CHA program at the beginning of the 4th quarter.

Tasks

1.2 Address Health Equity Issues- THN staff will participate in activities to address issues of inequity in healthcare.

Performance Measures

1.2.1 Attend Fighting Institutional Racism in Medicine (FIRM) meetings- THN Director will participate in FIRM meetings when scheduled with community partners.

Quarter 1 Report:
THN Director did not attend any FIRM meetings this quarter, but will continue participation outside of meetings and will continue to attend meetings in the 2nd quarter.

Quarter 2 Report:
THN Director attended a FIRM meeting on June 26th in the second quarter. The focus of this meeting was how to address personal safety concerns that are identified by patients of the local healthcare system. Additionally, with the impending legislation that will likely cause some to lose access to health insurance, there was discussion about how to better connect community members to affordable and accessible healthcare services such as the local free health clinic and the low-cost health clinic that charges on a sliding scale for those who are uninsured.

Quarter 3 Report:
THN Director did not attend any FIRM meetings this quarter, but will continue participation outside of meetings and will continue to attend meetings in the 4th quarter.

1.2.2 Promote healthy and safe environments for Medicaid beneficiaries- THN staff will gather and disseminate information for NYHER 1115 reimbursable services that promote healthy and safe environments for Medicaid beneficiaries including, but not limited to, mold remediation, pest removal and home improvements.

Quarter 1 Report:
No activity to report this quarter. Performance measure expected to be completed in the 3rd quarter.

Quarter 2 Report:
No activity to report this quarter. Performance measure expected to be completed in the 3rd quarter.

Quarter 3 Report:
THN Director worked with local health department to explore their participation in the NYHER 1115 waiver social care network (SCN) as a provider of some remediation services, but due to the inability of county agencies to participate in the SCN, it was not an ideal match for these services. The sole provider of these services is not local to our county, but we continue to promote the availability of these services with local community members who are eligible for these services via the SCN.

Tasks

1.3 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

1.3.1 Contract term enrollment targets – At least **558** applications are processed by navigator staff from January 1, 2025-September 30, 2025. Progress will be monitored quarterly. The impact is to increase enrollment of the uninsured and to help individuals maintain insurance.

Quarter 1 Report:
Two hundred and eighteen applications were processed during this quarter, approximately 39% of the contract-term goal. Annual open enrollment concluded in this quarter, so enrollment numbers tend to be higher during open enrollment months.

Quarter 2 Report:
Two hundred and fifty-three applications were processed during this quarter, approximately 45% of the contract-term goal, and combined with quarter 1; we have achieved 84% of the contract-term goal in the first two quarters.

Quarter 3 Report:
Two hundred and seven applications were processed during this quarter, approximately 37% of the contract-term goal, and combined with previous; we have achieved 122% of the contract-term goal.

1.3.2 Insurance Information presentations – THN staff will schedule at least 2 health insurance information sessions to community members, community based organizations or employers.

Quarter 1 Report:
No activity to report this quarter. Planning for insurance information presentations will commence in the 2nd quarter.

Quarter 2 Report:
Health insurance navigators have advertised on our local listserv and reached out to community partners about hosting a health insurance information presentation. We have scheduled 2 presentations for the 3rd quarter, one in partnership with Cornell for incoming students and another to assist a local community based organization about health insurance options for their staff.

Quarter 3 Report:
Due to recent changes in marketplace options, including increased cost of premiums and reduction in advacned premium tax credits, we have paused our presentations to the community to rethink how to structure the presentations to highlight affordability options. We plan to hold 8 of these types of presentations between October 2025-March 2026. Will report on the progress in the next quarter.

Objective

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

Tasks

2.1 Maintain the Community Health and Access Committee – The THN Director will support the Community Health and Access Committee and manage meeting logistics, communicating with members, and coordination of the agenda with the co-chairs. The Committee monitors emerging issues that impact healthcare access.

Performance Measures

2.1.1 Community Health and Access Committee Convened – The committee will continue to meet to support the CHIP Work Plan priorities and NYHER 1115 waiver services.

Quarter 1 Report:
The Community Health and Access Committee (CHAC) held a series in March that included three sessions, each on the difference enhanced health related social needs (HRSNs) available via the Social Care Network)SCN). The first session was held in conjunction with the March THN Advisory board meeting on March 10th and focused on enhanced housing services (see performance measure 5.1.6 for more details).

The second session was held on March 14th with a presentation from Katie Blaine, SCN Network Performance Transportation Specialist, on the available enhanced transportation services via the SCN for those who qualify. The presentation reviewed all of the available services, who qualifies for the enhanced services and how to get screened and navigated to providers who can provide these services.

The third and final session was held on March 28th with a presentation from Maria Musser, SCN Network Performance Nutrition Specialist , on the available enhanced food and nutrition services via the SCN for those who qualify. The presentation reviewed all of the available food and nutrition services, who qualifies for each type of food/nutrition enhanced service and how to get screened and navigated to providers who can provide these services.

Quarter 2 Report:
Due to the multiple meetings held in the first quarter, there was no CHAC meeting held this quarter.

Quarter 3 Report:
CHAC meetings were put on pause this quarter as we rethink the structure of the THN advisory board and the CHAC committee. The plan is to restructure the CHAC committee to be an outward facing (open to the public) forum to learn about health access programs, data and progress. These forums should start in the next quarter.

2.1.2 Status reports – Regular CHAC reports are provided to the Board during the reporting period.

Quarter 1 Report:
A report on the Community Health and Access Committee was provided on a monthly basis to the Advisory Board during the committee reports portion of the meeting, or as an addendum to the meetings minutes if not reported at the meeting.

Quarter 2 Report:
A report on the Community Health and Access Committee was provided on a monthly basis to the Advisory Board during the committee reports portion of the meeting, or as an addendum to the meetings minutes if not reported at the meeting.

