STEUBEN COUNTY

Community Health Assessment and Improvement Plan

2025-2030

Public Health
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Steuben County NY

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Advancing Public Health Performance
Public Health Accreditation Board

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Steuben County Public Health extends sincere appreciation to all agencies, organizations, and individuals who contributed their time, expertise, and perspectives to the development of the Community Health Assessment and Community Health Improvement Plan.

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A Message from the Public Health Director

To our community members and partners,

We are pleased to present the 2025–2030 Steuben County Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). Together, these documents provide a shared understanding of the health needs of Steuben County residents and a framework for coordinated, multisector efforts to improve community health.

Health outcomes in Steuben County are shaped by social, economic, behavioral, and environmental factors across the places where we live, learn, work, and play. As public health practice continues to evolve, collaboration and shared goals, particularly those focused on social determinants of health and health equity, remain critical.

The CHA examines key factors influencing health risks and outcomes in Steuben County and identifies priority areas including substance use, mental health, and community safety. While challenges exist, the county is supported by strong community-based organizations, engaged partners, and dedicated healthcare systems. In alignment with the New York State Prevention Agenda, the CHIP outlines priority areas and strategies that Steuben County Public Health, local hospitals, and community partners will implement together to improve population health.

The CHA and CHIP were developed through a collaborative process led by Steuben County Public Health, in partnership with [hospital partners], and informed by extensive community input. We thank all who contributed their time, expertise, and perspectives to this important effort and look forward to continued partnership in building a healthier Steuben County.

Sincerely,

Matthew Marmor

Matthew Marmor

Interim Public Health Director

Steuben County Public Health

Comprehensive Regional Community Health Assessment

PREPARED FOR: Chemung, Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne, and Yates Counties

Courtesy of Finger Lakes Tourism Alliance: Joe Carroll

PREPARED BY: Pivital Public Health Partnership | December 2025

pivital PUBLIC HEALTH PARTNERSHIP On a Rural Health Mission

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Executive Summary

Introduction

The New York State Department of Health (NYSDOH) Prevention Agenda 2025-2030 serves as a roadmap for county health departments, hospitals and other health care systems and partners to develop strategic priorities to ensure the health and well-being of New York State residents. Every six years, New York State requests that local health departments and their local hospital systems work together to create a joint community health assessment and improvement plan. Both should align with the NYSDOH Prevention Agenda and with priorities and requirements detailed by the Public Health Accreditation Board (PHAB).

Local health departments and hospitals must choose at least three areas from the Prevention Agenda on which to focus their community health improvement efforts. Local entities may choose from five domains and 23 priorities within those domains. The five domains are:

1. Economic Stability
2. Social and Community Context
3. Neighborhood and Built Environment
4. Health Care Access and Quality
5. Education Access and Quality

Photo: Watkins Glen State Park courtesy of Schuyler County

Throughout the Community Health Assessment cycle, public health and hospital systems value the input and engagement of key partners and community members who are critical in helping determine which priorities are most important to the community, and what actions ought to be taken to improve the population's health. The following report summarizes the pertinent information relating to the above priority areas. Residents live, work, and seek services beyond their county of residence. The health and well-being of residents in a neighboring county may impact the needs and services in other counties. In addition, collaborative practices such as shared messaging and lessons learned may expand the reach and success of like-minded interventions. Following the comprehensive assessment of the health of the entire region, this report contains a county-specific chapter from the region. Each county's chapter highlights specific needs, including additional demographic indicators, main health challenges, and underlying behavioral, political, and built environmental factors contributing to the county's overall health status.

Key Findings

The health of residents of the Finger Lakes region has been challenged by a variety of factors and circumstances ranging from demographic changes to public health crises. Addressing these challenges requires creative thinking, careful planning, and coordinated action, all of which are described in this community health assessment (CHA).

Although the region's overall population is projected to shrink, the region will experience an increase in the number of older adults over the next several years. This will result in the need to increase the capacity of healthcare and social service agencies, The expected increase in older adults and retirees, paired with a predicted decline in the number of working-age adults, will further exacerbate workforce demands.

