Rural Health Network Development Program
Performance Measures Report
October 1, 2025– September 30, 2026

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

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

Reporting Period: **July 1, 2026 to September 30, 2026**

Provide summary of significant progress achieved during the reporting period:

Network leadership and planning: The THN Advisory Board met on September 14th and reviewed its role in the county's Community Health Improvement Plan, identified data indicators and review processes for five selected interventions, discussed the next THN work plan, and received updates from the Long Term Care Committee and its subcommittees.

Community outreach and health insurance enrollment: THN participated in Senator Webb's September 2nd health fair and promoted Navigator services through local listservs reaching approximately 3,600 members. Navigators processed 243 applications during the quarter, bringing annual enrollment activity to 140% of the year-end target; demand remained elevated following the termination of the Essential Plan 200–250 program.

Medicaid-change preparation: In place of the quarterly Community Health Conversation, HSC launched a local Medicaid Changes Task Force co-facilitated by the THN Director and HSC Executive Director. More than 40 representatives from community organizations, public agencies, funders, and local businesses participated in planning to mitigate the effects of upcoming Medicaid work requirements.

Long-term care coordination: The Long Term Care Committee met in August to discuss hoarding resources, long-term care service information, caregiver supports, and updates from the Transition Planning and Fall Prevention workgroups. The subcommittees hosted presentations on Guthrie's discharge-planning process and the Long-Term Care Ombudsman Program, offered a caregiver training with seven participants,

researched fall-prevention resources for underserved populations, and explored adding fall-prevention resources to 211 and the CH&RN screening process.

Community Health & Resource Network: THN facilitated two Network Operations meetings and reported 786 referrals during the quarter. Housing, food security, and transportation were the leading needs, with 359, 257, and 236 referrals respectively; partner discussions also identified opportunities to improve platform awareness, referral workflows, notifications, and integration into organizational intake processes.

211 partnerships and transportation initiatives: 211 responded to 1,782 transportation-related contacts through the One Call, One Click Center and another 446 contacts related to the eRide program. Staff continued coordinating the volunteer transportation provider workgroup, developed a Zoho database for managing ride requests and volunteer-driver trips, provided community trainings, and helped establish a proposed partnership with Ithaca's ROOTS unarmed response team using the Community Health App for follow-up referrals.

Rural Health Network Development Program
Human Services Coalition Tompkins Health Network Work Plan
July 1, 2026 – September 30, 2026

Objective	
1	**Strengthen 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.

Quarter 1 Report:

Detailed minutes were taken for the one advisory board meeting in the first quarter (November 10th). The minutes were shared with the advisory board and will be approved at the following meeting in quarter 2. The minutes also included committee reports and any follow-up items.

Quarter 2 Report:

Detailed minutes were taken for the three advisory board meeting in the second quarter (January 12th, February 9th, March 9th). The minutes were shared with the advisory board and approved at each of the following meetings (with March's minutes being approved in the 3rd quarter). The minutes also included committee reports and any follow-up items.

Quarter 3 Report:

Detailed minutes were taken for the two advisory board meeting in the third quarter (April 13th, June 8th). The minutes were shared with the advisory board and approved at each of the following meetings (with June's minutes being approved in the 4th quarter). The minutes also included committee reports and any follow-up items.

Quarter 4 Report:

Detailed minutes were taken for the one advisory board meeting in the fourth quarter (September 14th). The minutes will be shared with the advisory board prior to the next meeting in the following quarter and will be approved at that meeting. The minutes also included committee reports and any follow-up items.

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.

Quarter 1 Report:

We held one Advisory Board meeting during this quarter. Attendance at the Advisory Board meeting is documents as part of the meeting record: November (16 board members, 4 staff, 1 guest).

Quarter 2 Report:

We held three Advisory Board meetings during this quarter. Attendance at the Advisory Board meeting is documents as part of the meeting record: January (14 board members, 2 staff, 4 guests), February (15 board members, 2 staff, 9 guests), March (15 board members, 2 staff, 4 guests).

Quarter 3 Report:

We held two Advisory Board meetings during this quarter. Attendance at the Advisory Board meeting is documents as part of the meeting record: April (11 board members, 3 staff, 4 guests), and June (14 board members, 4 staff, 10 guests).

Quarter 4 Report:

We held one Advisory Board meetings during this quarter. Attendance at the Advisory Board meeting is documented as part of the meeting record: September (12 board members, 4 staff, 2 guests).

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.

Quarter 1 Report:

At the November Advisory Board meeting, THN Director shared the work plan for the upcoming year. In lieu of a network assessment, the board completed a small group working session providing feedback on the THN work plan.

Quarter 2 Report:

A strategic planning session is scheduled for April 2026 which will have a facilitator working with the THN Advisory Board to engage in more specific planning efforts tied to the 2025-2030 Community Health Improvement Plan. Results of strategic planning session will be reported on in the 3rd quarter.

Quarter 3 Report:

THN Advisory Board met in April with a consultant facilitating a conversation about restructuring the core purpose and work of the advisory board. The meeting focused on how social determinants of health can be incorporated into the work we do, how do we collaborate with more intention and who is missing from the THN Advisory Board to further the purpose of this work. More details are reported on this in performance measure 3.2.3.

Quarter 4 Report:

THN Advisory Board met in September and evaluated HPC's role in the local county's Community Health Improvement Plan interventions. The discussion included what work should be included in the next THN work plan.

1.1.4 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 the board meeting during this quarter (November). Reports were given on the Long-Term Care Committee (LTCC) and shared the plan to transition the Community Health and Access Committee to Community Health Conversations. Additionally, the board was advised of the formation of two working groups for the LTCC: discharge and transition process, and falls prevention. The reports included any relevant updates and progress, meetings and upcoming events.

Quarter 2 Report:

The Advisory Board received committee reports following the board meetings during this quarter (January, February, March). Reports were given on the Long-Term Care Committee (LTCC) and the working subcommittees of the LTCC. The reports included relevant updates and progress, meetings and upcoming events.

Quarter 3 Report:

The Advisory Board received committee reports following the board meetings during this quarter (April, June). Reports were given on the Long-Term Care Committee (LTCC) and the working subcommittees of the LTCC. The reports included relevant updates and progress, meetings and upcoming events.

Quarter 4 Report:

The Advisory Board received committee reports following the board meetings during this quarter (September) as part of the minutes. Reports were given on the Long-Term Care Committee (LTCC) and the working subcommittees of the LTCC. The reports included relevant updates and progress, meetings and upcoming events.

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.

Quarter 1 Report:

No activity to report this quarter.

Quarter 2 Report:

The NYHER 1115 Waiver Social Care Network (SCN) for the Southern Tier Region attended the February 2026 THN Advisory Board meeting to provide an update on the local social care network efforts in Tompkins County. SCN staff shared the number of referrals for HRSNs including food, housing and transportation and highlighted where there are current gaps in services or capacity in the SCN.