Quarter 3 Report:
A report on the Community Health and Access Committee was provided on a monthly basis to the Advisory Board during the committee reports portion of the meeting, or as an addendum to the meetings minutes if not reported at the meeting.

2.1.3 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.

Quarter 1 Report:
THN Director and 2-1-1 Program Director continue to serve as members of the Tompkins County CHIP Steering Committee. The Committee held 2 meetings in the first quarter that focused on the dissemination of the Community Health Survey that was conducted in Tompkins County in the first quarter. THN Director also serves in the engagement subcommittee and 2-1-1 Program Director serves in the process subcommittee.

Quarter 2 Report:
THN Director and 2-1-1 Program Director continue to serve as members of the Tompkins County CHIP Steering Committee. The Committee held 3 meetings in the second quarter that focused on the dissemination of the Community Health Survey results. THN Director continues to serve on the engagement subcommittee and 2-1-1 Program Director serves on the process subcommittee.

Quarter 3 Report:
THN Director and 2-1-1 Program Director continue to serve as members of the Tompkins County CHIP Steering Committee. The Committee held 7 meetings in the third quarter that focused on the community health improvement partner convening to be held at the beginning of the 4th quarter. The steering committee worked on identifying the health priorities of the CHIP that is due to NYS at the end of the year. The partner convening that will occur next quarter will be an opportunity for community partners to weigh in on action items to address the health priorities identified for our local CHIP. THN Director continues to serve on the engagement subcommittee and 2-1-1 Program Director serves on the process subcommittee.

Tasks

2.2 Assist with carrying out Well-Being and Prevent Mental 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

2.2.1 Promote Wellbeing- THN Director will work with Tompkins County Health Department to support a maternal and perinatal health community advisory board to address barriers and inform solutions.

Quarter 1 Report:
THN Director worked with the Healthy Infants Partnership Community Advisory Board (CAB) to share information about the enhanced health related social needs services available through the Social Care Network, especially for those who are pregnant and post-partum. THN Director also provided logistical support to the CAB such as issuing participant payment for those with lived experiences.

Quarter 2 Report:
THN Director worked with the Healthy Infants Partnership Community Advisory Board (CAB) to prepare another Black Maternal Health event "Sister Circle." The event was held on April 12th and had nearly a dozen BIPOC parenting individuals attend to share their birth experiences and provide feedback on improving maternal, prenatal and postnatal health outcomes.

Quarter 3 Report:
THN Director was not able to attend CAB meetings this quarter, but will help to facilitate conversation at the Community Health Improvement Partner convening next quarter to identify action items to improve maternal health outcomes for the CHIP submitted to NYS at the end of the year.

2.2.2 Mental and Substance Use Disorders Prevention 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.

Quarter 1 Report:
THN Director attended 2 Community Services Board (CSB) meetings (January 6th, March 3rd) this quarter to support the local services plan in Tompkins County. THN Director worked with the CSB to review the hiring process of the new Tompkins County Whole Health Commissioner including providing feedback on qualifications (with equal emphasis on mental health and public health background/experience).

Quarter 2 Report:
THN Director attended 2 Community Services Board (CSB) meetings (April 7th, June 2nd) this quarter to support the local services plan in Tompkins County. THN Director provided feedback on any discussed topics around mental health hygiene and shared relevant information with THN Advisory Board.

Quarter 3 Report:
THN Director attended 2 Community Services Board (CSB) meetings (July 7th, September 8th) this quarter to support the local services plan in Tompkins County. THN Director provided feedback on any discussed topics around mental health hygiene and shared relevant information with THN Advisory Board.

2.2.3 Mental and Substance Use Disorders Prevention implementation- THN Director will join the substance use subcommittee to leverage collaboration of THN to ensure the availability of effective substance use prevention services programming in schools, colleges and universities, and the community.

Quarter 1 Report:
No activity to report this quarter.

Quarter 2 Report:
THN Director applied for the open board seat on the local Substance Use Subcommittee of the Community Services Board in the second quarter.

Quarter 3 Report:
The board seat on the local Substance Use Subcommittee was filled prior to THN Director's application in the previous quarter. Alternatively, THN Director is considering how the THN Advisory Board can work with the local Substance Use Subcommittee chairs to align work with the THN Advisory Board. In the 4th quarter, THN Director will have discussions about how there can be representation from the subcommittee on the THN Advisory Board to more intentionally collaborate on future initiatives.

2.2.4 Reporting- The THN Director will share the progress of the CHIP priorities identified in performance measure 2.2.1-2.2.3 with the THN Advisory Board on a quarterly basis. The Board will be knowledgeable about the CHIP interventions and their relation to THN.

Quarter 1 Report:
THN Director and staff from the Tompkins County Whole Health Department provided updates on CHIP interventions at each THN Advisory Board this quarter including the progress on the Community Health Survey.

Quarter 2 Report:
THN Director and staff from the Tompkins County Whole Health Department provided updates on CHIP interventions at each THN Advisory Board this quarter including a presentation on the Community Health Survey results.

Quarter 3 Report:
THN Director and staff from the Tompkins County Whole Health Department provided updates on CHIP interventions at each THN Advisory Board this quarter.

Tasks

2.3 Maintain the human services direct service staff peer support group, Compassion Corner- THN staff will support the continuation of a local human services direct service staff peer support group

Performance Measures

2.3.1 Regular meetings – Compassion Corner will meet on a monthly basis to provide support, address barriers and promote self-care.

Quarter 1 Report:
Compassion corner met twice this quarter on January 23rd and February 27th. The meetings provided a safe space for direct service staff from several organizations to come together and provide mutual support, along with engaging in self-care activities such as fun crafts.

Quarter 2 Report:
Compassion Corner did not meet in the 2nd quarter due to scheduling conflicts, but will resume in the 3rd quarter with regular meetings.

Quarter 3 Report:
Compassion Corner did not meet in the 3rd quarter due to low attendance in the summer months, and scheduling conflicts in September.