Despite the long-standing existence of several unique populations in the region, including migrant farm workers, Amish and Mennonite, Native American and Alaska Natives, researchers have been challenged to collect and interpret data related to their unique health needs. In addition to these populations, there are other demographic and cultural factors which may impact health outcomes and status in a particular county including race, ethnicity, age, income, education, and the infrastructure that makes up the built environment. The 2025–2030 New York State Prevention Agenda organizes these conditions into five domains of social determinants of health: Economic Stability; Social and Community Context; Neighborhood and Built Environment; Health Care Access and Quality; and Education Access and Quality. The data shared below corresponds to the five domain areas of the Prevention Agenda and provides a summary of findings. For more detailed information, please refer to the specific Prevention Agenda sections in this CHA.

Economic Stability

Economic stability refers to socioeconomic disparities, unemployment and underemployment, access to affordable, nutritious food, and housing security. All are closely linked to poor health, affecting physical, mental, and educational outcomes. Children and older adults are especially vulnerable.

Socioeconomic conditions strongly shape community health. Higher poverty levels are associated with more chronic disease, mental health challenges, and limited access to essential resources such as food, housing, education, healthcare, and employment. Poverty also creates wider societal burdens, including homelessness, crime, and higher healthcare costs. Data across counties show notable variation in poverty rates, with several counties exceeding the New York State average. Poverty among older adults is rising in every county, which is concerning given the expected growth of the 65+ population. While household incomes have increased, they are not keeping pace with the living wage needed to meet basic costs.

Access to healthy foods is another key concern. The Food Environment Index (FEI), which reflects food insecurity and distance to grocery stores, indicates that many counties in the region face greater food access challenges than the state overall. High food insecurity rates and large numbers of residents with incomes below the SNAP threshold highlight ongoing economic strain, particularly in rural areas. Limited access to nutritious food contributes to elevated rates of obesity, diabetes, and premature death.

Housing stability also plays an important role in health. When housing is unaffordable or poor in quality, it can create stress, contribute to chronic illness, and limit access to other necessities. The Area Deprivation Index (ADI), which measures socioeconomic disadvantage, shows substantial variation across the region, with some communities experiencing significantly higher levels of deprivation and associated health risks.

Children and older adults are especially vulnerable, as poverty, food insecurity, and unstable housing can disrupt healthy development, worsen chronic conditions, and compound disadvantages over time.

Social and Community Context

Social and community context encompasses the relationships, environments, and local systems that shape people's health and well-being. Strong social connections, a sense of belonging, and access to community resources support positive health outcomes, while factors such as discrimination, isolation, and inequities in the surrounding environment can undermine health.

Mental health concerns are rising across the Finger Lakes region, with increasing rates of depressive disorders and adults reporting frequent poor mental health. Factors such as economic strain, chronic illness, political polarization, and adverse childhood experiences contribute to anxiety and stress, while access to mental health providers remains a challenge. Suicide rates among adults are climbing in most counties, and youth suicide trends vary, with some counties reporting decreases and others showing significant increases.

Drug-related deaths, including opioid overdoses, have escalated sharply in many counties, surpassing statewide averages. Community focus groups also identified growing substance use as a major concern, prompting new local partnerships aimed at addressing addiction.

While smoking has declined across the region, binge drinking has increased, and both behaviors occur at rates higher than the New York State average. Adverse childhood experiences remain a significant issue, with many adults reporting two or more ACEs, which can affect long-term health.

Healthy eating patterns remain a concern across the region. Fewer than half of adults in most counties eat fruit daily, though this is improving, and daily vegetable consumption is declining. Sugary drink consumption is below the state average in most counties yet remains an important target for prevention given its link to obesity and chronic disease. Focus group participants consistently emphasized the importance of healthy eating but noted that affordability and limited grocery access make it difficult to sustain healthy eating habits.

Neighborhood and Built Environment

Neighborhood and built environment depend on clean air and water, safe and affordable housing, well-maintained streets and sidewalks, adequate lighting, low violence, and accessible parks and trails. Although physical activity is essential for preventing chronic disease, many focus group participants reported feeling unsafe on local roads and sidewalks, and residents with mobility limitations often struggle to navigate their surroundings, safely.