Quarter 3 Report:

At the April THN Advisory Board, THN Director reviewed the Community Health Improvement Plan priorities, objectives and interventions, and the data from the Community Health Assessment that led to choosing those interventions. The presentation included highlighting the interventions that would address HRSN needs, specifically food, housing and transportation. During this meeting, we included how the interventions that would be chosen for the THN Advisory Board to focus on, would directly, or indirectly, intersect with HRSN needs (eg. the need to improve transportation access in rural areas to improve access to healthy, nutritious foods to reduce the onset of chronic disease).

At the June THN Advisory Board, leading local experts on transportation, food/nutrition and housing needs came to share information about how each of these needs present in our community, the barriers to access that exist, how these needs impact health outcomes and identifying possible pathways to improve access and improve health outcomes. We had representation on these panels from REACH Medical (housing), Continuum of Care (housing), Tompkins County Planning (transportation), Gadabout (transportation), YMCA (food/nutrition), Foodnet (food/nutrition), Foodbank of the Southern Tier (food/nutrition) and Tompkins Food Future (food/nutrition).

Quarter 4 Report:

Performance measure completed in quarter 3.

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).

Quarter 1 Report:

No activity to report this quarter.

Quarter 2 Report:

No activity to report this quarter.

Quarter 3 Report:

No activity to report this quarter.

Quarter 4 Report:

No activity to report this quarter. College student support to hold focus groups in rural communities fell through which resulted in lack of capacity to complete this performance measure.

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.

Quarter 1 Report:

THN Director advised the THN Advisory Board of the plans to put out a call for rural health worker nominations this quarter to recognize workers or organizations on National Rural Health Day.

Quarter 2 Report:

Planning for 2026 recognition will commence in the 4th quarter.

Quarter 3 Report:

Planning for 2026 recognition will commence in the 4th quarter.

Quarter 4 Report:

THN Director requested nominations for National Rural Health Day in September from the local community. Nominations for local rural health workers or organizations were requested. THN Director received two nominations that will be recognized in the following quarter.

1.2.2 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:

Unfortunately, we did not receive any nominations for recognition of any rural health workers or organizations this year. Instead, we recognized previous year's honorees via listserv and social media.

Quarter 2 Report:

Performance measure completed in 1st quarter.

Quarter 3 Report:

Performance measure completed in 1st quarter.

Quarter 4 Report:

Performance measure completed in 1st quarter.

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)

Quarter 1 Report:

THN staff tabled at 3 local events this quarter. One 10/7/2025, tabling occurred at our NYS Senator's community health fair. On 10/23/2025, tabling occurred at the Community Health & Resource Network mixer. And on 11/13/2025, tabling occurred at a gathering for childcare organizations.

Quarter 2 Report:

We promoted our health insurance navigator and community health advocate programs on our local listservs (reaching 3600 members). THN staff conducted in-person outreach at every pharmacy in Tompkins County and over 50% of clinical providers this quarter. Lastly, we advertised our Community Health Advocate services on social media (Facebook) and on the local public bus transportation (TCAT).

Quarter 3 Report:

Performance measure completed in 2nd quarter.

Quarter 4 Report:

THN staff tabled at NY State Senator Webb's health fair on 09/02/2026. We promoted our health insurance navigator on our local listservs (reaching 3600 members).

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

Quarter 1 Report:

The Continuum of Care Coordinated (CoC) Entry Lead presented to the THN Advisory Board this quarter (November meeting) about Code Blue.

Quarter 2 Report:

After the local health department presented on the proposed Community Health Improvement Plan (CHIP) priorities to the THN Advisory Board (including housing priorities) at the March meeting, THN advisory board members ranked the top priorities for the THN Advisory Board to take a role in in the next 1-5 years. The top 10 priorities chosen by the advisory board included housing priorities and the April THN Advisory Board meeting will narrow the priorities further.

Quarter 3 Report:

Director of Housing Initiatives at Human Services Coalition participated in the April THN Advisory Board meeting to contribute a housing and homelessness perspective in planning for restructuring of the THN Advisory Board. The meeting included discussion about identifying a more formal role for the CoC as part of the THN Advisory Board. The CoC Entry Lead participated as a panel member at the June THN Advisory Board to answer questions about housing and health impacts.

Quarter 4 Report:

THN Director met with Continuum of Care (CoC) Director to discuss collaboration between THN and CoC. Together, data suppliers were identified for the housing related Community Health Improvement Plan intervention that THN will be

helping to collect, synthesize and review data. Additionally, CoC members were identified who could join THN Advisory Board to have an identified CoC liaison on the advisory board.

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.

Quarter 1 Report:

No activity to report this quarter.

Quarter 2 Report:

THN staff shared community health advocate and health insurance navigator information with 100% of Tompkins County pharmacies and over 50% of primary care providers via in-person outreach (providing print materials including brochures for patients) this quarter.

Quarter 3 Report:

Performance measure completed in 2nd quarter.

Quarter 4 Report:

Performance measure completed in 2nd quarter.

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.

Quarter 1 Report:

Two hundred and sixty-nine applications were processed during this quarter, approximately 36% of the year-end goal. Annual Open Enrollment began this quarter, so enrollments numbers are a bit inflated this quarter compared to other quarters. The uncertainty of Affordable Care Act (ACA) enhanced subsidies extensions/expiration led to more people choosing bronze qualified health plans compared to the previous year due to the increase in premiums (and the decrease of subsidies for many).

Quarter 2 Report:

Two hundred and nine applications were processed during this quarter, approximately 28% of the year-end goal (bringing the total to 64% of the year end goal for the first two quarters). In preparation for the Essential Plan 200-250 plan (available via the NYS of Health marketplace) ending on 7/1/26, health insurance navigators are scheduling appointments now for 5/16/26-6/15/26 to ensure beneficiaries of this plan do not experience a gap in coverage.

Quarter 3 Report:

Three hundred and twenty-four applications were processed during this quarter, approximately 44% of the year-end goal (bringing the total to 108% of the year end goal for the first three quarters). As a result of the termination of the Essential Plan 200-250 plan (available via the NYS of Health marketplace), health insurance enrollments spiked this quarter.

Quarter 4 Report:

Two hundred and forty-three applications were processed during this quarter, approximately 33% of the year-end goal (bringing the total to 140% of the year end goal). As a result of the termination of the Essential Plan 200-250 plan (available via the NYS of Health marketplace), health insurance enrollments continued to remain higher than usual this quarter.

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.

Quarter 1 Report:

THN staff conducted two health insurance presentations this quarter. The first presentation (11/13/2025) was to Ithaca Child Care organizations and the second presentation (12/17/2025) was a partnership with our NYS Assemblywoman at our local public library that was offered to the public.

Quarter 2 Report:

THN staff provided educational presentations 6 times this quarter about cost-sharing reduction qualified health plans available on the NYS of Health marketplace, as well as an overview of some of our direct services programming (health insurance navigator, community health advocate) at the Newfield public library, Lansing public library, Homeless & Housing Task Force meeting, Tompkins County Whole Health (public health department, mental health department), and St. Paul's United Methodist church.