2.3.2 Evaluation- THN Staff will work with Tompkins County to assess the impact Compassion Corner has on mental wellbeing and job satisfaction.

Quarter 1 Report:
No activity to report this quarter.

Quarter 2 Report:
THN Director worked with Compassion Corner facilitator to come up with an evaluation to provide to attendees. The plan is to administer evaluations at each meeting, as well as send out a general evaluation to anyone who has attended a meeting in the past. Results will be collected and reported on in the 3rd quarter.

Quarter 3 Report:
Due to no meetings in the 3rd quarter, evaluation was held for the next meeting in the 4th quarter.

2.3.3 Reporting- THN Director will share the progress of the regular meetings with the THN Advisory Board on a quarterly basis.

Quarter 1 Report:
THN Director shared Compassion Corner meeting information at monthly THN Advisory Board meetings.

Quarter 2 Report:
THN Director shared Compassion Corner meeting information at monthly THN Advisory Board meetings.

Quarter 3 Report:
THN Director shared Compassion Corner meeting information at monthly THN Advisory Board meetings.

Objective	
3	**Support healthy aging through the Long Term Care Committee**

Tasks

3.1 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

3.1.1 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.

Quarter 1 Report:
The Long Term Care Committee (LTCC) continues to meet on a quarterly basis, and met on February 7th during the 1st quarter. This meeting included a presentation by Jan Lynch highlighting all of the services available at the Finger Lakes Independence Center.

Quarter 2 Report:
The Long Term Care Committee (LTCC) continues to meet on a quarterly basis and met on May 2, during the second quarter. This meeting included a presentation from Mark Napierkowski, Community Engagement Manager, from the Alzheimer's Association of Central New York. He provided information on services available and the impact of the disease.

Quarter 3 Report:
The Long Term Care Committee (LTCC) continues to meet on a quarterly basis and met on August 1st, during the third quarter. This meeting focused on focusing on issues of discharge planning, hoarding and falls prevention. It was discussed that discharge planning would be the focus of the group for 2025 with hoarding becoming the 2026 focal issue. Falls prevention week materials were distributed in the meeting minutes, email and an announcement on the Human Services Listserv.

3.1.2 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.

Quarter 1 Report:
During the February 7th Long Term Care Committee meeting, 25 people were in attendance representing community based organizations including Ithaca College, Tompkins County Office for the Aging, funders, nursing services, health system, independence programs and advocacy organizations.

Quarter 2 Report:
During the May 2nd, Long Term Care Committee, 19 people attended and represented Tompkins County Office for the Aging, Independence Center, Alzheimer's Association, advocacy organizations, and community members.

Quarter 3 Report:
For our Aug 1st LTCC meeting, 18 individuals representing organizations that included Finger Lakes Independence Center, COFA, CHA, LTCOP, CMC Foundation, McGraw House, Gadabout, VNS, HPC, Kendal, Slaterville EMR, FCS, and New York Statewide Senior Action Council. A guest member was solicited to attend the LTCC and present at the November meeting on falls in Tompkins County. John Halaychik is the Assistant Director – 911 Tompkins County Department of Emergency Response.

3.1.3 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.

Quarter 1 Report:
No activity to report this quarter.

Quarter 2 Report:
The Long Term Care Committee Coordinator (LTCCC) is currently updating the committee member lists. This involves reviewing a previous survey to identify members' areas of expertise, interests, and availability. A primary focus for the immediate future is to re-establish the Discharge/Transition Planning Work Group.

Quarter 3 Report:
A brief survey was distributed to Long Term Care Committee members and partner organizations to assess current challenges, best practices, and training needs related to discharge and transition planning in Tompkins County. Responses were limited but provided useful insight into ongoing barriers such as difficulty navigating post-discharge options and the need for improved access to facility and service information.

Key themes identified include the importance of community-based education, stronger coordination of post-discharge services, and improved access to primary care. Several respondents expressed interest in participating in training and informational sessions.

Findings from the survey will help guide the re-establishment of the Discharge/Transition Planning Work Group, which will develop specific objectives and report activities to the Long Term Care Committee in the coming quarter. Looking ahead to Quarter 4, the Long Term Care Committee Coordinator plans to redistribute the survey to a broader group of non-committee stakeholders to gather additional input. Outreach will include follow-up phone calls and direct contact with organizations to encourage participation. Current survey respondents will also be asked to assist with recruitment efforts to help ensure broader representation across the continuum of care.

Tasks

3.2 Discharge Planning Work Group creation- THN staff will work with LTCCC members to improve discharge-planning coordination between Cayuga Medical Center (CMC) and long-term care providers.

Performance Measures

3.2.1 Work group formed- THN Director and LTCC will reach out to CMC and local long-term care providers to create a work group to improve the discharge planning process.

Quarter 1 Report:
No activity to report this quarter. Planning will commence in the 2nd quarter.

Quarter 2 Report:
The LTCCC is actively reaching out to former members to reconvene this group. Their initial tasks will include updating the discharge planning directory and identifying suitable professionals, organizations, and community members to invite to join the work group. A survey was created to gather this information.

Quarter 3 Report:
Progress on the formation of the Discharge Planning Work Group was limited this quarter due to staff illness. Preliminary outreach and planning activities were delayed but will resume in Quarter 4. The next steps include redistributing the discharge planning survey to a broader group of stakeholders and re-engaging potential members from Cayuga Medical Center and local long-term care providers to participate in the work group.

3.2.2 Regular meetings- Discharge planning workgroup will meet on a regular basis after formed.

Quarter 1 Report:
No activity to report this quarter. Meeting expected to commence in the 3rd quarter.

Quarter 2 Report:
Outreach to past members to prepare for 3rd quarter meeting.

Quarter 3 Report:
No formal meetings were held this quarter due to delays in work group formation resulting from illness. Planning for initial meeting logistics and membership confirmation will take place in Quarter 4, with the goal of convening the first meeting once participation is confirmed.

