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Onondaga County
Health Department

Onondaga County **Community**

Health Improvement Plan
2025- 2027



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Participating Health Department and Hospitals

Onondaga County Health Department

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Syracuse, NY 13202
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Syracuse, NY 13210
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St. Joseph's Health

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UPSTATE
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HEALTH
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A Member of Trinity Health

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ONONDAGA COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN

Introduction

As we strive to advance health equity and protect and improve the health of all Onondaga County residents, it is important that public health efforts are aligned with the needs of our community. The Onondaga County Health Department (OCHD), Crouse Health (Crouse), St. Joseph's Health (SJH), and Upstate University Hospital (Upstate) jointly developed the [2025-2027 Community Health Improvement Plan \(CHIP\)](#). Additional support was provided by the Central New York Healthcare Equity Task Force and public health partners. This document contains a summary of key community health priorities, the selection process for including priorities in the CHIP, community engagement efforts, health needs not addressed, a workplan for achieving plan objectives, and plans for progress reporting. The CHIP process is rooted in data, equity, and community feedback to ensure this document is meaningful to our community.

Selection of Health Priorities

The 2025-2027 CHIP was developed in alignment with the 2025-2030 New York State (NYS) Prevention Agenda, which identifies five domains of focus.¹ More information about the NYS Prevention Agenda Framework is available in Appendix 1.

In July-August 2025, the Steering Committee reviewed results from the quantitative data analysis and community engagement activities that comprised the community health assessment to inform the identification of priority areas for the CHIP. In September 2025, following the comprehensive review of health indicator data and community input results and thoughtful discussion, the Steering Committee unanimously agreed to select the following three priority areas for the CHIP:

- [Nutrition Security](#)
- [Preventive Services for Chronic Disease Prevention and Control](#)
- [Prevention of Infant and Maternal Mortality](#)

The following factors were considered in the decision-making process for selection of CHIP priorities:

- The severity of the issue as demonstrated through quantitative data collection
- Feedback from the community as assessed through quantitative and qualitative methods
- The ability to implement interventions with current resources
- The ability to identify shared projects within the priority areas
- Whether or not interventions could address health disparities

¹ NYS Department of Health, 2025-2030 Prevention Agenda. Accessed 11/10/2025 from https://health.ny.gov/prevention/prevention_agenda/2025-2030/.

Once the priorities were confirmed, the Steering Committee began developing interventions using the NYSDOH Prevention Agenda 2025-2030 Action Plan as a framework. Interventions were selected to be attainable within the specified timeframe, measurable, and impactful. Each agency represented on the Steering Committee has a role in the implementation of interventions, whether as the lead on an activity or as a supporting partner. The OCHD and participating hospitals have committed significant resources to support the implementation of interventions included in the CHIP. These resources include, but are not limited to, staff time and financial resources. Several of the initiatives outlined in the CHIP are funded through federal, state, and local grants which have been awarded to support improved community health. The support of many local and statewide agencies in Onondaga County makes implementation of CHIP activities possible. The CHIP work plan (pages 4-17) outlines interventions, activities, responsible agencies and staff, performance measures, and timelines for each objective being addressed in the CHIP. A progress reporting and revision plan for continued evaluation of relevance and effectiveness is outlined in Appendix 2. The dissemination plan for sharing the CHIP with the public is described in Appendix 3.

Community Engagement

The Steering Committee agreed that conducting a Community Health Survey (CHS) would be an appropriate method to gather direct feedback from community members. The CHS was developed by the OCHD, with input from the Hospital Steering Committee, the Central New York Regional Healthcare Equity Task Force, and public health partners. The CHS was carried out from late May to late July 2025 and collected more than 1,900 eligible responses. To improve community feedback, an in-person focus group was hosted by the OCHD in partnership with the Syracuse Healthy Start Community Consortium and the OCHD Public Health Education Team in July 2025. Additionally, a brief survey was carried out with public health partners to further inform identification of priority areas.

Community engagement results indicated the following topics as priority areas for the community:

- Access to affordable healthy food
- Chronic disease prevention and control
- Employment that pays a living wage
- Health and wellness in schools
- Mental health concerns
- Poverty
- Safe and affordable housing
- Substance use
- Violence-related injuries

A full summary of CHS results is presented in the Onondaga County **2025 Community Health Survey Report**, available on the OCHD website: <https://onondaga.gov/health/>.