Quarter 3 Report:

Performance measure completed in 2nd quarter.

Quarter 4 Report:

Performance measure completed in 2nd quarter.

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.

Quarter 1 Report:

Due to the transition from the Community Health & Access Committee (CHAC) to Community Health Conversations (CHC), there was no meeting scheduled this quarter to allow for additional planning time.

Quarter 2 Report:

In lieu of the CHC meeting this quarter, the THN Advisory Board invited the community to attend the February THN Advisory Board meeting to learn about the current progress on the NYHER 1115 waiver services in Tompkins County. Additionally, community members were invited to the March THN Advisory Board meeting to learn about the Community Health Assessment that was submitted to NYS in December of 2025 and the proposed priorities of the local Community Health Improvement Plan that will be submitted by June 2026.

Quarter 3 Report:

The CHC meeting this quarter was scheduled for June, but the presenter had to cancel due to a family emergency. The presentation will be rescheduled for a later meeting. There was not enough time to find an alternative presenter.

Quarter 4 Report:

The CHC meeting was not held this quarter because of launching a local Medicaid Changes Task Force that was scheduled for when the regular CHC meeting would have been held. THN Director co-facilitated the Medicaid Changes Task Force with Human Services Coalition Executive Director. The task force brought together over 40 individuals working together to mitigate the impacts of the upcoming Medicaid work requirements. The individuals on the task force represented local community-based organizations, public sector organizations, funders, and small local businesses.

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

Quarter 1 Report:

THN Director shared with the THN Advisory Board this quarter that the CHAC will be transitioning to community health forums (CHC) beginning in 2026.

Quarter 2 Report:

THN Director shared that the CHC meeting was postponed until the 3rd quarter in lieu of two community focused meetings of the THN Advisory Board this quarter (see performance measure 3.1.1 for more information).

Quarter 3 Report:

Due to the presenter needing to cancel, promotion for the CHC meeting had not yet begun with the THN Advisory Board. They will be notified when the presentation is rescheduled for a later date.

Quarter 4 Report:

Due to the cancellation of the CHC meeting, it was not promoted to the THN Advisory Board, however, the advisory board was informed about the launch of the Medicaid Changes Task Force.

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.

Quarter 1 Report:

THN Director and Deputy Director, John Mazzello, continue to serve as members of the CHIP Steering Committee. Both assisted with a Community Health Improvement partner convening on October 9th. Several community partners were gathered to share the results of the Community Health Assessment and given a chance to weigh in on interventions for the 5 different priority areas chosen for the 2025-2030 CHIP. THN Director and Deputy Director both facilitated break out groups to discuss interventions (maternal healthcare and housing).

Quarter 2 Report:

THN Director and Deputy Director, John Mazzello, continue to serve as members of the CHIP Steering Committee. We had a full CHIP steering committee in January where feedback was given on the CHIP implementation community partner survey being disseminated this quarter. Over 30 community partners responded to the survey to provide information on how they could contribute to the CHIP interventions. In March we reviewed the data collected by the survey so that we could organize the results at the next meeting in preparation for the CHIP submission in June 2026.

Quarter 3 Report:

THN Director and Deputy Director, John Mazzello, continue to serve as members of the CHIP Steering Committee. We had a full CHIP steering committee in April to review community partner survey results and completed the CHIP implementation framework. At the May CHIP steering committee meeting we reviewed and finalized 3/6 CHIP priorities/implementation plans. We did not meet in June as the CHIP was being finalized by Tompkins County Whole Health (TCWH), but THN Director worked with TCWH staff to review potential CHIP interventions that THN Advisory Board will be tasked with.

Quarter 4 Report:

While the CHIP Steering Committee did not meet over this quarter, THN Director and Deputy Director, John Mazzello, worked with local CHIP staff at the health department and local health system to review CHIP interventions and make a plan on how to best gather data, review data and make recommendations on how to make progress on the CHIP objectives.

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.

Quarter 1 Report:

THN director continues to work with our local health department to assist with maternal and perinatal health interventions planned through the Community Advisory Board (CAB). THN Director also facilitated breakout group discussions at the CHIP convening this quarter to gather input on maternal and perinatal interventions to address CHIP objectives.

Quarter 2 Report:

THN director attended the Healthy Infants Partnership (HiP) CAB in March this quarter. The HiP is sponsoring a free doula certification training in the 3rd quarter. The intent of this training is to increase the number of local certified doulas, especially those from marginalized communities.

Quarter 3 Report:

HiP held a free 3-day doula training that was attended by 9 people in May. Tompkins County Whole Health is seeking additional funding to expand this training to additional community members since nearly 30 people completed an application to participate in the doula training.

Quarter 4 Report:

No activity to report this quarter.

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.

Quarter 1 Report:

THN Director attended two Tompkins County CSB meetings this quarter (November, December). The CSB nominated THN Director to serve as Vice Chair of the CSB for 2 years (2026-2027). Voting to confirm officers will happen in the next quarter.

THN Director, Deputy Director and Executive Director attended a gathering of behavioral health leaders for Tompkins County convened by Care Compass Network (regional open network) to discuss local priorities to address behavioral health challenges. A convening is planned for quarter 2 to continue these conversations.

Quarter 2 Report:

THN Director attended two Tompkins County CSB meetings this quarter (January, March). THN Director was confirmed as Vice Chair of the CSB for 2 years (2026-2027).

THN Director and Executive Director attended a gathering of behavioral health leaders for Tompkins County convened by Care Compass Network (regional open network) again this quarter (in January) to discuss local priorities to address behavioral health challenges. As a result of this convening, THN Director is organizing a separate local convening in the 3rd quarter of behavioral health network to find alignment of priorities and identify opportunities for collaboration.

Quarter 3 Report:

THN Director attended two Tompkins County CSB meetings this quarter (April, May).

THN Director, Deputy Director and Executive Director convened a local Tompkins County group around behavioral health access in April and June. The April meeting focused on identifying recent progress, local assets, current barriers and possible solutions. The June meeting focused on promoting understanding and awareness of different Medicaid billing policies and reimbursement rates. In the 4th quarter, the group will explore the possibility of creating a system shift of behavioral health referrals to best meet individual organizations' needs (and ensure financial stability).

Quarter 4 Report:

THN Director attended two Tompkins County CSB meetings this quarter (July, September).

THN Director met with local family and children services Executive Director this quarter to discuss how to better serve Medicaid beneficiaries for their behavioral health services in Tompkins County. Out of this meeting came the desire to determine local capacity to serve different levels of care for behavioral health services. THN Director will connect with local mental health department to determine what work has been accomplished to evaluate local behavioral health services capacity.

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.

Quarter 1 Report:

THN Advisory Board received an update on the CHIP priorities as well as the Community Health Assessment that was to be submitted to NYS by the end of this quarter. THN Advisory Board will have an opportunity to contribute to the 2025-2030 CHIP in quarter 2 and 3.