3.2.3 Discharge Planning Resource Directory- Discharge planning workgroup will create a discharge planning and care transitions resource list for community partners to access to increase efficiency of discharge process.

Quarter 1 Report:
No activity to report this quarter. Performance measure expected to be completed in the 3rd quarter.

Quarter 2 Report:
No activity to report this quarter. Performance measure expected to be completed in the 3rd quarter.

Quarter 3 Report:
No new progress was made on the resource directory this quarter due to staff illness and the delayed formation of the work group. Efforts to collect input through the discharge planning survey will continue into Quarter 4 to inform the development of the directory once the work group is established. Request to assist in distributing the survey from LTCC members and other community members was sent in late October and results likely not to show until the fourth quarter.

Objective	
4	**Strengthen data and information sharing among providers and community-based organizations to improve coordination**
Tasks	

4.1 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

4.1.1 Representation in regional and local collaborations – Attendance at meetings (web conference, phone, or in-person) around emerging data partnerships. Report quarterly.

Quarter 1 Report:
2-1-1 Tompkins/Cortland staff participate in local, regional, and statewide collaborations around data partnerships. During the third quarter, activities included:

2-1-1 Program Director John Mazzello served as a board member for Care Compass Network (former DSRIP Performing Provider System for the Southern Tier region) and Care Compass Collaborative (awardee for the Social Care Network lead under the current Medicaid 1115 waiver amendment, New York Health Equity Reform. He also served as IT, Informatics & Data Governance Committee chair for Care Compass. The Social Care Network includes many data partnership elements, including use of a common data platform to facilitate referrals and track service data. Due to committee member schedule conflicts, the committee did not meet this quarter (meetings are scheduled every other month), but the 2-1-1 Program Director supported Care Compass leadership in recruiting new committee members, in providing updates to committee members, and in planning for the May committee meeting. The Care Compass Network board of directors met on 2/4, and the Care Compass Collaborative board of directors met on 1/28, 3/3, and 3/25.

During the quarter, 2-1-1 also pursued continued discussions with Cayuga Health System (now Centralus Health) around a data project to integrate 2-1-1 resource records into their clinical referral platform, to allow providers to see information

about area programs and services. This work led to the development of an MOU (signed in Q2) to begin data sharing work. Through the 2-1-1 Life Line in Rochester, the Tompkins County 2-1-1 also contributed to a similar resource data sharing project with the University of Rochester Medical Center.

Quarter 2 Report:
2-1-1 Tompkins/Cortland staff participate in local, regional, and statewide collaborations around data partnerships. During the third quarter, activities included:

2-1-1 Program Director John Mazzello served as a board member for Care Compass Network (former DSRIP PPS for the Southern Tier region) and Care Compass Collaborative (Social Care Network lead under NYHER). He also served as IT, Informatics & Data Governance Committee chair for Care Compass. The development and expansion of the SCN over the quarter was significantly dependent on data partnership, including use of the common platform Unite Us for referrals and service tracking. The committee met on May 8 and the 2-1-1 Program Director supported Care Compass leadership in onboarding new committee members, planning for the meeting, and throughout the quarter on IT and data governance related activities. The Care Compass Network board of directors met on April 8 and June 10 (Program Director not in attendance on June 10), and the Care Compass Collaborative board of directors met on May 22.

During the quarter, 2-1-1 also continued work with Cayuga Health System (now Centralus Health) around a data project to integrate 2-1-1 resource records into their clinical referral platform, to allow providers to see information about area programs and services. An MOU was signed in this quarter to begin the data sharing exploration. Cayuga Health System IT staff are now working on implementing an integration between 2-1-1 data and their clinical referral platform, with the initial testing expected in Q3.

Quarter 3 Report:
2-1-1 Tompkins/Cortland staff participate in local, regional, and statewide collaborations around data partnerships. During the quarter, activities included:

2-1-1 Program Director John Mazzello served as a board member for Care Compass Network (former DSRIP PPS for the Southern Tier region) and Care Compass Collaborative (Social Care Network lead under NYHER). He also served as IT, Informatics & Data Governance Committee chair for Care Compass. The Social Care Network (SCN) continued to develop and mature over the quarter as it grows in participation. The data partnership of the SCN is a key component of the work, including use of the data platform Unite Us for referrals and service tracking alongside inter-organizational relationships

between partner CBOs. The Care Compass Network board of directors met on 8/12 and the Care Compass Collaborative board of directors met on 7/22, 8/18, and 9/22.

During the quarter, 2-1-1 also continued work with Cayuga Health System (now Centralus Health) around a data project to integrate 2-1-1 resource records into their clinical referral platform, to allow providers to see information about area programs and services. After the data sharing MOU was signed in the previous quarter, 2-1-1 and Centralus Health staff have had discussions around integrating the records. Work will initially focus on the records of organizations participating in the Community Health & Resource Network (see 4.1.3) and then expand to other resources as Centralus Health's IT capacity allows.

4.1.2 Support the development of the Community Health Assessment- Attendance at Community Health Improvement Steering Committee meetings to assist with the implementation of the Community Health Assessment. Report progress.

Quarter 1 Report:
The 2-1-1 Program Director serves on the steering committee for the Tompkins County Community Health Assessment/Community Health Improvement Plan (CHA/CHIP). This group is responsible for advising Tompkins County Whole Health on the community health improvement process, identifying priorities, reviewing data for prioritizing and evaluation, and making recommendations for engagement with the community. In addition to the steering committee, the 2-1-1 Program Director is also part of the Process Subcommittee, guiding the overall planning of activities. Steering Committee meetings were attended on 1/23 and 3/6, and the 2-1-1 Program Director also attended a planning session for community health improvement agenda-setting with Tompkins County Whole Health staff and selected partners on 1/21. During the quarter, the 2-1-1 Program Director supported Tompkins County Whole Health by recommending locations to distribute the Community Health Survey, reaching out to prospective distribution partners, and advising on interpretation of survey results and next steps for analysis.