Several counties have expanded access to physical activity resources, but rising injuries and violence across the region undermine residents' sense of safety. Regionally, violent crime has risen in recent years, especially since 2020, and is currently at its highest level since 2013. Most counties now exceed the state average in unintentional injury deaths.

Transportation barriers in rural areas further limit access to food and healthcare, as many residents live far from essential services and grocery stores. Low walkability and high social vulnerability scores reflect these challenges. Perceived increases in community violence, regardless of the cause, also discourage community engagement.

Despite these concerns, respondents to the 2024 Regional Access to Care Survey highlighted strong community assets, including volunteers, local non-profit organizations, and hospitals, which help offset shortcomings in the built environment.

Health Care Access and Quality

Health care access and quality play a critical role in preventing disease, supporting healthy development, and reducing inequities. Early and consistent prenatal care lowers risks for mothers and infants, while regular screenings, immunizations, and management of chronic conditions help prevent serious illness and death. Oral health, often tied to socioeconomic status, is another key component of overall well-being. Despite the benefits of these services, many residents face barriers, including transportation challenges, inequitable access, and mistrust, that limit their ability to receive timely, high-quality care.

Access to early prenatal care and abstinence from alcohol, tobacco, and illicit drugs during pregnancy are critical in ensuring healthy starts for our youngest residents. While only a small share of births in the region receive late (third-trimester) or no prenatal care, some counties have rates that are more than twice those of the best-performing counties, underscoring ongoing geographic disparities in timely access. The use of harmful substances during pregnancy has decreased in the region, as have the incidences of preterm births and low birth weights. This is encouraging as the eight counties represented in this regional CHA continue to work collaboratively on maternal child health indicators, interventions, and unified messaging.

Access to primary care and dental care is problematic in rural counties, particularly for low-income and Medicaid-eligible residents. Provider shortages, cost, transportation barriers, and scheduling difficulties hinder timely care. Though mammography rates are high, colorectal cancer and diabetes screenings lag. Dental care, particularly for individuals with Medicaid, remains limited due to a lack of participating providers.

High emergency department use, preventable hospitalizations, and increased behavioral-health visits reflect gaps in primary and specialty care. Public health activities such as TB screening and treatment, blood lead testing, childhood vaccination clinics, and STI testing and treatment remain important stop gaps for individuals who otherwise would lack access to these services. Future improvements may come from telehealth expansion, better broadband, urgent care expansion, and social care networks, though the advent of concierge medicine may worsen inequities.

A 2024 regional survey of more than 1,700 residents confirmed persistent barriers to care (for more detail, please see Regional Access to Care Report section of this CHA). Findings included:

- Shortages of medical, dental, and mental health providers
- Transportation difficulties, especially in rural areas
- Insurance-related challenges for uninsured and Medicaid patients
- Greater access barriers for non-White, rural, and Plain community residents
- Strong community assets, including local organizations and hospitals

Emerging issues include workforce shortages—particularly in behavioral health—limited broadband for telehealth, policy changes affecting Medicaid and SNAP, difficulties integrating new care models, ongoing equity gaps, and the potential benefits of expanding Social Care Networks and urgent care services.

Education Access and Quality

Education is a major determinant of health. People with higher levels of schooling tend to live longer, experience fewer chronic conditions, and enjoy greater economic security. Student absenteeism can stem from a range of issues, including physical and mental health concerns, substance use, unsafe school environments, and low physical fitness. Beyond high school, additional education offers significant advantages: adults with a bachelor's degree typically have higher earnings, lower unemployment, and improved health and living conditions compared to those with only a high school diploma. However, cost and disparities in access continue to limit these opportunities for many.

Education opportunities are reflected in high school graduation rates, per-student spending, and graduation rates among economically disadvantaged students. Most counties surpass the state average for adults with a high school diploma, suggesting that educational attainment may support greater economic stability.