Quarter 2 Report:

THN Advisory Board received an update at the THN Advisory Board meeting in March this quarter on the CHIP draft as well as the Community Health Assessment that was submitted to NYS last quarter. THN Advisory Board members provided ranking of CHIP interventions that can be a focus for the next 1-5 years of THN advisory board planning efforts.

Quarter 3 Report:

At the April meeting, THN Advisory Board reviewed the top 10 ranked CHIP interventions chosen by the THN Advisory Board. At this meeting, the group narrowed the CHIP interventions to 5. At the June THN Advisory Board meeting, THN Director reviewed the interventions which had some revisions (since they were not finalized and submitted to NYS until

the end of June). The top 5 CHIP interventions informed the panel discussion at the June THN Advisory Board meeting around food access, transportation and housing needs.

Quarter 4 Report:

At the September meeting, THN Advisory Board reviewed the 5 CHIP interventions chosen by the THN Advisory Board. We identified different data indicators for the interventions, data synthesizers and process of reviewing the data for the different CHIP interventions.

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.

Quarter 1 Report:

The Long Term Care Committee (LTCC) continues to meet on a quarterly basis, and met on November 7th during the 1st quarter. This meeting included a presentation by John Halaychik from Tompkins County Department of Emergency Response highlighting falls rates in Tompkins County.

Quarter 2 Report:

The Long Term Care Committee (LTCC) continues to meet on a quarterly basis, and met on Feb 6th, 2026. A speaker from the Center for Aging Resources and Enrichment (CARE) at Le Moyne attended our meeting – Paul Musso, OT . Paul gave an overview of the services his organization provides. We discussed the data from Upstate Medical and the impact falls have on Cortland and Tompkins County. After the speaker, we broke out into two workgroups - Falls Prevention, and Transition Planning. The groups addressed priorities, goals and committed to meeting on a regular basis and selected a facilitator. Andrea Davis (Falls Prevention) and Thena Lindhorst (Transition Planning) agreed to facilitate the groups and provide updates to LTCC.

Quarter 3 Report:

The Long Term Care Committee (LTCC) continues to meet on a quarterly basis, and met on May 1st, 2026. We had updates from our subcommittee chairs, Andrea Davis (Falls Prevention) and Thena Lindhorst (Transition Planning), and then spent the remainder of the time discussing what is working well and identify additional opportunities to collaborate.

Quarter 4 Report:

The Long Term Care Committee (LTCC) continues to meet on a quarterly basis, and met on August 7th, 2026. We had updates from our subcommittee chairs, Andrea Davis (Falls Prevention) and Thena Lindhorst (Transition Planning), and then spent the remainder of the time discussing hoarding resources, long term care services resources and caregiver support resources dissemination.

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.

Quarter 1 Report:

In October, the LTCC coordinator worked on recruiting members. We lack adequate representation from LTC facilities on the committee. A direct email was sent to LTC facilities requesting consideration to select an employee to join the committee. A general email was posted to the Tompkins County Human Services Listserv inviting community members and organizations to join.

John Halaychik from Tompkins County Emergency Response Department accepted an invitation to join. As the assistant director, he has access to data related to falls in Tompkins County. He agreed to present this data at the November 2026 meeting. His knowledge and access to EMS will be informative and help guide the group for priorities. We had more than 15 members attend the LTCC this quarter, but sometimes there are a few agencies with multiple employees attending. We are working on improving the membership of the LTCC.

Quarter 2 Report:

We had 21 members (representing 13 organizations) attend the Feb 6th LTCC meeting. Emily Mallar from Centralus/Cayuga Health (larger local health system) has rejoined the group and is working with the Transition Planning group and has offered feedback on who to include in this working group.

Quarter 3 Report:

We had 19 members (representing 13 organizations) attend the May 1st LTCC meeting. Representation included health system, local office for Aging, independent living organizations, assisted living organizations, food assistance organizations and home health aide organizations.

Quarter 4 Report:

We had 9 members representing 9 organizations attend the August 8th LTCC meeting. Representation included health system, local office for Aging, independent living organizations, assisted living organizations, housing assistance organizations and home health aide organizations. Attendance was low due to it being a summer month meeting and many people out of the office.

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.

Quarter 1 Report:

In quarter 1, LTCC coordinator started the process of developing a Discharge & Transition Planning work group. We sent out a survey to gather feedback on membership, directory, and training needs. We directly reached out to Emily Mallar, Senior Director of Care Transitions at Centralus, Ithaca College Gerontology Institute, Lifelong (local senior community center), and County Office for Aing (COFA) asking for help to get the survey to folks. Part of the survey asks who should be contacted to join the group.

LTCC coordinator also started the process of developing a Falls Prevention work group. Met with John Halaychikto to discuss his interest in workgroup and ideas around getting the group going. Outreached to Ithaca College Occupational

Therapist, Jes Valdez-Taves, to gauge interest. John Halaychik presented data on falls in Tompkins County at the November LTCC meeting.

Quarter 2 Report:

The Transition Planning group has a new name, after feedback that Discharge Planning can be a loaded term when trying to collaborate with organizations. Workgroups began working together to find times to meet. Our Transition Planning Workgroup will address and identify discharge needs and propose solutions. They met on March 6 and worked on a survey to find a regular meeting time moving forward.

The Falls Prevention group decided to have THN Director work with CARE program at LeMoyne to contract for Falls Prevention workshops and the group will work on supporting that initiative. The workgroups will provide the LTCC coordinator with requests for support when needed, updates on progress and meeting times so that they can be shared with the large group. The momentum is picking up, and the groups are making progress.

Quarter 3 Report:

The Fall Prevention established a monthly reoccurring meeting this quarter and started reviewing some of the current fall prevention materials/programs that we have in place. THN contracted with CARE @ Le Moyne College to bring two fall prevention centered trainings to Tompkins County. The Workgroup worked with CARE to schedule the Fall Prevention training program in July at FLIC, and suggested that we target service providers, property managers, and PCAs to broaden the reach out the program. The Workgroup also scheduled the Caregiver Training with CARE, looking to share the information with informal caregivers, which will be held at COFA in August.

Members of the Workgroup compiled all of the work, data, and other relevant pieces of information from the previous Fall Prevention Coalition and created a shared space where all workgroup members can access the materials. Some of the work from the previous Coalition included Fall Prevention logos and flyers from the Health Foundation of Western & Central NY (HFWCNY). Workgroup members committed to reaching out to the HFWCNY about the possibility of continuing to use the logos/branding on materials that will be shared within the community. The workgroup also suggested building out the Fall Prevention webpage on COFA's website. The idea is to have a central location to highlight the available resources and programs, and the work that is being done by the workgroup. Once completed, the webpage will be maintained and linked to other service providers webpages.