Quarter 2 Report:
The 2-1-1 Program Director serves on the steering committee for the Tompkins County Community Health Assessment/Community Health Improvement Plan (CHA/CHIP). This group is responsible for advising Tompkins County Whole Health on the community health improvement process, identifying priorities, reviewing data for prioritizing and evaluation, and making recommendations for engagement with the community. In addition to the steering committee, the 2-1-1 Program Director is also part of the Process Subcommittee, guiding the overall planning of activities. Steering

Committee meetings were attended on April 3, May 29, and June 12. During the quarter, the 2-1-1 Program Director supported Tompkins County Whole Health by providing information about 2-1-1 contact data and how that data is categorized, in support of understanding community needs, available programs and services, and gaps. As a result, the Program Director was invited to present 2-1-1 needs data to the steering committee at its July meeting.

Quarter 3 Report:
The 2-1-1 Program Director serves on the steering committee for the Tompkins County Community Health Assessment/Community Health Improvement Plan (CHA/CHIP). This group is responsible for advising Tompkins County Whole Health on the community health improvement process, identifying priorities, reviewing data for prioritizing and evaluation, and making recommendations for engagement with the community. In addition to the steering committee, the 2-1-1 Program Director is also part of the Process Subcommittee, guiding the overall planning of activities. Steering Committee meetings were attended on 7/10, 8/21, 9/4, and 9/18. The 2-1-1 Program Director presented on 2-1-1 data to inform the Community Health Improvement planning process, including around trending community needs, at the 7/10 meeting. The 2-1-1 Program Director also supported Tompkins County Whole Health by serving on the planning team for a Community Health Improvement Partner Convening to be held in October.

4.1.3 211 participation in the Community Health & Resource Network (CH&RN)- 211 will provide referral services for community members referred to 211 via the CH&RN.

Quarter 1 Report:
Since its launch a few months ago, the Community Health & Resource Network (CH&RN) has been expanding in terms of the number of users actively making referrals. Over the course of the first quarter, initial referrals to 2-1-1 have begun coming in. During the quarter, 2-1-1 fielded 10 CH&RN contacts, with the number expected to increase in subsequent quarters and more users and organizations join the network. During this quarter, 2-1-1 staff also collaborated with clinical partners and other resource referral providers to improve pathways for referrals in order to improve the patient/client experience and streamline workloads for those using the system.

Quarter 2 Report:
The Community Health & Resource Network (CH&RN) continues to expand in terms of the number of users actively making referrals. Over the course of the second quarter, referrals to 2-1-1 increased fielding 68 CH&RN referrals.

Quarter 3 Report:
2-1-1 staff continues to play a vital role in the Community Health & Resource Network as Navigators within the Social Care Hub. We anticipate an uptick in referral volume as Cohort 2 is onboarded.

Tasks	

4.2 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

4.2.1 Trainings held – At least two training sessions about 2-1-1 resources are documented.

Quarter 1 Report:
A workshop on volunteer driver services in Tompkins County, including those administered by 2-1-1, was held on 3/31. One new volunteer driver was recruited at this event, and three were recruited overall in the first quarter.

Quarter 2 Report:
A number of trainings or presentations were provided in Q2, including:

- 4/16 - Information session about One Call, One Click Transportation Center provided to Tompkins Consolidated Area Transit (TCAT) staff
- 4/17 - Public launch and training of Tompkins Transportation Scout “one-stop-shop” transportation information mobile app, held at Tompkins County History Center in partnership with Tompkins County, GO Ithaca (transportation provider organization) and other partners
- 5/13 and 6/3 - Presentations/trainings with Ithaca Community School District transportation liaisons (staff members in each school responsible for supporting student transportation needs)
- 5/15 - Southern Tier Social Care Network Stakeholders Meeting, presentation on 2-1-1 and Human Services Coalition services available through the SCN, to inform other SCN providers who might make referrals
- 5/29 - 2-1-1 presentation at Brookdale Senior Living
- 6/17 - 2-1-1 presentation with Ithaca Housing Authority
- 6/18 - Volunteer driver information session for prospective volunteers

Quarter 3 Report:

Trainings or presentations provided in Q3 include:

- 7/30 - 2-1-1 presentation at Longview Senior Living Retirement Community
- 9/16 - 2-1-1 presentation at the Greater Ithaca Activities Center (GIAC)
- 9/17 - 2-1-1 presentation at McGraw senior apartment building
- In partnership with Tompkins County Transportation Planning and other local organizations, 2-1-1 participated in "Scout September," an outreach campaign to encourage use of the Tompkins Transportation Scout mobile app and website. Activities included public activities and outreach events providing information on the program and available transportation supports. 2-1-1 hosted sessions at three rural library locations: 9/24 Southworth Library (Dryden, NY), 9/25 Ulysses Philomathic Library (Trumansburg, NY), and 9/26 Newfield Public Library

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

Quarter 1 Report:
2-1-1 is involved in multiple projects to respond to other organizations' needs in supporting client social determinants of health needs.

- 2-1-1 has been a partner in a Federal Transit Administration-funded demonstration project that was awarded to Tompkins County to develop "Mobility as a Service," which aims to provide a "one-stop-shop" app and web interface for transportation information, referral, and booking service for participating clients. There are several partners, including transportation providers and human service agencies, as well as county government personnel. In the first quarter, 2-1-1 staff supported the development and testing of the app and web interface, working alongside Tompkins County staff and the app vendor. The app "soft launched" in the first quarter, and a public kickoff event is planned for early in the second quarter.

