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Onondaga County
Health Department

Onondaga County 2025-2027
Community Health Assessment and Improvement Plan

Executive Summary

PHAB Accredited Health Department – Advancing Public Health Performance – Public Health Accreditation Board

CROUSE HEALTH

UPSTATE UNIVERSITY HOSPITAL

ST. JOSEPH'S HEALTH Hospital
A Member of Trinity Health

Message from the Commissioner of Health

To our community members and partners,

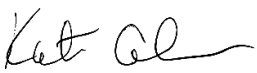
I am pleased to present the 2025 Onondaga County Community Health Assessment and 2025-2027 Community Health Improvement Plan. These documents provide a foundation for understanding the health of Onondaga County and serve as a guide for how we can work together to improve our community's health.

We know that our health is impacted by a variety of social, economic, behavioral, and environmental factors. The health needs of our community are shaped by the places we live, learn, work, and play. Social determinants like poverty, education, housing, and trauma can provide the framework to implement strategies focused on health equity. As we continue our public health work, it is important for us to work collaboratively with partners across multiple sectors to address health disparities, improve health outcomes, and promote health, safety, and quality of life for our residents.

The Community Health Assessment (CHA) explores several factors which influence health risk and outcomes among our County's residents. Access to affordable healthy food, chronic disease, employment, infant and maternal health, mental health concerns, safe and affordable housing, substance use, and violence related injuries were identified as factors that significantly affect the health and well-being of our community. Fortunately, Onondaga County has numerous assets and resources, including many community-based organizations and a strong healthcare sector, which can be mobilized to address the health needs of our residents. In alignment with the 2025-2030 New York State Prevention Agenda, the Community Health Improvement Plan (CHIP) identifies priority areas for our community and outlines several activities and initiatives that will be carried out by the Health Department in collaboration with local hospitals and other partners to improve the health of County residents.

The Community Health Assessment and Improvement Plan were developed by the Onondaga County Health Department in partnership with Crouse Health, St. Joseph's Health, and Upstate University Hospital. These documents were also made possible with the support of the Central New York Healthcare Equity Task Force and with the feedback of more than 1,900 County residents whose voices provided the foundation for identifying health priorities for our community. Thank you to all who were involved in this collaborative effort!

Sincerely,



Kathryn Anderson, MD PhD MSPH
Commissioner
Onondaga County Health Department

Executive Summary

Overview

Onondaga County's **2025 Community Health Assessment (CHA)** and **2025-2027 Community Health Improvement Plan (CHIP)** were conducted as a comprehensive public health planning effort by the Onondaga County Health Department (OCHD) in collaboration with the CHA/CHIP Steering Committee. The Steering Committee was made up of representation from the OCHD, Crouse Health, St. Joseph's Health, and Upstate University Hospital. Additional support was also provided by the Central New York Healthcare Equity Task Force to ensure that equity was at the forefront of planning efforts.

The CHA/CHIP planning process was carried out in alignment with the 2025-2030 New York State (NYS) Prevention Agenda, which includes five domains of focus:[1]

- Economic Stability
- Social and Community Context
- Neighborhood and Built Environment
- Health Care Access and Quality
- Education Access and Quality

The CHA/CHIP serves as a guiding document for local public health initiatives and provides a framework for understanding health needs in our community. Included in the CHA is a comprehensive overview of the current health status of residents in Onondaga County. The CHA also includes many assets and resources in our community. Using the comprehensive CHA planning process as a framework, the Steering Committee thoughtfully reviewed health indicator data and community input to develop the CHIP. The CHIP is focused on advancing health equity and addressing local public health challenges within three priority areas:

- **Nutrition Security**
- **Preventive Services for Chronic Disease Prevention and Control**
- **Prevention of Infant and Maternal Mortality**

Community Health Assessment

The CHA is completed to better understand the current health status and health needs of Onondaga County residents. As part of the CHA process, the OCHD reviewed local, state, and national data sources to assess resident's health status. Primary and secondary sources of data were reviewed, including the following:

- CDC PLACES: Local Data for Better Health
- County Health Rankings

- Feeding America: Map the Meal Gap
- New York State Community Health Indicator Reports (CHIRS)
- New York State County Health Indicators by Race/Ethnicity (CHIRE)
- New York State Expanded Behavioral Risk Factor Surveillance System
- New York State Maternal and Child Health Dashboard
- New York State Opioid Dashboard
- New York State Prevention Agenda Dashboard
- OCHD Division of Community Health
- Onondaga County Medical Examiner's Office
- U.S. Census Bureau

Comparisons by demographic characteristics including age, sex, race and ethnicity are presented throughout the CHA. Comparisons by geography including the Central New York region and statewide data are also included as appropriate.