Regional Assets and Resources to be Mobilized

In the Finger Lakes Region, there is a long history of collaboration and coordination among local health departments (LHDs) and community partners. The counties work together on programming, policy development, and unified messaging and have inter-municipal agreements for emergency response. Six of the counties worked together to become nationally accredited in 2020 and are now pursuing multi-jurisdictional reaccreditation. Additionally, LHDs work collaboratively with hospital partners in emergency preparedness, community health priorities, at co-sponsored events, during communicable disease outbreaks, and on boards and coalitions. Each county maintains a group of hospital and community stakeholders with which they complete the CHA and the CHIP. In addition to these relationships, eight Finger Lakes counties are members of the Pivital Public Health Partnership and collaborate with Common Ground Health and the Forward Leading IPA (FLIPA).

Pivital Public Health Partnership

Pivital Public Health Partnership is a collaboration of eight local health departments including Chemung, Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne, and Yates Counties. The

network focuses on improving the health and well-being of Finger Lakes residents by promoting health equity in populations who experience disparities. The Pivital board is made up of community members, medical professionals, and public health directors from member counties. Directors meet monthly to strategize and coordinate efforts to improve the health and wellbeing of Finger Lakes residents.

Common Ground Health

Common Ground Health covers the same geographic area as Pivital, with the addition of Monroe County, which has both urban and rural populations. The agency brings together leaders from healthcare, business, education and other sectors to find common ground on health challenges and bring attention to health inequities based on geography, socio-economic status, race and ethnicity. Members meet quarterly at Regional Leadership meetings to discuss challenges in health outcomes and available resources.

Forward Leading IPA (FLIPA)

FLIPA's mission is to strengthen healthcare through meaningful connections by creating opportunities for member organizations to collaborate, build relationships, and share best practices to support the health and wellbeing of communities across upstate New York. The executive director of Pivital represents the eight Pivital counties on the FLIPA board of directors. Current work is centered on the 1115 waiver and creation of a social care network.

These agencies support the work of the CHA and the eventual execution of the CHIP and continually strive toward highlighting alignment, leveraging shared resources, and creating opportunities for shared learning. With facilitation and coordination by each agency, local leaders are able to regularly meet to discuss health challenges and issues as a team and devise plans toward improving the health of all Finger Lakes residents.

In addition to the resources available through Pivital, Common Ground Health, and FLIPA, LHD's are active in regional workgroups and local nonprofit organizations. For a list of partners in each county, please see the specific County chapter.

Keuka Lake, Source: Steuben County

County-Specific Priority Areas

The eight counties of the Finger Lakes region each chose three or four priority areas on which to focus their Community Health Improvement Plans as shown in Table 1.

Table 1: County-Specific Priority Areas

County	Prevention Agenda Domain	Priority Area
Chemung	1. Economic Stability 2. Health Care Access and Quality 3. Neighborhood and Built Environment	• Poverty • Housing Stability and Affordability • Preventive Services – Lead Screening • Access to Community Support Services
Livingston	1. Economic Stability 2. Social and Community Context 3. Health Care Access and Quality	• Nutrition Security • Depression • Oral Health Care
Ontario	1. Economic Stability 2. Health Care Access and Quality 3. Social and Community Context	• Poverty • Preventive Services for Chronic Disease Prevention and Control • Depression
Schuyler	1. Health Care Access and Quality 2. Social and Community Context 3. Economic Stability	• Preventive Services for Chronic Disease Prevention and Control • Primary Prevention, Substance Misuse and Overdose Prevention • Poverty
Seneca	1. Health Care Access and Quality 2. Social and Community Context 3. Economic Stability	• Healthy Children/Preventive Services • Primary Prevention, Substance Misuse and Overdose Prevention • Nutrition Security
Steuben	1. Economic Stability 2. Social and Community Context	• Housing Stability and Affordability • Poverty • Primary Prevention, Substance Misuse, and Overdose Prevention

Wayne	1. Social and Community Context 2. Economic Stability	• Anxiety and Stress • Nutrition Security • Housing Stability and Affordability
Yates	1. Economic Stability 2. Health Care Access and Quality 3. Social and Community Context	• Housing Stability and Affordability • Preventive Services for Chronic Disease Prevention and Control • Anxiety and Stress

Steering Committee

Regional Community Health Assessment Structure and Approach

The regional Community Health Assessment (CHA) effort was led by the Pivital Public Health Partnership, a non-profit affiliation of eight county Public Health Departments in the Finger Lakes region of New York State. Regional CHA partners included: County-level public health departments from Chemung, Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates; Pivital Public Health Partnership; Common Ground Health; local steering committees; and diverse sectoral organizations. See also County Chapters for specific partners.