- 2-1-1 was the successful respondent to Tompkins County's RFP to implement a "One Call, One Click Contact Center," which will be the successor to the Mobility as a Service center as the pilot concludes. 2-1-1 began hosting the Center in January. Two new positions were hired to support the Center, with new staff coming on at the end of the quarter.
- Both staff will support community members' transportation needs; one will also have a component of their job that includes building the capacity of the county's volunteer transportation services, including those that provide non-emergency medical transportation through volunteer drivers. Three new volunteer drivers were recruited in the quarter, and new avenues for recruitment were developed, including prospective partnerships with existing volunteer groups.
- 2-1-1 has also been part of the Ithaca Electric Transportation Access Project (IETA), led by Tompkins Consolidated Area Transit (TCAT), Tompkins County's public transit provider, and funded by NYSERDA's Clean Transportation Prize. 2-1-1's role in this project will be to provide contact center services in support of expanded services to underserved neighborhoods and populations. In the quarter, 2-1-1 continued to work with TCAT to plan for a public launch of this program, which is expected approximately mid-summer 2025.

Quarter 2 Report:
2-1-1 is involved in multiple projects to respond to other organizations' needs in supporting client social determinants of health needs.

- As described in the Q1 report, 2-1-1 has been a partner in a Federal Transit Administration-funded demonstration project that was awarded to Tompkins County to develop "Mobility as a Service," which aims to provide a "one-stop-shop" app and web interface for transportation information, referral, and booking service for participating clients. There are several partners, including transportation providers and human service agencies, as well as county government personnel. After the "soft launch" of the app in Q1, a public kickoff event (see 4.2.1) was held on April 17 to publicize the service to the community and train potential users on its features.
- 2-1-1 was the successful respondent to Tompkins County's RFP to implement a "One Call, One Click Contact Center," which is the successor to the Mobility as a Service center as the pilot concludes. Two staff members joined 2-1-1 as Transportation Specialists at the end of Q1, and they spent much of Q2 learning about Tompkins County's

transportation systems, meeting with providers and other stakeholders, conducting outreach, and responding to community member needs, especially providing subsidized bus passes to individuals with transportation insecurity.

- Both staff support community members' transportation needs; one also has a component of their job that includes building the capacity of the county's volunteer transportation services, including those that provide non-emergency medical transportation through volunteer drivers. Significant outreach was conducted, especially in support of seeking volunteers in or willing to work in more rural areas, including articles in local municipal newsletters, attendance at community events, and engagement with other providers.

- 2-1-1 has also been part of the Ithaca Electric Transportation Access Project (IETA), led by Tompkins Consolidated Area Transit (TCAT), Tompkins County's public transit provider, and funded by NYSERDA's Clean Transportation Prize. 2-1-1's role in this project will be to provide contact center services in support of expanded services to underserved neighborhoods and populations. After much planning, TCAT is now awaiting for final approval of its service plan by NYSERDA prior to beginning services under this project.

- Beyond the advisement from the 2-1-1 Program Director to the Care Compass Collaborative Social Care Network, 2-1-1 has also been involved in supporting client social determinants of health needs through this program directly. All 2-1-1 staff have been trained to conduct screenings and eligibility assessments under the Social Care Network, and have begun to do so. 2-1-1 received startup capacity-building funding to hire a dedicated Social Care Navigator for SCN activities, and the interview process was conducted in Q2 with the candidate's start date in early Q3 (the Human Services Coalition also received startup funding for an Enhanced Housing Services position, which will work closely with 2-1-1 staff and which will also begin in early Q3).

Quarter 3 Report:
2-1-1 is involved in multiple projects to respond to other organizations' needs in supporting client social determinants of health needs.

- As described in the Q2 report, 2-1-1 has been a partner in a Federal Transit Administration-funded demonstration project that was awarded to Tompkins County to develop "Mobility as a Service," which provides a "one-stop-shop" app and web interface for transportation information, referral, and booking service for participating clients. The mobile app and website is branded as "Tompkins Transportation Scout. " A "Scout September" campaign (see 4.2.1) was held in September to encourage community members to sign up for and use this resource.

- 2-1-1 holds a contract with Tompkins County to implement the “One Call, One Click Contact Center,” which is the long-term successor to the Mobility as a Service project. Two 2-1-1 staff members focus on transportation: both support community member needs and one has an additional responsibility to develop the county’s volunteer driver capacity.
- 2-1-1 has also been part of the Ithaca Electric Transportation Access Project (IETA), led by Tompkins Consolidated Area Transit (TCAT), Tompkins County’s public transit provider, and funded by NYSERDA’s Clean Transportation Prize. 2-1-1’s role in this project will be to provide contact center services in support of expanded services to underserved neighborhoods and populations. TCAT is now awaiting a contract extension from NYSERDA that would allow the program to run through 2027, with the estimate for program launch around February or March 2026.
- 2-1-1 has been involved in supporting client health-related social needs through the Medicaid 1115 Care Compass Collaborative Social Care Network. A social care navigator has been hired to facilitate screening and navigation of clients eligible for services through the Social Care Network (a separate housing position works closely with 2-1-1 staff). The Human Services Coalition/2-1-1 was recently highlighted by Care Compass Collaborative as a top performer in Tompkins County SCN services, including screening/navigation, housing, and transportation.
- The City of Ithaca and Tompkins County are collaborating on the development of an unarmed response team that would respond to appropriate urgent situations when a police response is not necessary. 2-1-1 worked with the City of Ithaca Deputy City Manager and the Tompkins County Community Justice Center Director to explore 2-1-1 involvement in this much larger initiative. 2-1-1 could potentially be involved in supporting households with unmet social care needs after their interaction with the response team. The direction of the overall initiative will be taken up by the Ithaca Common Council and Tompkins County Legislature in future meetings.

Objective	
5	**Strengthen the collaborative leadership of the Tompkins Health Network**

Tasks

5.1 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

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

Quarter 1 Report:
Detailed minutes were taken for each advisory board meeting in the first quarter (January 13th, March 10th). The minutes were shared with the advisory board and approved each of the following meetings. The minutes also included committee reports and any follow-up items.