Transition Planning workgroup met on a monthly basis this quarter (April 10, May 13, June 10). In April, the subcommittee developed a charter that included rationale, defined scope, proposed work plan and next steps. In May, Cayuga Medical Center presented on the discharge process to the subcommittee to increase awareness and understanding and identify opportunities for improvement. In June, the subcommittee focused on transition and discharge challenges for skilled nursing facilities and potential solutions.

Quarter 4 Report:

The Transition Planning workgroup met on a monthly basis this quarter, with the exception of August (July 8 and September 12). In July, Cine Crisp, Senior Director for Systems Care Coordination at Guthrie, presented an overview of Guthrie's discharge planning process to 17 attendees. In August, the meeting was cancelled because so many attendees were on vacation on the recurring meeting date. In September, Katherine (Kate) Lyon explained the Ombudsman Program's role in protecting the rights, safety, dignity, and choices of residents in nursing homes and adult care facilities across Tompkins, Schuyler, and Chemung counties.

The Fall Prevention Workgroup (FPW) met on a monthly basis, with the exception of August (July 29 and September 30). The FPW was able to host a Caregiver Training led by CARE (Center for Aging Resources and Enrichment) at LeMoyne College. There were 7 participants in attendance. The FPW has also been working on a new Fall Prevention logo to ensure that the work, events, and the group is easily identifiable. The FPW has done some research on fall prevention resources and information for people under 65, those with disabilities, chronic conditions, and low vision. There has also been discussion within the group on creating a "Fall Prevention Programs and Resources" category within the 211 Resource Directory and adding Fall Prevention as a screening option in the CH&RN system.

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.

Quarter 1 Report:

LTCC coordinator researched hoarding resources, trainers, etc. Discussed hoarding at November LTCC meeting related to falls and plan to work on hoarding in the upcoming quarters.

Quarter 2 Report:

No activity to report this quarter.

Quarter 3 Report:

No activity to report this quarter.

Quarter 4 Report:

Long Term Care Committee (LTCC) members gathered some information about hoarding resources available at the August LTCC meeting. We shared this information with LTCC members and THN Director has joined a recently launched local hoarding task force that is being led by local health department.

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.

Quarter 1 Report:

No activity to report this quarter.

Quarter 2 Report:

No activity this quarter. LTCC coordinator will connect with the Transition Planning chair to identify opportunities in quarter 3.

Quarter 3 Report:

No activity to report this quarter.

Quarter 4 Report:

Long Term Care Committee (LTCC) members gathered some information about long term care resources available at the August LTCC meeting. We shared this information with LTCC members and we compiled a list of potential outreach rural locations to share these resources (churches, food pantries, senior groups, community centers).

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.

Quarter 1 Report:

No activity to report this quarter.

Quarter 2 Report:

No activity to report this quarter.

Quarter 3 Report:

No activity to report this quarter.

Quarter 4 Report:

Long Term Care Committee (LTCC) members gathered some information about caregiver support resources available at the August LTCC meeting. We shared this information with LTCC members and we discussed the importance of including licensed agencies and organizations that serve those with disabilities in resource dissemination.

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 in the CH&RN

Quarter 1 Report:

In quarter 1, staff facilitated two network operations meetings in addition to one in-person mixer event. The mixer was attended by around 70 people with a goal of introducing Cohort 1 and Cohort 2. Staff planned and implemented a "speed dating" type of format, which allowed organizations to quickly learn about each other's service offerings. Staff also facilitated one strategic visioning session with project team members and health system leaders, and community partners. This is the first of several planning meetings that will drive the direction of the work for the remainder of the grant period.

Quarter 2 Report:

In quarter 2, THN staff facilitated three network operations meetings (January 27, February 24th, March 24th). Network Operations featured network partner spotlights at each meeting (January- Tompkins County Whole Health & Mental Health Association, February- Alzheimer's Association, March- Finger Lakes Independence Center), as well as data dashboard updates, community member feedback survey results and platform features updates. In quarter 2, 337 referrals were sent via the CH&RN with housing (96 referrals), food/nutrition (88 referrals) and transportation (51 referrals) identified as the top 3 social care needs.

Quarter 3 Report:

In quarter 3, THN staff facilitated two network operations meetings (April 21, May 19). Network Operations featured network partner spotlights at each meeting (April- Tompkins Community Action, May- Human Services Coalition), as well as data dashboard updates, community member feedback survey results and platform features updates. In quarter 3, 764 referrals were sent via the CH&RN with housing (283 referrals), transportation (163 referrals) and food/nutrition (143 referrals) identified as the top 3 social care needs.

Quarter 4 Report:

In quarter 4, THN staff facilitated two Network Operations meetings (July 14 and August 11). Meetings included network updates, referral volume reporting, community member feedback survey results, platform feature updates, partner announcements, and network partner spotlights. Staff also facilitated discussion about platform feedback, opportunities to strengthen referral practices, and barriers to integrating the referral platform into existing organizational workflows. Partner feedback highlighted the need for practical reminders, increased awareness of the network, and relationship-building opportunities to encourage referral activity. 786 referrals were sent via the CH&RN with housing (359), food security (257), and transportation (236) identified as the top social care needs.

Community member survey results presented in July and August indicated positive experiences with resource navigation and connection to community resources.

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.

Quarter 1 Report:

In October, a new version of the referral platform was released. Prior to release, staff spent significant time testing the improvements. Changes to the platform increased the usability of the interface and incorporated systematic changes, as requested by network partners. Several trainings were held for new and existing users. Added features included urgency flags for high priority referrals, cross organizational visibility into shared clients, more relevant fields to capture encounter data, dashboard widgets enabling dynamic filtering, and the concept of linked referrals to create a longitudinal record.

Quarter 2 Report:

In January, network platform updates included organizations that accept urgent referrals, field for community member's residential county, additional social needs categories (health care access, food security, other option with free text) and requiring at least one encounter (eg. case notes) before a case can be closed. In February the platform added "uninsured" option for insurance type. In March, the new customized notification feature on the platform was shared with the network but that feature is planned to go live in the 3rd quarter.

Quarter 3 Report:

In June, the new customized notification feature went live on the network platform. Additionally, the health system electronic health records were integrated with the network platform so that referrals no longer needed to be manually entered into the platform from a report generated from the health system EHR system.

Quarter 4 Report:

In quarter 4, THN staff continued communicating platform updates and supporting network partners in using available features. Network Operations meetings highlighted five notification capabilities: referral and community member notifications, saved search notifications, user mentions, a centralized notifications dashboard, and referral assignment notifications. These features help users monitor referrals, stay informed of activity, and coordinate communication across organizations.

Staff also solicited partner feedback about platform usability and referral workflows through 1:1 partner conversations. Discussions identified opportunities to improve awareness of the platform, integrate referral processes into organizational intake workflows, and address competing internal referral pathways.

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.

Quarter 1 Report:

In quarter 1, the project team onboarded and trained staff from 8 new organizations as part of our Cohort 2 development. Several other organizations have agreed to participate, and onboarding will be finalized in quarter 2.