Health Needs Not Addressed

The three priority areas included in the 2025-2027 CHIP are supported by community health assessment results, however, these priorities areas alone do not reflect the full breadth of health needs in Onondaga County. Additionally, the three priority areas do not reflect the full scope of work of the OCHD, participating hospitals, and public health partners. The CHIP is meant to reflect activities that each agency has committed to for the duration of the 2025-2027 CHIP cycle.

Available resources (i.e. financial resources, staff time) do not support the inclusion of all identified priorities in the CHIP, however, the OCHD, participating hospitals, and public health partners remain dedicated to working together to improve the health and well-being of all Onondaga County residents.

Community health assessment results indicated a significant need for improvement in many areas, particularly areas related to meeting basic needs. Although there are priorities not addressed in the CHIP, there are agencies and programs dedicated to improving community health in these areas:

Priority Area Not Addressed	Community Assets and Resources
Employment that pays a living wage	<ul style="list-style-type: none"> • New York Hiring for Emergency Limited Placement Statewide (NY HELPS) program • TA Employment Program • Onondaga County Office of Economic Development
Health and wellness in schools	<ul style="list-style-type: none"> • Creating Healthy Schools & Communities (CHSC) • Promise Zone • Alcohol-Drug Abuse Prevention Education Program (ADAPEP) • OCHD Immunization Clinic • Universal Free School Meals Program
Safe and affordable housing	<ul style="list-style-type: none"> • Catholic Charities • Liberty Resources • Onondaga County Department of Social Services • Syracuse Housing Authority • PEACE, Inc. • The Salvation Army

In addition to those mentioned above, there are many other assets and resources within Onondaga County that address health needs and health disparities in our community. Numerous community assets and resources are included in the Onondaga County [2025 Community Health Assessment \(CHA\)](#), available on the OCHD website: <https://onondaga.gov/health/>.

NUTRITION SECURITY

Goal: Improve consistent and equitable access to healthy, affordable, safe, and culturally appropriate foods.

Objectives:

- Increase consistent household food security from 76.1% to 80.9%.¹
- Increase food security in households with an annual total income of less than \$25,000 from 42.0% to 51.1%.²

Intervention 1: Conduct standardized screening of unmet Nutrition Security needs and provide referrals to state, local, and federal benefit programs and community-based, health-related social needs providers to address unmet needs.					
Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Implement standardized nutrition security screenings across patient and client populations. Provide referrals to address unmet needs.	Crouse, OCHD, SJH, Upstate	<u>Crouse:</u> Care Coordination, Social Work <u>UCHD:</u> Administration <u>SJH:</u> Community Health & Wellbeing <u>Upstate:</u> Inpatient & Outpatient	# departments or clinical settings screening for food insecurity # screenings conducted	Jan 2025 to Dec 2027	Low-income residents

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Intervention 2: Expand or create access points to get affordable, high quality, nutritious food.					
Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Operate a food pantry serving employees and patients experiencing food insecurity.	SJH	<u>SJH</u> : Community Health & Wellbeing	# attendees visiting the food pantry	Jan 2025 to Dec 2027	Low-income residents
Operate food pantries and distribute monthly produce boxes for qualifying patients with food insecurities.	Upstate	<u>Upstate</u> : Primary Care	# patients utilizing food pantries # monthly produce boxes distributed	Jan 2025 to Dec 2027	Low-income residents

Intervention 3: Implement nutrition standards and food service guidelines (FSG) for meals and snacks served in facilities, worksites, and institutions (e.g., vending machine options, meals served in cafeterias, etc.).					
Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Support the adoption of food service guidelines at worksites and community settings, through: <ul style="list-style-type: none"> Assessment Technical assistance 	OCHD, Worksites, Community settings	<u>OCHD</u> : Creating Healthy Schools & Communities Program (CHSC)	# worksites adopting FSG # community settings adopting FSG	Jan 2025 to Dec 2027	Low-income residents
Offer food service menu that adheres to guidelines set by the American Dietetic Association.	Crouse, SJH	<u>Crouse</u> : Nutritional Services <u>SJH</u> : Nutritional Services	# hospitals that implement nutrition standards for meals served	Jan 2025 to Dec 2027	Patients with disabilities