Quarter 2 Report:
Detailed minutes were taken for each advisory board meeting in the second quarter (April 14th, May 12th, June 9th). The minutes were shared with the advisory board and approved each of the following meetings. The minutes also included committee reports and any follow-up items.

Quarter 3 Report:
Detailed minutes were taken for each advisory board meeting in the third quarter (September 8th). The minutes were shared with the advisory board and approved each of the following meetings. The minutes also included committee reports and any follow-up items.

5.1.2 Board and Network Membership – Report of Board member meeting attendance, membership terms, and compliance with work rules presented to Nominating and Executive Committee by October 2025.

Quarter 1 Report:
We held two Advisory Board meetings and one executive committee meetings during this quarter. Attendance at the Advisory Board meetings is documented as part of the meeting record: January (18 board members, 4 staff, 2 guests); March (18 board members, 4 staff, 26 guests). At the Executive Committee Meeting in January, 3 members and one staff attended. The Executive Committee remains the same. Our Long Term Care Committee Chair and Community Health and Access Committee co-chairs are remaining the same for 2025.

Quarter 2 Report:
We held three Advisory Board meetings and one executive committee meetings during this quarter. Attendance at the Advisory Board meetings is documented as part of the meeting record: April (11 board members, 2 staff, 4 guests); May (9 board members, 3 staff, 2 guests); June (19 board members, 4 staff, 5 guests). At the Executive Committee Meeting in June, 2 members and 3 staff attended.

Quarter 3 Report:
We held one Advisory Board meeting and one executive committee meeting during this quarter. Attendance at the Advisory Board meetings is documented as part of the meeting record: September (13 board members, 3 staff, 3 guests). At the Executive Committee Meeting in August, 4 members and 2 staff attended.

5.1.3 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.

Quarter 1 Report:
No assessment activity this quarter. Assessment planning will commence in the 3rd quarter.

Quarter 2 Report:
No assessment activity this quarter. Assessment planning will commence in the 3rd quarter.

Quarter 3 Report:
Assessment activities started in this quarter. At the September THN Advisory Board meeting, board members broke into groups to provide feedback on the restructuring of the advisory board to more intentionally include the 3 health related social needs (HRSNs) that are part of the NYHER 1115 waiver social care network enhanced services. The intent is to bring together champions working on both these social care needs, as well as clinical care (including physical and behavioral

health), and more intentionally align initiatives aimed at similar outcomes. THN Advisory Board members provided feedback on the issues, priorities and populations that should be considered when restructuring the advisory board for more inclusive representation.

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

Quarter 1 Report:
The Advisory Board received committee reports following each board meeting during the first quarter (January, March). Reports were given on the Long Term Care Committee, and Community Health and Access Committee. The reports included any relevant updates and progress, meetings and upcoming events.

Quarter 2 Report:
The Advisory Board received committee reports following each board meeting during the second quarter (April, May, June). Reports were given on the Long Term Care Committee, and Community Health and Access Committee. The reports included any relevant updates and progress, meetings and upcoming events.

Quarter 3 Report:
The Advisory Board received committee reports following each board meeting during the third quarter (September). Reports were given on the Long Term Care Committee, and Community Health and Access Committee. The reports included any relevant updates and progress, meetings and upcoming events.

5.1.5 Presentations on community issues – At least three presentations on relevant community health topics will be provided during board meetings. The purpose of the presentations is to educate the board on related work plan topics.

Quarter 1 Report:
At the March 10th THN Advisory Board meeting, Nicole Cashman presented on the enhanced housing services available via the Social Care Network (SCN). See performance measure 5.1.6 for more detailed information.

Quarter 2 Report:
At the April 14th THN Advisory Board meeting this quarter, Travis Brooks presented the Tompkins County Health & Human Services Committee priorities and goals for 2025, and Anushka Bhargave presented the 2025 Community Health Survey results. See performance measure 5.1.6 for more detailed information

Quarter 3 Report:
At the September 8th THN Advisory Board meeting this quarter, THN Director and Executive Director (Cindy Wilcox) presented the plan to restructure the advisory board including a systems level approach to aligning clinical, behavioral and social care planning efforts.

5.1.6 Community engagement- THN Advisory Board will host or collaborate at least one time throughout the year to provide a space for community members to engage on health issues affecting the local community gather community-driven solutions.

Quarter 1 Report:
THN Advisory Board opened up the March 10th meeting this quarter to the community to come and learn about enhanced housing services available to qualifying Medicaid members via the SCN. Nicole Cashman, Housing Network Specialist for our regional SCN (Care Compass Collaborative), presented on all of the available enhanced housing services including qualification criteria and guidance on how to get access to the services. Community partners and community members were asked how to best reach Medicaid beneficiaries in the local community to spread awareness of the enhanced housing services.

Quarter 2 Report:
THN Advisory Board opened up the April 14th meeting this quarter to the community to come and learn about the Tompkins County Health & Human Services Committee priorities and goals for 2025. This was presented by Tompkins County Legislator, Travis Brooks, the Health & Human Services Committee Chair, and he identified opportunities for THN and the legislator to collaborate. Anushka Bhargave, Public Health Fellow, presented the results from the 2025 Community Health Survey administered by Tompkins County Whole Health Community Health Improvement Steering Committee including highlighting strength and opportunities for improvements.

Quarter 3 Report:
Performance measure met in previous quarters.

Tasks

5.2 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

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

Quarter 1 Report:
No activity this quarter, planning will commence during the third quarter.

Quarter 2 Report:
No activity this quarter, planning will commence during the third quarter.

Quarter 3 Report:
THN Director shared with THN Advisory Board the intention to request nominations for local rural health champions, including rural health workers or organizations that serve rural areas in Tompkins County. THN Director will put out an open call for nominations in the beginning of the next quarter.

5.2.2 Plan Implementation – Plan to recognize rural health partners or workers will be finalized prior to completion of this contract term (with plan to recognize rural partners and workers on National Rural Health Day in November 2025).