The remaining organizations identified as priority partners will continue to be informed of Network development and may choose to join as part of Cohort 3. Many cited decreased staff capacity as the primary reason for not joining as part of Cohort 2. We anticipate beginning the next wave of recruitment in quarter 3.

Quarter 2 Report:

In quarter 2, the project team onboarded and trained staff from one new organization (South Side). Two additional organizations (Ithaca Youth Bureau and Tompkins County BOCES) are still in the process of being onboarded, and one additional organization (Institute for Human Services) was approached to join the network with onboarding and training pending for the 3rd quarter. Institute for Human Services (IHS) is joining the network to expand the region that will be served by incorporating outgoing referrals from Arnot Health (located in Chemung County). IHS is the organization that manages the 211 program for Allegany, Chemung, Schuyler, Steuben, and Yates Counties.

Quarter 3 Report:

In quarter 3, the project team onboarded and trained staff from one new organization, Institute for Human Services (IHS). Both IHS and Tompkins County BOCES are now live on the network, while the Ithaca Youth Bureau has decided to hold off joining the network until they have greater capacity to manage incoming and outgoing referrals.

Quarter 4 Report:

In quarter 4, the project team continued supporting existing network partners in connecting community members with local health and social care resources through the CH&RN. The team has been working to onboard an additional community partner and will continue to identify potential organizations to recruit in the coming months.

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.

Quarter 1 Report:

In quarter 1, we onboarded one workforce organization, one education opportunity organization, two food/nutrition provider organizations, one housing services provider organization, one mental health organization, and two social service providers (independent living and chronic condition providers).

Quarter 2 Report:

In quarter 2, we onboarded one childcare and food/nutrition provider organization.

Quarter 3 Report:

In quarter 3, we onboarded one social care hub organization to expand referral services and navigation to 5 additional counties. This organization provides 211 information and referrals in Allegany, Chemung, Schuyler, Steuben & Yates counties. This organization is also participating as a transportation 1115 services provider.

Quarter 4 Report:

No activity to report in this quarter. We will continue to identify potential opportunities for organizations to participate in the NYHER 1115 Waiver and 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.

Quarter 1 Report:

No activity to report this quarter.

Quarter 2 Report:

No activity to report this quarter.

Quarter 3 Report:

No activity to report this quarter.

Quarter 4 Report:

CH&RN staff used lessons learned from NYHER 1115 waiver to inform network platform development. We have incorporated some features into our network, such as the self-screener and data outputs, that were insights from participation in the NYHER 1115 waiver.

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.

Quarter 1 Report:

211 Tompkins/Cortland staff participate in local, regional, and statewide collaborations around data partnerships. During the quarter, activities included:

211 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) expanded in participation and in services provided over the course of the year. 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 boards meet on alternating months, though the Care Compass Network board met an additional time this quarter. The Care Compass Network board of directors met on 10/14, 11/11, and 12/19 and the Care Compass Collaborative board of directors met on 11/19. The IT & Data Governance Committee reviewed, approved, and recommended a set of policy updates to the full board as part of the annual security policy update process. The 211 program director also worked with Care Compass IT and Analytics staff on committee planning throughout the quarter, including hosting a meeting for the IT Director in Ithaca on 10/31.

During the quarter, 211 supported multiple transportation initiatives. As part of the One Call, One Click Transportation Center Initiative, 211 is working to support and increase Tompkins County's volunteer driver capacity, especially for non-emergency medical transportation and transportation to health-related social needs services. As a component of this work, 211 began exploring securing a data platform to be used for ride scheduling, volunteer, management, and related tasks. This platform could potentially be used by other volunteer transportation providers in Tompkins County (see more details on this work in 6.2.2).

211 partners with the United Way of Tompkins County and its network of impact partners in the United Way/211 ALICE Program, which supports low- to moderate-income households by providing modest financial assistance for unmet basic needs (ALICE stands for Asset Limited, Income Constrained, Employed, which is a United Way Worldwide acronym that refers to households in the moderate income range). In this quarter, the ALICE Program supported two groups: 1) individuals moving from homeless into housing and needing financial support to purchase basic household items like furniture, food, and supplies, and 2) households unable to pay for utility or home heating fuel costs, especially those impacted by the delay in NYS HEAP (Home Energy Assistance Program). During this quarter, 211 created and implemented a new database system to capture program intakes, allow for case coordination, notify United Way staff when cases are approved for payment, and track case status.

Quarter 2 Report:

211 Tompkins/Cortland staff participate in local, regional, and statewide collaborations around data partnerships. During the quarter, activities included:

211 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 during this quarter. The use of the shared data platform, Unite Us, is a critical component of carrying out the SCN services and analyzing performance and need. The Care Compass boards meet on alternating months. The Care Compass Network board of directors met on 2/10 and the Care Compass Collaborative board of directors met on 1/22 and 2/26. The 211 program director also worked with Care Compass IT and Analytics staff on relevant planning throughout the quarter.

During the quarter, 211 continued to supported multiple transportation initiatives. As part of the One Call, One Click Transportation Center Initiative, 211 is working to support an increase in Tompkins County's volunteer driver capacity,

especially for non-emergency medical transportation and transportation to health-related social needs services. 211 has begun to facilitate a working group of organizations that provide volunteer transportation services, including health-related social needs. Continuing work from the previous quarter, 211 evaluated options for a data platform to be used for ride scheduling, volunteer, management, and related tasks. This platform could potentially be used by other volunteer transportation providers in Tompkins County (see more details on this work in 6.2.2). Feedback and input from the partner volunteer driver organizations have helped to identify use cases and needs for the platform evaluation.

211 continues to collaborate with the United Way of Tompkins County and its network of impact partners in the United Way/211 ALICE Program, which supports low- to moderate-income households by providing modest financial assistance for unmet basic needs (ALICE stands for Asset Limited, Income Constrained, Employed, which is a United Way Worldwide acronym that refers to households in the moderate income range). As in the previous quarter, in this quarter the ALICE program supported two groups: 1) individuals moving from homelessness into housing and needing financial support to purchase basic household items like furniture, food, and supplies, and 2) households unable to pay for utility or home heating fuel costs. 211 maintained a database we created to capture program intakes, allow for case coordination, notify United Way staff when cases are approved for payment, and track case status. In this quarter, funding was exhausted for the first service, purchasing basic household items for individuals moving from homelessness into housing. Moving into the next quarter, the second service, utility support, will continue.

Quarter 3 Report:

211 Tompkins/Cortland staff participate in local, regional, and statewide collaborations around data partnerships. During the quarter, activities included:

211 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. Data sharing through the Unite Us platform is a key component of the SCN initiative. The Care Compass boards meet on alternating months. The Care Compass Network board of directors met on 4/14 and the Care Compass Collaborative board of directors met on 5/21; the regular June Care Compass Network board meeting was replaced by a strategic planning session on 6/2 . The 211 program director worked with Care Compass IT and Analytics staff on relevant planning throughout the quarter. The boards of both Care Compass Network and Care Compass Collaborative have approved a joint as IT, Informatics & Data Governance Committee for both organizations. After planning and reorganization over the summer, the joint committee will re-launch in September.

