Rural Health Network Development Program

Human Services Coalition Tompkins Health Network Work Plan

October 1, 2026 - September 30, 2027

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.
	1.1.2	Board and Network Membership - A report of Board member meeting attendance, membership terms, and compliance with work rules will be presented to the Executive Committee by July 2027. Network membership will be reviewed to ensure representation from the health-related social needs categories of food, housing, and transportation.
	1.1.3	Network Assessment - The Board will complete a network assessment by November 2026 to measure members' understanding of THN's role in the community.
	1.1.4	Committee Reports - Board members will receive at least six committee and workgroup reports during the 2026-2027 reporting period.
	1.1.5	Presentations on Health-Related Social Needs - At least three presentations on food, housing, transportation, or other relevant health-related social needs will be provided during Board meetings to support education and work-plan implementation.
	1.1.6	Medicaid Changes Task Force Reporting - THN Director will share progress and emerging needs from the Medicaid Changes Task Force to the Advisory Board at least quarterly.
Tasks		
1.2	Create a plan for National Rural Health Day in November - THN staff will develop and implement a plan to promote National Rural Health Day.	
	Performance Measures	
	1.2.1	Plan and timetable developed - A plan for promoting National Rural Health Day will be drafted and presented to the Advisory Board by fall 2026.
	1.2.2	Plan implemented - National Rural Health Day promotion activities will be completed by the end of November 2026.

Objective		
2	**Expand access to health care and address issues of health equity**	
Tasks		
2.1	Increase access to information and resources that address health care disparities and inequities - THN staff will conduct outreach, share information, and convene partners to increase awareness of resources and prepare for health coverage changes affecting Tompkins County residents.	
	Performance Measures	
	2.1.1	Outreach and media opportunities - From October 1, 2026 through September 30, 2027, THN staff will complete at least five outreach opportunities, including media activities, presentations, and tabling, to promote THN and Human Services Coalition direct-service programs.
	2.1.2	Medicaid changes presentations - THN staff will provide at least four presentations or information sessions for community members, community partners, or service providers about upcoming Medicaid changes, how to navigate the changes, and where to obtain assistance.
Tasks		
2.2	Reduce the number of people without health insurance - The THN Director will ensure that health insurance Navigators meet deliverables for enrolling and re-enrolling individuals and families in plans offered through the NY State of Health Marketplace.	
	Performance Measures	
	2.2.1	Annual enrollment targets - At least 744 applications will be processed by THN staff from October 1, 2026 through September 30, 2027. Progress will be monitored quarterly and at year end to increase enrollment among uninsured residents and help individuals maintain coverage.
	2.2.2	Medicaid Changes Task Force Convening - THN staff will facilitate a community task force that regularly convenes partners to prepare for, coordinate responses to, and monitor the local effects of federal Medicaid changes, including HR1 requirements. Task Force will be convened at least 6 times in the 2026-2027 reporting period.

Objective		
3	**Support the priorities of the local Community Health Improvement Plan developed from the NYS Prevention Agenda**	
Tasks		
3.1	Convene Community Health Conversations - The THN Director will support Community Health Conversations, manage meeting logistics, invite community members, and coordinate agendas with the co-chairs. The purpose is to provide educational presentations on emerging issues affecting health care access and community health.	
	Performance Measures	
	3.1.1	Community Health Conversations convened - Forums will be held at least 4 times in the 2026-2026 reporting period and will include relevant CHIP priorities, NYHER 1115 waiver services, or other emerging community health issues.
	3.1.2	Status reports - Regular Community Health Conversations updates will be provided to the Advisory Board during the reporting period.
	3.1.3	Representation on the CHIP Steering Committee - The THN Director will continue to serve on the Tompkins County CHIP Steering Committee and contribute to CHIP implementation.
Tasks		
3.2	Housing Stability and Affordability - Collaborate with new and current partners to increase access to safe and affordable housing, especially supportive housing and wraparound services, and to protect and maintain existing housing.	
	Performance Measures	
	3.2.1	Housing and health data review - THN will work with partners to review available quantitative and qualitative information annually, including hospital, community-based organization, assessment, and home-visit data, to better understand how housing and social care services affect health outcomes.
Tasks		
3.3	Nutrition Security - Support standardized screening for unmet nutrition security needs and referrals to state, local, and federal benefit programs and community-based health-related social needs providers.	
	Performance Measures	
	3.3.1	Nutrition security data review - THN will review collected screening and referral data annually with partners and make recommendations to improve identification of needs, access to benefits, and connections to community-based nutrition resources.
Tasks		
3.4	Primary Prevention, Substance Misuse, and Overdose Prevention - Support a countywide environmental change strategy, such as a campaign, to increase awareness of the harms associated with underage substance use and strengthen connections with mental health initiatives.	