Quarter 1 Report:
No activity this quarter, implementation will occur in the fourth quarter.

Quarter 2 Report:
No activity this quarter, implementation will occur in the fourth quarter.

Quarter 3 Report:
No activity this quarter, implementation will occur in the fourth quarter.

Objective	
6	**Support the development of a community health network to connect health and social care providers**

Tasks

6.1 Support development of the Community Health & Resource Network (CH&RN) – THN staff will continue the development 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

6.1.1 Regular network meetings- THN staff will coordinate regular network meetings to support current community based organizations in the CH&RN

Quarter 1 Report:
The Community Health & Resource Network (CH&RN) launched on January 22, 2025 with 13 participating organizations. In Q1, the project team facilitated bi-weekly network meetings to evaluate the operations of the network, review high-level trends, and share organizational information. Discussion topics included updated consent (to conform to the NYHER 1115 Waiver language), a field review within the technical system, and ways in which we can bolster support for CBOs referring to each other and a review of existing network connections through a mapping exercise. Each meeting includes an "Organization Spotlight" segment, which highlights the various programs of each participating partner to enhance knowledge among staff and improve the quality of referrals between partners. In Q1, there have been 460 referrals sent on the platform.

In addition, the project team launched a public facing Network website and published an informational RAC card, which is displayed at local primary care offices.

Quarter 2 Report:
In Q2, the project team continued to facilitate bi-weekly network meetings to evaluate the operations of the network, review high-level trends, and share organizational information. Discussion topics included a review of referral patterns, a comprehensive training on the network resource directory, the development of an intranet for network members, creation of a self-screening tool accessible to all community members, an action plan to address participant feedback from our Evaluation team, planning for Cohort 2, and a technical design session. We continue to spotlight organizations or programs at each meeting to share valuable service information between partners. Based on meeting attendance, content and participant feedback, the network meeting will be moved to a monthly occurrence starting in Q3. In the first two quarters, there have been 660 referrals sent on the platform.

Quarter 3 Report:
In Q3, the network operations meetings moved to a monthly cadence based on CBO capacity and feedback. In October, we hosted a platform training for our existing network partners. This training focused on version 2.0 of our referral platform. Since the network launch, there have been 757 referrals sent on the platform.

6.1.2 Expansion of network- THN staff will add at least 5 community based organizations to the network over the course of the reporting period.

Quarter 1 Report:
The project team anticipates onboarding a second cohort of 15 CBOs onto the network. These organizations will be chosen based on a variety of criteria, including Cohort 1 referral patterns, gaps in service, and interest level. The project team has drafted a list of potential organizations who may be interested in joining our second cohort and will continue to expand the list as we receive more information.

Quarter 2 Report:
The project team has decided to remove the cap of 15 CBOs for cohort 2 to more quickly expand the network and meet the needs of our community members. We will be using referral data and participant feedback, to inform the prioritization of CBO recruitment. We aim to recruit 15-20 CBOs for cohort 2 by Q4. Future organizations who are interested in joining the network will be considered on a rolling basis.

Quarter 3 Report:
Much of Q3 was spent recruiting organizations to join the network as part of Cohort 2. The recruitment list was developed in collaboration with Cohort 1 CBO and the project team. As part of our analysis, we reviewed social needs gaps in the network. Organizations providing services in these service areas were prioritized for recruitment. We aim to finalize and onboard our second cohort by early November.

Tasks

6.2 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

6.2.1 Local HRSN inclusion into the CH&RN -THN staff will identify services providers from at least three of the six HRSNs areas that are included in the NYHER 1115 screening tool to be included in the CH&RN

Quarter 1 Report:
Collectively, the CH&RN partners provide services in 9 social needs domains: childcare, employment, finances, food security, transportation housing/ utilities, legal services, medical services, social support, and transportation. Four are included in the NYHER 1115 screening tool (housing/ utilities, food security, transportation, employment). We will continue to evaluate the gaps in service provision as we gather and analyze more referral data.

Quarter 2 Report:
The project team, with network support, has created a self-screening tool, which can be accessed directly by community members. The screening tool includes 9 social needs domains. The screener can be submitted by an individual needing assistance or on behalf of a friend or family member. Once submitted, the community member will receive a phone call, email or text (based on individual preference) to get connected to additional support.

Quarter 3 Report:
We continue to revise the self screening tool to ensure it is easily accessible to all community members. With the expertise of our second cohort of CBOs, we anticipate adding two additional social need domain questions by the end of Q4.

6.2.2 Assume the role as NYHER 1115 Social Care Network (SCN) Ambassador for Tompkins County- THN staff will work with regional SCN to ensure HRSN reimbursable services are available and accessible for Medicaid beneficiaries in Tompkins County.

Quarter 1 Report:
THN Director served in the role as the Tompkins County (TC) Lead Ambassador for the Social Care Network (SCN). In the first quarter, THN Director and THN staff connected with local TC community-based organizations (CBOs) to discuss participation in the regional SCN. We individually reached out to 67 CBOs that had not yet contracted with the SCN. We held 6 group sessions in the first quarter to level-set what the SCN is and provide an opportunity for CBOs to ask questions in addition to the one-on-one meetings THN staff held with several organizations. We also held a TC agency meeting to discuss with County Agencies how they could work with the SCN (since they are unable to contract with the SCN). We also gathered all CBOs that provide food and nutrition services in TC to discuss enhanced food and nutrition services available through the SCN. Lastly, we gathered SCN contracted TC CBOs on March 21st to review what HRSN services organizations were contracted to provide, what additional services they would be willing to offer via the SCN, and identify additional organizations that could provide services with less than 3 providers in TC. We were able to ensure by the end of the first quarter that at least one provider was identified to provide every HRSN service to TC Medicaid beneficiaries.

Quarter 2 Report:
Performance measure met in quarter 1.

Quarter 3 Report:
Performance measure met in quarter 1.