During the quarter, 211 continued to support multiple transportation initiatives. As part of the One Call, One Click Transportation Center Initiative, 211 is working to support an increase in Tompkins County's volunteer driver capacity, especially for non-emergency medical transportation and transportation to health-related social needs services. 211 has been facilitating a working group of organizations that provide volunteer transportation services, including health-related social needs. Continuing work from the previous quarter, 211 evaluated options for a data platform to be used for ride scheduling, volunteer, management, and related tasks. The results of this evaluation were presented to working group members and Tompkins County's transportation planning staff, who manage the One Call, One Click contract. This platform could potentially be used by other volunteer transportation providers in Tompkins County (see more details on this work in 6.2.2). Discussions with the vendor for the leading option took place toward the end of the quarter; subscription to the platform is anticipated in the next quarter.

211 has had a multi-year collaboration with the United Way of Tompkins County and its network of impact partners through the United Way/211 ALICE Program, which was designed to support low- to moderate-income households by providing modest financial assistance for unmet basic needs (ALICE stands for Asset Limited, Income Constrained, Employed, which is a United Way Worldwide acronym that refers to households in the moderate income range). This initiative went on indefinite pause during this quarter as the United Way of Tompkins County's funding for the program was exhausted. Unfortunately, the United Way's capacity to raise and dedicate additional funds for this program in its new 2026-2027 fiscal year is uncertain at this time. Over the last twelve months, the program supported 72 households with $29,596 in utility assistance. Overall, since the ALICE Program launched in September 2020, it supported more than 900 households with over $415,000 in support (households may be duplicated across years). While the program has had various focus areas, it always provided low- to moderate-income households with basic support such as assistance with utility payments, automobile repairs, household supplies, and related needs.

After planning discussions over the past several months, 211 submitted a proposed plan to the City of Ithaca around supporting the City's new ROOTS initiative (see 6.2.2). ROOTS, or Responders Offering Outreach Trust and Support, is an unarmed responder program currently in development, which will enable the City to respond to situations when an armed police response is not necessary. 211's role would be to support responders and clients with follow-up services after a response. The model in discussion would include ROOTS responders identifying a client need for which 211 might be able to provide referrals. The need would be communicated to 211, and then 211 would assist the client and "close the loop" on the referral with ROOTS. 211's proposal included various data sharing options to exchange information between ROOTS and 211, including use of the Community Health & Resource Network (see 6.1.2) or a separate platform. 211 and ROOTS team members met on 6/29 to review the plan; the ROOTS team will consider their options over the summer in advance of a potential overall initiative launch in the fall.

Quarter 4 Report:

211 Tompkins/Cortland staff participate in local, regional, and statewide collaborations around data partnerships. During the quarter, activities included:

211 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. Data sharing through the Unite Us platform is a key component of the SCN initiative. The Care Compass boards meet on alternating months. The Care Compass Network board of directors met on 8/11, and the Care Compass Collaborative board of directors met on 7/21 and 9/23. The boards of both Care Compass Network and Care Compass Collaborative have approved a joint IT, Informatics & Data Governance Committee for both organizations. Planning and reorganization was conducted over the summer, and the committee relaunched supporting both entities on 9/10.

During the quarter, 211 continued to support multiple transportation initiatives. As part of the One Call, One Click Transportation Center Initiative (see 6.2.2), 211 is working to support an increase in Tompkins County's volunteer driver capacity, especially for non-emergency medical transportation and transportation to health-related social needs services. 211 has been facilitating a working group of organizations that provide volunteer transportation services, including health-related social needs. Continuing work from the previous quarter, 211 developed a new database, built on the Zoho database platform, for managing ride requests and volunteer driver-provided rides. This development was based on an initial evaluation of needs and prioritization efforts made by the working group in the previous quarter. Future work will include demonstrating the new database and related workflows and pathways to the working group and incorporating feedback.

In the previous quarter, 211 submitted a proposed plan to the City of Ithaca around supporting the City's new ROOTS Team (Responders Offering Outreach Trust and Support) unarmed responder program, currently in development. This team will enable the City to respond to situations when an armed police response is not necessary. 211's role would be to support responders and clients with follow-up services after a response. The City of Ithaca responded favorably to 211's proposal and work during this quarter resulted in the development of a scope of work for 211 services, to be approved by the City prior to the ROOTS partnership launching. In addition, the ROOTS Team has decided that it will communicate the requests for follow-up services to 211 via the Community Health App platform managed by the Community Health & Resource Network (see elsewhere in this report). Therefore, the Human Services Coalition, through the Tompkins Health Network and the 211 program, has been able to support this locally-significant initiative in multiple ways.

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.

Quarter 1 Report:

211 has been receiving requests for assistance as appropriate through the CH&RN, and fields and documents them alongside requests made through 211's own channels. 211 staff participated in a CH&RN network gathering on October 23, including tabling during the event and participating in a networking session to make connections with personnel from other participating agencies in the network. 211 staff began training in the updated version of the network platform; this training will continue into the next quarter.

Quarter 2 Report:

211 continued to receive requests for assistance as appropriate through the CH&RN, and fields and documents them alongside requests made through 211's own channels. 211 staff participated in a CH&RN training on 2/3.

Quarter 3 Report:

211 continued to receive requests for assistance as appropriate through the CH&RN, and fields and documents them alongside requests made through 211's own channels. During this quarter, 211 assigned a primary staff member to be responsible for managing requests for assistance through the CH&RN, including receiving requests and reassigning to other staff members as needed.

Quarter 4 Report:

211 continued to receive requests for assistance as appropriate through the CH&RN, and fields and documents them alongside requests made through 211's own channels. 211 also supported engagement with the ROOTS unarmed response team (see 6.1.1) to facilitate their exploration of the CH&RN as a referral platform (and ultimate selection by ROOTS).

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.

Quarter 1 Report:

On November 19th we presented to Tompkins County COAD (Community Organizations Assisting in Disasters) group on 211 and how it can be a resource during and after disaster. COAD is being established in Tompkins County and 211 subsequently participates in the COAD advisory board.

Quarter 2 Report:

On 3/13, 211 presented to the full staff of Tompkins Community Action (approx. 75 people), the Community Action Agency for Tompkins County, as part of their annual professional development and training day. The training covered 211 services, transportation options, and a discussion about the needs that staff are seeing with their clients. 211 staff also made a number of transportation-specific presentations and trainings related to the One Call, One Click transportation center initiative, which also included a general 211 component.

Quarter 3 Report:

On 4/6, 211 made three separate presentations at Boynton Middle School in Ithaca. This presentation included an overview of all 211 services. On 5/19, 211 presented to the Tompkins County COAD group (Community Organizations Active in Disaster). This presentation included an overview of 211 services and a specific focus on housing-related services, especially supports for when tenants need to vacate a rental. 211 services were also included as part of several Ithaca Electric Transit Access kickoff events (see 6.2.2) on 5/11 at West Village Apartments, 5/29 at Overlook Apartments, 5/30 at Lehman Alternative Community School, 6/2 at Titus Towers senior housing complex, 6/4 at West Village Apartments, and 6/11 at Overlook Apartments. These locations all fall within the initiative's targeted service area.