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Intervention 4: Expand Food as Medicine approaches across the lifespan, especially for populations at a higher risk of nutrition-related health disparities (e.g., medically tailored meals and groceries, produce prescription programs, etc.).					
Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Operate a Food Farmacy Program	SJH	<u>SJH</u> : Community Health & Wellbeing	# nutritional education sessions # enrollees in Food Farmacy Program # meals provided # nutritional education presentations/cooking demonstrations	Jan 2025 to Dec 2027	Low-income residents

Intervention 5: Implement healthy food and nutrition guidelines (e.g., Healthy Eating Research (HER) Guidelines, Hunger Prevention and Nutrition Assistance Program (HPNAP) nutrition standards) to improve the quality of foods offered within the charitable food system (e.g., food banks, food pantries, community kitchens, emergency shelters, etc.).					
Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Work with local food pantries to categorize charitable food offerings into the following selections based on HER guidelines with behavioral design strategies: <ul style="list-style-type: none"> • Choose often (green) • Choose sometimes (yellow) • Choose rarely (red) 	OCHD, SJH, Food pantries	<u>OCHD</u> : CHSC <u>SJH</u> : Community Health & Wellbeing	# participating pantries	Jan 2025 to Dec 2027	Low-income residents

PREVENTIVE SERVICES FOR CHRONIC DISEASE PREVENTION AND CONTROL

Goal: Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases.

Objectives:

- Increase the percentage of adults aged 45 to 75 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 64.6% to 73.2%.³
- Increase the percentage of adults aged 45 to 54 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 55.8% to 63.4%.⁴

Intervention 1: Expand screening for social care needs among all adults and those with chronic diseases (prediabetes, diabetes, hypertension, cancer screening) and provide referrals to appropriate community resources and supports.					
Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Implement standardized social care needs screenings across patient populations. Provide referrals to address unmet needs.	Crouse, SJH, Upstate	Crouse: Care Coordination SJH: Community Health & Wellbeing Upstate: Outpatient & Inpatient	# social care screenings conducted	Jan 2025 to Dec 2027	Low-income individuals
Reduce barriers to participating in Cancer Services Program (CSP) by screening eligible patients for social needs.	OCHD	OCHD: CSP	# barrier assessment forms completed	Jan 2025 to Dec 2027	Uninsured and under-insured populations

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Intervention 2: Partner with community-based organizations to promote access to prevention and screening services.					
Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Partner with trusted community-based organizations (CBOs) to promote access to screenings through the CSP. Including: <ul style="list-style-type: none"> • At least one partner focused on addressing access to care barriers. • At least one partner with ties to the CSP's population of focus. • At least one healthcare provider serving the population of focus. 	OCHD CBOs	OCHD: CSP	# partners engaged	Jan 2025 to Dec 2027	Uninsured and under –insured populations, Access to care

Intervention 3: Integrate community health workers (CHW)s into health care teams to improve chronic disease management for patients experiencing health inequities.					
Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Embed a CHW into care teams across SJH's accountable care organization (ACO) network and at Primary Care West.	SJH	SJH: Primary Care West & ACO network, Community Health & Wellbeing	# community health worker positions	Sept 2025 to Dec 2027	Populations with health inequities

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Intervention 4: Implement or increase health insurance enrollment outreach and support programs.

Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Refer clients in need of treatment for breast, cervical, colorectal, and/or prostate cancer for enrollment in the Medicaid Cancer Treatment Program (MCTP).	OCHD, MCTP	OCHD: CSP	# new referrals made to MCTP	Jan 2025 to Dec 2027	Uninsured and under-insured populations

Intervention 5: Implement treatment and follow-up protocols within hospitals and ambulatory care settings, such as, Federally Qualified Health Centers (FQHCs) for patients exhibiting two or more in office blood pressure readings indicating stage 1 hypertension: 130-139/80-89 per American Heart Association guidelines.

Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
For adults with uncontrolled hypertension, an integrated treatment model that includes accurate BP measurement, prompt treatment, patient engagement, and ongoing review of home blood pressure monitoring (HBPM).	SJH	SJH: Ambulatory Care, Community Health & Wellbeing	hypertension control rate	Jan 2025 to Dec 2027	Disparities by race and ethnicity

Intervention 6: Recruit, train, and deploy community health workers to deliver evidence-based, "self" monitoring blood pressure management programs.

Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
CHW at SJH's accountable care organization (ACO) network and at Primary Care West will distribute blood pressure cuffs to patients in need.	SJH	SJH: Community Health & Wellbeing	# blood pressure cuffs distributed	Jan 2025 to Dec 2027	Low-income individuals

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Intervention 7: Work with local cancer screening programs such as the NYS Cancer Screening Program (CSP), to improve access to cancer screening and diagnostic testing for individuals without health insurance.

Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Administer Onondaga County's CSP.	OCHD	OCHD: CSP	# cancer screenings delivered to uninsured individuals	Jan 2025 to Dec 2027	Uninsured and under –insured populations

Intervention 8: Improve provider participation in cancer screening programs that benefit individuals without health insurance.

Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Recruit and maintain a network providing access to breast, cervical and colorectal cancer screening and diagnostic services.	OCHD	OCHD: CSP	# providers participating in CSP	Jan 2025 to Dec 2027	Uninsured and under –insured populations

Intervention 9: Encourage the use of client reminders by providers to increase cancer screening per the Community Guide national guidelines.

Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Support patient autonomy and greater compliance with cancer screening by tailoring consent notifications to client preferences.	OCHD	OCHD: CSP	# methods available for CSP cancer screening reminders (i.e. voicemail, email, etc.)	Jan 2025 to Dec 2027	Uninsured and under –insured populations

PREVENTION OF INFANT AND MATERNAL MORTALITY

Goal: Improve health outcomes by lowering mortality and morbidity rates for infants and birthing persons.

Objectives:

- Decrease the rate of infant mortality per 1,000 live births from 5.1 to 4.2.⁵
- Decrease the rate of maternal mortality per 100,000 live births from 20.3 to 16.1.⁶

Intervention 1: Provide free sleep sacks and/or portable cribs to families in need during prenatal period or before discharge from the hospital.					
Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Distribute free sleep sacks to families in need.	OCHD Crouse	<u>OCHD</u> : Syracuse Healthy Start (SHS) Program <u>Crouse</u> : Women & Children	# sleep sacks distributed	Jan 2025 to Dec 2027	Low-income families
Refer families in need to community-based agencies for access to free portable cribs.	OCHD, REACH CNY, Catholic Charities	<u>OCHD</u> : Division of Healthy Families	# referrals made	Jan 2025 to Dec 2027	Low-income families

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Intervention 2: Establish policies and practices to support doula care and services, especially in areas of maternal deserts and historic underinvestments.					
Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Create awareness and support for community doulas as part of healthcare team through: <ul style="list-style-type: none"> Offering education about roles of doulas in health care teams Providing educational opportunities for doulas (Perinatal/postpartum mood and anxiety disorder, CPR) Implementing “Standing in the Gap” program 	Crouse	Crouse: Women & Children, Employee Community Engagement OCHD: Division of Healthy Families SJH: Women & Infant Service Line Upstate: Inpatient & Outpatient	# Standing in the Gap participants # education programs attended by doulas	Jan 2025 to Dec 2027	Birth justice, Access to Care

Intervention 3: Provide screenings to prenatal and post-partum patients using validated tools.					
Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Provide mental health screenings for prenatal and post-partum patients and clients using validated screening tools (Edinburgh and PHQ-9). Refer patients screening positive to mental health treatment providers.	Crouse, OCHD, SJH, Upstate	Crouse: Women & Children, Employee Community Engagement OCHD: Division of Healthy Families SJH: Women & Infant Service Line Upstate: Inpatient & Outpatient	# individuals screened # referrals made	Jan 2025 to Dec 2027	Access to Care