	Performance Measures	
	3.4.1	Prevention data review - THN will review available implementation and outcome data annually with partners and make recommendations to strengthen the strategy and its connections to mental health efforts.
Tasks		
3.5	Preventive Services for Chronic Disease Prevention and Control - Support the integration of chronic disease prevention and self-management resource navigation into existing health-related social needs navigation.	
	Performance Measures	
	3.5.1	Chronic disease navigation data review - THN will review available screening, referral, utilization, and outcome data annually with partners and make recommendations to strengthen chronic disease prevention and self-management navigation.
Tasks		
3.6	Access to and Use of Prenatal Care - Support screening of prenatal and postpartum clients for health-related social care needs, especially mental health needs, and strengthen referrals to appropriate services.	
	Performance Measures	
	3.6.1	Prenatal and postpartum data review - THN will review available screening and referral data annually with partners and make recommendations to improve connections to prenatal, postpartum, mental health, and social care services.

Objective		
4	**Support healthy aging through the Long-Term Care Committee**	
Tasks		
4.1	Maintain the Long-Term Care Committee and ensure broad representation from multiple community sectors - The THN Director will support the LTCC, manage meeting logistics and member communications, and coordinate agendas with the chair and LTCC Coordinator.	
	Performance Measures	
	4.1.1	Partnership with NY Connects - A contract will be maintained with the local Office for the Aging to staff the advisory group known as the Long-Term Care Committee. The intended outcome is to identify and address issues in the long-term services and supports system.
	4.1.2	Broad representation - Combined meeting attendance records will indicate participation from at least 15 organizations or community sectors. Membership will be reviewed and expanded to encourage broad inclusion of nontraditional sectors.
	4.1.3	Formation of workgroups - Workgroups will be established as needed to address emerging problems, with specific objectives and activities reported to the Long-Term Care Committee.
	4.1.4	Subcommittee progress - The Transition Planning and Fall Prevention subcommittees will meet monthly. The THN Director will monitor their activities, document progress toward identified goals, and provide updates to the Long-Term Care Committee and THN Advisory Board at least quarterly.

Objective		
5	**Maintain a community health network that connects health and social care providers**	
Tasks		
5.1	Maintain the Community Health and Resource Network - THN staff will continue the growth and improvement of a closed-loop referral network that connects health and social care providers and reduces the burden on community members navigating separate systems of care.	
	Performance Measures	
	5.1.1	Regular network meetings - THN staff will coordinate regular network meetings, at least 8 per year, to support community-based organizations participating in the CH&RN.
	5.1.2	Network platform improvements - THN staff will monitor platform improvement requests on behalf of community-based organizations and work with health-system staff to implement appropriate changes.
	5.1.3	Network expansion - THN staff will add community-based organizations to the network in planned waves throughout the reporting period.
	5.1.4	Connection of health outcomes and social care referral data - THN staff will work with health care, research, and community partners to make measurable progress toward linking health outcomes with social care screening, referral, and service data. Progress, barriers, and next steps will be documented and reported to the Advisory Board at least quarterly.

Objective		
6	**Strengthen data and information sharing among providers and community-based organizations to improve coordination of care**	
Tasks		
6.1	Support development of data-driven collaborations - THN staff will participate in collaborations that develop and share community data among organizations providing health-related social needs services. These collaborations will support information exchange, referral systems, health care transformation, and the ability of social care organizations to participate in value-based arrangements.	
	Performance Measures	
	6.1.1	Representation in regional and local collaborations - THN staff will attend meetings related to emerging data partnerships and report progress quarterly.
	6.1.2	211 participation in the Community Health and Resource Network - 211 will provide referral services for community members referred through the CH&RN.
Tasks		
6.2	Promote use of 211 for information about health-related social needs services - THN staff, in coordination with the 211 Call Center Manager, will promote 211 as a resource for information about community programs and services.	
	Performance Measures	
	6.2.1	Trainings held - At least two training sessions about 211 resources will be documented.
	6.2.2	Domain-specific developments - At least two 211 projects will be completed in response to the needs of health and social care organizations in specific service domains.