Quarter 4 Report:

211 made presentations, which included an overview of 211 services and a specific focus on transportation needs and resources, to Tompkins County Whole Health (Mental Health providers) on 8/11 and to Cornell Cooperative Extension of Tompkins County social care navigators on 9/14. While it is outside Tompkins County, 211 also conducted a session with Catholic Charities of Cortland County on 9/11.

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.

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 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," which was pilot funded by the Federal Transit Administration. 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. In this quarter, 211 staff met with partner organizations to discuss their volunteer driver needs (more volunteers, reimbursement, insurance, etc.) in preparation for the establishment of a volunteer driver workgroup to be facilitated by 211. Invitations for the workgroup went out in December with the first meeting planned for early in the next quarter.

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 (Note: while it is outside the scope of this report, the contract extension between TCAT and NYSERDA was executed in February 2026. 211's role is likely to begin after the TCAT project manager is hired).

211 has been involved in supporting client health-related social needs through the Medicaid 1115 Care Compass Collaborative Social Care Network. During this quarter, a social care navigator worked as part of 211 to facilitate screening and navigation of clients eligible for services through the Social Care Network (a separate housing position worked closely with 211 staff). 211's transportation staff were cited during this quarter for their participation, with Care Compass staff specifically highlighting how 211's questions, comments, and suggestions directly improved the design of the transportation service processes in the Social Care Network.

Quarter 2 Report:

211 is involved in multiple projects to respond to other organizations' needs in supporting client social determinants of health needs.

211 holds a contract with Tompkins County to implement the "One Call, One Click" Transportation Contact Center. Two 211 staff members focus on transportation: both support community member needs and one has an additional responsibility to develop the county's volunteer driver capacity. In this quarter, 211 launched a volunteer driver program working group, pulling together a number of providers supporting community transportation needs with volunteers. The initial meeting focused on identifying areas of potential collaboration, including on recruitment of volunteers, shared scheduling platforms, and possibly on engaging volunteers to drive for multiple programs.

211 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. 211's role in this project will be to provide contact center services in support of expanded services to underserved neighborhoods and populations, including through on-demand car and van service. TCAT received a contract extension from NYSERDA in February and began the process of hiring a contract manager to oversee the implementation of this project. 211 is now working with TCAT to plan for the public launch of this program later in 2026.

211 has been involved in supporting client health-related social needs through the Medicaid 1115 Care Compass Collaborative Social Care Network. During this quarter, a social care navigator continued to work as part of 211 to facilitate

screening and navigation of clients eligible for services through the Social Care Network (a separate housing position worked closely with 211 staff).

On 3/3, the 211 program director met with the Director of the Community Justice Center, a City of Ithaca and Tompkins County initiative that is exploring how to reimagine public safety services in the community. The discussion focused on the possibility of using 211 as part of the follow-up to an unarmed response team's work with members of the community—as needs are identified when the team engages with members of the public, it may be possible to draw upon 211's expertise to provide options to address those needs. Planning will continue as the Community Justice Center moves forward with its recommendations.

Quarter 3 Report:

211 is involved in multiple projects to respond to other organizations' needs in supporting client social determinants of health needs.
As in previous quarters, 211 continues to hold a contract with Tompkins County to implement the "One Call, One Click" Transportation Contact Center. Two 211 staff members focus on transportation: both support community member needs and one has an additional responsibility to develop the county's volunteer driver capacity. In this quarter, 211 continued to facilitate a volunteer transportation provider working group, pulling together a number of providers supporting community transportation needs with volunteers. After meeting for the first time in the previous quarter, the group is now working on prioritizing areas where working together could lift the capacity of all members. Topics for the 5/28 meeting included: volunteer transportation management software platform evaluation, takeaways from a recent conversation with the Community Transportation Association of America, combined volunteer recruitment efforts, potential partnerships, and marketing . Overall, 211 responded to 1,072 transportation-related contacts through the One Call, One Click Center during the quarter.

211 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. 211's role in this project will be to provide contact center services in support of expanded services to underserved neighborhoods and populations, including through on-demand car and van service. This project has been delayed for contracting reasons, and finally launched publicly in June. In addition to fielding customer service requests during the business day and on evenings and weekends, 211 staff also participated in public outreach events hosted by TCAT related to the IETA kickoff (see 6.2.1).

211 has been involved in supporting client health-related social needs through the Medicaid 1115 Care Compass Collaborative Social Care Network. During this quarter, a social care navigator continued to work as part of 211 to facilitate screening and navigation of clients eligible for services through the Social Care Network (a separate housing position worked closely with 211 staff).

On 6/29, the 211 program director met with the Director of the Community Justice Center, a City of Ithaca and Tompkins County initiative that is exploring how to reimagine public safety services in the community (see 6.1.1). The Community Justice Center is leading the development of the City of Ithaca's ROOTS Team (Responders Offering Outreach Trust and Support). Also participating was the Community Justice Center's data analyst, the Tompkins Health Network director, the Human Services Coalition's director of housing initiatives (also lead staff member for the Ithaca-Tompkins County Continuum of Care), and 211's contact center manager. The discussion focused on: data sharing options for exchanging information between the ROOTS Team and 211 to enable 211 to provide referrals related to unmet social care needs of individuals who interact with the ROOTS Team; logistics and expectations for the type of support to be provided; anticipated types of calls the ROOTS Team would respond to; and future decision points.

Quarter 4 Report:

211 is involved in multiple projects to respond to other organizations' needs in supporting client social determinants of health needs.

As in previous quarters, 211 continues to hold a contract with Tompkins County to implement the "One Call, One Click" Transportation Contact Center. Two 211 staff members focus on transportation: both support community member needs and one has an additional responsibility to develop the county's volunteer driver capacity. In this quarter, 211 continued to facilitate a volunteer transportation provider working group, which met on 7/23 and 9/24. Meeting topics included: demonstrations of the data platform concept, ride options for older adults, volunteer driver advertising, identification and prioritization of needs to meet through volunteer efforts, and program coordination. Overall, 211 responded to 1,782 transportation-related contacts through the One Call, One Click Center during the quarter.

211 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. 211's role in this project is to provide contact center services in support of expanded "eRide" services to underserved neighborhoods

and populations, including through on-demand car and van service. 211 continued to serve on the initiative's planning committee. 211 fielded 446 contacts related to eRide in the quarter.

211 has been involved in supporting client health-related social needs through the Medicaid 1115 Care Compass Collaborative Social Care Network. During this quarter, a social care navigator continued to work as part of 211 to facilitate screening and navigation of clients eligible for services through the Social Care Network (a separate housing position worked closely with 211 staff).