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Intervention 3: Provide screenings to prenatal and post-partum patients using validated tools.					
Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
In alignment with the 1115 New York Health Equity Reform Waiver, provide screenings for social care needs among prenatal and post-partum patients. Refer patients to available services if they screen positive.	Crouse, SJH, Upstate	<u>Crouse</u> : Care Coordination <u>SJH</u> : Community Health & Wellbeing <u>Upstate</u> : Inpatient & Outpatient	# individuals screened # referrals made	Jan 2025 to Dec 2027	Access to Care
Conduct screenings for domestic violence among prenatal and post-partum clients. Refer any clients screening positive to domestic violence support services.	OCHD Vera House	<u>OCHD</u> : Syracuse Healthy Start	# individuals screened # referrals made	Jan 2025 to Dec 2027	Access to Care

Intervention 4: Connect birthing people, particularly those at high risk for postpartum mental health and substance use challenges, to evidence-based or evidence-informed home visitation programs.					
Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Implement evidence- based or evidence-informed home visitation programs for birthing people at high risk for postpartum mental health and substance use challenges. Programs administered include: <ul style="list-style-type: none"> • Syracuse Healthy Start • Perinatal and Infant Community Health Collaborative • Community Health Nursing 	OCHD	<u>OCHD</u> : Division of Healthy Families	# clients served by each program	Jan 2025 to Dec 2027	Low-income families

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Intervention 5: Implement a lactation care coordination system that begins during the prenatal period and continues through weaning stages. The system can include formal referral systems, follow-up accountability, and hand-off protocols during transitions of lactation care from one provider or setting to another.					
Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Engage health care providers to increase adoption of policies and practices supportive of breastfeeding, chestfeeding, and lactation through: <ul style="list-style-type: none"> • Identification and recruitment of health care practices • Assessment of practice’s current policies • Provision of practice-specific technical assistance and resources 	OCHD	OCHD: Breastfeeding, Chestfeeding, & Lactation Friendly New York (BFFNY)	# practices engaged	Jan 2025 to Dec 2027	
Recognize practices achieving NYS Breastfeeding, Chestfeeding, and Lactation Friendly Practice designation; prioritizing those that employ low-income, racially/ethnically diverse individuals.	OCHD	OCHD: BFFNY	# practices achieving designation	Jan 2025 to Dec 2027	Low-income families, Disparities by race and ethnicity
Identify and engage breastfeeding, chestfeeding, and lactation champions at participating health care practices to support organizational policy, systems, and environmental changes.	OCHD	OCHD: BFFNY	# champions engaged	Jan 2025 to Dec 2027	

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Intervention 6: Support the adoption of healthy nutrition policies and standards at early childcare centers.

Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Support the adoption of healthy nutrition policies and standards at early childcare centers through: <ul style="list-style-type: none"> Assessment Technical assistance Training 	OCHD	<u>OCHD</u> : Creating Healthy Schools & Communities (CHSC)	# childcare centers that adopt healthy nutrition policies	Jan 2025 to Dec 2027	

Intervention 7: Implement ZERO TO THREE's Healthy Steps Program in pediatric primary care offices.

Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Continue Healthy Steps program at St. Joseph's Primary Care Center – Main and West to help children achieve developmental milestones and foster a healthy living environment.	SJH, NYS Office of Mental Health, Zero to Three/Healthy Steps, Reach Out and Read	<u>SJH</u> : Healthy Steps	# enrolled participants	Jan 2025 to Dec 2027	Low-income children

Intervention 8: Collect and stratify clinical data by race, ethnicity, and language (REAL) data to analyze and identify drivers of inequity and targets for quality improvement.

Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Continue to work with the New York State Birth Equity Improvement Collaborative (NYSPQC Respectful Care & Safe Reduction of Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Project).	Crouse, SJH, Upstate, NYSPQC	<u>Crouse</u> : Employee Community Engagement <u>SJH</u> : Women & Infants Service Line Leadership <u>Upstate</u> : Family Birth Center	# Patient Reported Experience Measure (PREM) surveys completed	Jan 2025 to Dec 2027	Disparities by race and ethnicity