Community Engagement

The Steering Committee conducted an extensive community engagement process in 2025 to gather feedback directly from County residents. Engagement activities involved more than 1,900 County residents and included a community health survey and a focus group. Survey respondents shared that improvements are especially needed in areas such as access to affordable healthy food, safe and affordable housing, and employment that pays a living wage. Additionally, mental health concerns, violence-related injuries, and substance use were identified as key community health issues.

Social Determinants of Health

The World Health Organization defines health as a "state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[2] Health is shaped by several factors ranging from the biological traits we were born with to the complex social and economic environments. The term **determinants of health** is often used to describe factors which affect our ability to achieve health. More specifically, social determinants of health refer to several factors in the environments in which we live, learn, work, and play that influence health outcomes. There are five domains of social determinants of health. The domains and notable findings from the CHA are presented below:

Domain Category	Notable Findings
Economic Stability	• 13.2% of Onondaga County residents experience food insecurity compared to 14.5% of NYS residents. Notably, Black residents (30.0%) and Hispanic residents (28.0%) experience the highest rate of food insecurity in the County.[3]

Domain Category	Notable Findings
	• The median household income in Onondaga County is $74,740 compared to $45,845 in Syracuse.[4] • 29.6% of Syracuse residents live below the federal poverty level, compared to 13.9% of County residents as a whole[5]
Social and Community Context	• The average family size in Onondaga County (2.98 people per family) and Syracuse (3.10 per family) are similar.[6] • 38.7% of Onondaga County adults report experiencing two or more adverse childhood experiences.[7] • In Onondaga County, 13.9% of adults report poor mental health.[8]
Neighborhood and Built Environment	• 72.9% of workers (age 16 years and older) commute alone by car each day.[9] • In Syracuse, 25.2% of households do not have a vehicle available at home. Among Onondaga County residents, this rate is 11.7%.[10] • The violent crime rate in Onondaga County (321.8 per 100,000) is substantially higher than the rate for NYS excluding NYC (192.7 per 100,000).[11]
Health Care Access and Quality	• 89.7% of adults in Onondaga County report having a regular healthcare provider.[12] • 98.0% of children in Onondaga County have health insurance.[13] • The overall infant mortality rate for Onondaga County was 5.1 per 1,000 live births in 2022-2024.[14]
Education Access and Quality	• 91.7% of Onondaga County adults (age 25 years and older) have a high school degree or higher compared to 85.2% in the City of Syracuse.[15] • Onondaga County's 4-year high school graduation rate is 85.2%, which is slightly lower than NYS overall (86.4%).[16] • Within Onondaga County, 27.1% of elementary and middle school students experience chronic absenteeism.[17]

Community Health Improvement Plan

The CHIP addresses local public health challenges within three priority areas:

- **Nutrition Security**
- **Preventive Services for Chronic Disease Prevention and Control**
- **Prevention of Infant and Maternal Mortality**

Outlined in the CHIP are several interventions and activities selected by the Steering Committee to address health issues within the priority areas. Steering Committee members are each responsible for shared and/or individual components of the CHIP. Many community agencies are also actively involved in CHIP activities, and their support makes implementation of CHIP activities possible.

Interventions and Activities

Evidence-based interventions in the CHIP were selected directly from the 2025-2030 NYS Prevention Agenda Action Plan.[18] Additionally, interventions were chosen based on potential for broad impact and considerations for strengths, capacity, and resources of the Steering Committee and partners. The interventions are focused on equity and addressing disparities in health access and outcomes. The selected interventions and activities in the CHIP address disparities by disability status, health care access, income, race, and ethnicity. Outlined below are the goals and activities for each priority area.

Priority Area: Nutrition Security	
Goal	Improve consistent and equitable access to healthy, affordable, safe, and culturally appropriate foods.
Activities	• Implement nutrition security screenings and referrals. • Provide direct food access through pantries, monthly produce boxes, and a Food Farmacy Program. • Promote healthy eating by supporting food service guidelines and organizing charitable food offerings using evidence-based standards.

Priority Area: Preventive Services for Chronic Disease Prevention and Control	
Goal	Reduce disparities in access and quality of evidence-based preventive and diagnostic services and chronic diseases.
Activities	• Implement standardized social care screenings to identify unmet needs and connect patients to services, while reducing barriers to cancer screening through the Cancer Services Program.