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Intervention 9: Develop peer support services for the prevention of perinatal depression and connect birthing persons to peer support services as part of prenatal care.					
Activity	Participating Agencies	Responsible staff	Performance Measure(s)	Timeline	Disparities Addressed
Increase the number of support groups that provide high quality and culturally responsive breastfeeding, chestfeeding, and lactation supports, through: <ul style="list-style-type: none"> Assessing existing lactation support groups Establishing new lactation support groups if indicated Provide technical assistance to new and existing groups 	OCHD	<u>OCHD</u> : BFFNY	# support groups # groups receiving technical assistance	Jan 2025 to Dec 2027	Culturally responsive support
Promote new and existing lactation support groups to birthing persons.	OCHD, Crouse	<u>OCHD</u> : BFFNY <u>Crouse</u> : Women & Children, Employee Community Engagement	# support group participant counts	Jan 2025 to Dec 2027	
Offer a perinatal mood and anxiety support group to pregnant and postpartum families.	Crouse	<u>Crouse</u> : Women & Children, Family Support Program	# participants in groups	Jan 2025 to Dec 2027	

Data Sources and Notes

¹ NYS Expanded Behavioral Risk Factor Surveillance System (eBRFSS), data as of 2021. Retrieved on 11/12/2025 from <https://www.health.ny.gov/statistics/brfss/expanded/>.

² NYS BRFSS, data as of 2022. Retrieved on 11/18/2025 from https://apps.health.ny.gov/public/tabvis/PHIG_Public/pa/.

³ NYS BRFSS, data as of 2022. Retrieved on 11/18/2025 from CDC PLACES: <https://www.cdc.gov/places/index.html>.

⁴ NYS Prevention Agenda Dashboard. Retrieved on 11/18/202 from https://www.health.ny.gov/prevention/prevention_agenda/2025-2030/. Note: Data are from 2023 and reflect state-wide rate; County level data are not currently available for this sub-population.

⁵ NYS Statewide Perinatal Data System (accessed by OCHD) and OCHD, Office of Vital Statistics. Note: A 3-year rolling average (2022-2024) is used to account for small numbers of deaths. Data are provisional.

⁶ Vital Records data, 2020-2022. Retrieved on 11/17/2025 from the NYS Prevention Agenda Dashboard: https://apps.health.ny.gov/public/tabvis/PHIG_Public/pa/. Note: Rate is unstable due to small numbers.

Appendices

Appendix 1: NYS Prevention Agenda 2025-2030 Framework

Vision	
Every individual in New York State has the opportunity, regardless of background or circumstances, to attain their highest level of health across the lifespan	
Foundations	
Health Equity Prevention Across the Lifespan Health Across All Policies Local Collaboration-Building	
Domain	Priorities
Economic Stability	Economic Wellbeing <ul style="list-style-type: none"> Poverty Unemployment Nutrition Security Housing Stability and Affordability
Social and Community Context	Mental Wellbeing and Substance Use <ul style="list-style-type: none"> Anxiety and Stress Suicide Depression Drug Misuse and Overdose Including Primary Prevention Tobacco/ E-cigarette Use Alcohol Use Adverse Childhood Experiences Healthy Eating
Neighborhood and Built Environment	Safe and Healthy Communities <ul style="list-style-type: none"> Opportunities For Active Transportation and Physical Activity Access to Community Services and Support Injuries and Violence
Health Care Access and Quality	Health Insurance Coverage and Access to Care <ul style="list-style-type: none"> Access to and Use of Prenatal Care Prevention of Infant and Maternal Mortality Preventive Services for Chronic Disease Prevention and Control Oral Health Care Healthy Children <ul style="list-style-type: none"> Preventive Services Early Intervention Childhood Behavioral Health
Education Access and Quality	PreK-12 Student Success And Educational Attainment <ul style="list-style-type: none"> Health and Wellness Promoting Schools Opportunities for Continued Education

Appendix 2: Onondaga County 2025-2027 CHIP Progress Reporting and Revision Plan

The OCHD and Hospital Steering Committee will regularly evaluate the relevance and effectiveness of the interventions included in the CHIP throughout the 2025-2027 cycle. The following progress reporting and revision plan will be followed to ensure that interventions outlined in the CHIP will continue to meet the evolving needs of the Onondaga County community. The progress reporting and revision plan allows for members of the Steering Committee to review progress on a regular basis and assess the interventions for changes as needed.

In addition to the timelines laid out below, the Steering Committee will schedule ad hoc meetings as appropriate whenever there is a need to discuss challenges, successes, and/or revisions to the CHIP.

Timeframe	Activities	Responsible Agencies
July 2026	Complete the 6 Month Progress Update chart reflecting activities from 1/1/2026 to 6/30/2026.	OCHD Crouse Health St. Joseph’s Hospital Upstate University Hospital
December 2026	Provide annual CHIP update to New York State Department of Health (NYSDOH). Update will reflect activities undertaken in 2026.	OCHD Crouse Health St. Joseph’s Hospital Upstate University Hospital
January 2027	Complete Annual Review form for 2026 activities.	OCHD Crouse Health St. Joseph’s Hospital Upstate University Hospital
Quarter 1 2027	Attend Steering Committee Meeting.	OCHD Crouse Health St. Joseph’s Hospital Upstate University Hospital
July 2027	Complete the 6 Month Progress Update chart reflecting activities from 1/1/2027 to 6/30/2027.	OCHD Crouse Health St. Joseph’s Hospital Upstate University Hospital
December 2027	Provide annual CHIP update to NYSDOH. Update will reflect activities undertaken in 2027.	OCHD Crouse Health St. Joseph’s Hospital Upstate University Hospital

Timeframe	Activities	Responsible Agencies
January 2028	Complete Annual Review form for 2027 activities.	OCHD Crouse Health St. Joseph’s Hospital Upstate University Hospital
Ongoing	Comply with all CHIP reporting requirements as outlined by the NYSDOH.	OCHD Crouse Health St. Joseph’s Hospital Upstate University Hospital

The following factors will be considered when changes to the CHIP are made:

Revisions to the CHIP will be made if one or more of the following conditions are met:

- Significant barriers to feasibility of proposed activities
- Changes in agency resources (i.e. funding, staffing)
- Changes in legislation (i.e. making a new policy obsolete)
- Capitalizing on an emerging opportunity
- Response to emerging health issues

Proposed revisions to the CHIP will consider the following:

- Newly available data sources
- Availability of data for performance measures
- Existence of evidence based or promising practices to support desired outcomes
- Agency readiness to pursue proposed projects
- Current assets and resources in the community

Onondaga County 2025-2027 Community Health Improvement Plan 6 Month Progress Update

Priority Area: _____

Agency name: _____

Reporting period: _____

Completion date: _____

Completed by: _____

Goal:						
Intervention:						
Activity	Performance Measures	Partner Agencies	Timeline	Current Status (<i>Not started, In progress, Completed</i>)	Performance Measure Data	Updates, Changes, Comments

Onondaga County 2025-2027 Community Health Improvement Plan Annual Review Form

Instructions: Please answer the following questions in regards to activities completed by your agency in the last 12 months as part of the Onondaga County Community Health Improvement Plan.

Agency name: _____
Reporting period: _____
Completion date: _____
Completed by: _____

1. Please provide any relevant updates related to activities and strategies included in your agency's CHIP that were not already reported in the *6 Month Progress Updates*.
2. Have there been any changes in your agency's resources that will affect the completion of activities outlined in your agency's CHIP? If yes, please explain.
3. Please identify any new community partnership opportunities relevant to the priority areas of *Nutrition Security, Preventive Services for Chronic Disease Prevention and Control, and Prevention of Infant and Maternal Mortality*.
4. Are you aware of any newly available data sources or updated indicators within the priority areas of *Nutrition Security, Preventive Services for Chronic Disease Prevention and Control, and Prevention of Infant and Maternal Mortality*. If yes, please explain.
5. Please describe the emerging health issues that your agency believes should be given priority in the current or future CHIP cycle(s).
6. Please use the space below to provide any recommendations for changes to the work outlined in your agency's CHIP. Recommendations may include changes to planned activities, actions, target dates, responsible parties, or process measures.
7. Please provide any additional feedback below.

Thank you!

Appendix 3: Dissemination to the Public

The Onondaga County 2025-2027 CHIP document will be publicly available through several venues. This will include publication on the OCHD website (<https://onondaga.gov/health/>). Each participating hospital will also publish a link directing the public to the document on their respective websites. The document will also be shared with key stakeholder groups including the CNY Regional Healthcare Equity Task Force. Local media outlets will also be notified of the publication of the document through a press release. In addition, to solicit feedback on the final document from members of the public and stakeholders, a brief survey will be made available on the OCHD website and will accept feedback during Spring 2026.



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