	• Partner with community-based organizations and healthcare providers, embed Community Health Workers in care teams, and maintain a strong provider network to support access to cancer screening, treatment referrals, and hypertension management. • Promote patient-centered care by tailoring outreach and consent to individual preferences.

Priority Area: Prevention of Infant and Maternal Mortality	
Goal	Improve health outcomes by lowering mortality and morbidity rates for infants and birthing persons.
Activities	• Provide comprehensive prenatal, postpartum, and early childhood support by addressing safe sleep, mental health, social care, and domestic violence needs through screening, referral, and education. • Strengthen maternal and infant health outcomes by integrating community doulas, Community Health Workers, and evidence-based home visitation programs for high-risk birthing people. • Promote breastfeeding, chestfeeding, and lactation through healthcare practice engagement, policy adoption, technical assistance, and culturally responsive support groups. • Support healthy child development and nutrition through early childcare standards, the ZERO TO THREE's Healthy Steps program, and collaboration with state birth equity initiatives to advance respectful, equitable care.

Progress and Evaluation

The Steering Committee will regularly meet to evaluate the relevance and effectiveness of the interventions included in the CHIP throughout the 2025-2027 cycle. Progress towards CHIP activities will be documented every six months and shared with the Steering Committee. The Steering Committee will review progress and make modifications to the CHIP as appropriate based on changing community needs and availability of resources. Process measures used to evaluate performance are incorporated directly in the CHIP workplan to ensure an outcome focused approach to meeting plan goals.

Closing

Throughout the CHA/CHIP process, it was clear that there is a strong and diverse network of dedicated community partners in Onondaga County. While the health issues identified in this document are substantial, the collaboration and engagement present during the development of the CHA/CHIP reinforced that there is a shared commitment to work together as partners to advance health equity and improve the health and well-being of Onondaga County residents.

Data Sources and Notes

[1] NYS Prevention Agenda, 2025-2030. Accessed 11/10/2025, from https://health.ny.gov/prevention/prevention_agenda/2025-2030/.
[2] WHO, Constitution, 2025. Retrieved 12/24/2025, from https://www.who.int/about/governance/constitution.
[3] Feeding America, Map the Meal Gap, 2023. Retrieved 12/17/2025 from https://map.feedingamerica.org/
[4] U.S. Census Bureau, 2019-2023 American Community Survey, 5-Year Estimates, Table S1903.
[5] U.S. Census Bureau, 2019-2023 American Community Survey 5-Year Estimates, Table S1701.
[6] U.S. Census Bureau, 2019-2023 American Community Survey, 5-Year Estimates, Table S1101.
[7] New York State Prevention Agenda Dashboard. Retrieved 2/20/2025 from https://apps.health.ny.gov/public/tabvis/PHIG_Public/pa/.
[8] CDC PLACES: Local Data for Better Health, 2022. Retrieved 3/3/2025, from: https://www.cdc.gov/places.
[9] U.S. Census Bureau, 2019-2023 American Community Survey, 5-Year Estimates, Table B08301.
[10] U.S. Census Bureau, 2019-2023 American Community Survey, 5-Year Estimates, Table DP04.
[11] NYS Division of Criminal Justice Services; Uniform Crime Reporting System, 2024. Retrieved 12/3/2025, from https://www.criminaljustice.ny.gov/crimnet/ojsa/stats.htm.
[12] NYS Expanded BRFSS, 2021. Retrieved 2/27/2025, from https://www.health.ny.gov/statistics/brfss/expanded/.
[13] U.S. Census Bureau, 2019-2023 American Community Survey, 5-Year Estimates, Table S2701.
[14] NYS Statewide Perinatal Data System (accessed by OCHD) and OCHD, Office of Vital Statistics. Notes: A 3-year average is used to account for small number of deaths and fluctuations in individual years. Data are provisional.
[15] U.S. Census Bureau, 2019-2023 American Community Survey, 5-Year Estimates, Table S1501.
[16] NYS Department of Education. Retrieved 2/21/2025, from https://data.nysed.gov/gradrate.php?year=2023&county=42.
[17] Kids' Wellbeing Indicators Clearinghouse, Council on Children and Families: www.nyskwic.org. Retrieved 3/12/2025.
[18] NYS Prevention Agenda Action Plan, 2025-2030. Accessed 11/10/2025, from https://health.ny.gov/prevention/prevention_agenda/2025-2030/docs/prevention_agenda_plan.pdf.