Pivital provided county staff with targeted education on the Mobilizing for Action through Planning and Partnership (MAPP) 2.0 Framework; a tool created by the National Association of County and City Health Officials. Additionally, they attended stakeholder meetings and facilitated monthly meetings with health department staff assigned to CHA/CHIP activities. Pivital also provided technical assistance and data support by collecting and entering county-level Community Status Assessment (CSA) data into the Clear Impact performance management scorecard. This ultimately created a regional CSA scorecard to identify shared regional health issues and challenges. County-level teams customized the processes for their local needs and priorities (see specific County Chapters for detailed information.)

While planning was coordinated regionally, each county designated a chairperson who facilitated the CHA process at the local level. Each local health department formed a steering committee best suited to its local needs in order to implement each step of the MAPP 2.0 framework. This adaptive approach allowed each county to follow recognized best practices for collaborative health improvement, while ensuring that local priorities and resources shaped their process.

To enhance data analysis and promote equity, Pivital partnered with Common Ground Health, a health research and planning organization based in Rochester, NY. Common Ground Health supports the nine Finger Lakes counties (the eight represented in this CHA and Monroe County) and is recognized for maintaining the region's most comprehensive health and health care data resources. Their expertise enabled deeper investigation of health trends and identification of health inequities by geography, socio-economic status, race, and ethnicity.

During the Community Context Assessment (CCA), the eight counties worked together regionally to identify key unified questions for focus groups. Each local health department was given the opportunity to customize and enrich CCA questions to meet local needs but agreed to use a minimum set of questions decided upon by regional consensus, ensuring consistency and comparability across the region.

New York State 2025-2030 Prevention Agenda

The NYSDOH Prevention Agenda 2025-2030 serves as a roadmap for county health departments, hospitals and other health care systems and partners to develop strategic priorities to ensure the health and well-being of New York State residents. It guides communities to set priorities, address health disparities, and improve the health and well-being of all New Yorkers. The NYSDOH Prevention Agenda is closely tied to Social Determinants of Health. These determinants are everyday life conditions, such as where people live, work, learn, and play, that affect health, well-being, and opportunities to thrive. (Figure 1)

Figure 1 Social Determinants of Health

Source: CDC

Local health departments, hospitals and partners used the Prevention Agenda to align their CHA and CHIP with statewide goals, ensuring that efforts are data-driven and focused on advancing health equity.

The Prevention Agenda outlines five domains with their associated priority areas as detailed in Table 2. Each domain is a Social Determinant of Health.

Table 2: NYSDOH Prevention Agenda Domains, Priorities and Targets

Domain	Priorities
1. Economic Stability	Poverty
	Unemployment
	Nutrition Security
	Housing Stability and Affordability
2. Social and Community Context	Anxiety and Stress
	Suicide
	Depression
	Primary Prevention, Substance Misuse, and Overdose Protection
	Tobacco/E-cigarette Use
	Alcohol Use
	Adverse Childhood Experiences
	Healthy Eating
3. Neighborhood and Built Environment	Opportunities for Active Transportation and Physical Activity
	Access to Community Services and Support
	Injuries and Violence
4. Health Care Access and Quality	Access to and Use of Prenatal Care
	Prevention of Infant and Maternal Mortality
	Preventive Services for Chronic Disease Prevention and Control
	Oral Health Care
	Preventive Services
	Early Intervention
	Childhood Behavioral Health
5. Education Access and Quality	Health and Wellness Promoting Schools
	Opportunities for Continued Education

Source: NYSDOH Prevention Agenda 2025-2030

Data Method and Process (Methodology)

The CHA provides a comprehensive picture of a community's current health status, including factors that contribute to health risks and challenges. It also identifies priority health needs by analyzing local data and community input.

The eight counties in the Finger Lakes region of New York State represented in this CHA adopted the NACCHO MAPP 2.0 Framework for community improvement in developing this regional CHA. (Figure 2). This broad framework allowed the counties to work as one collective unit while also

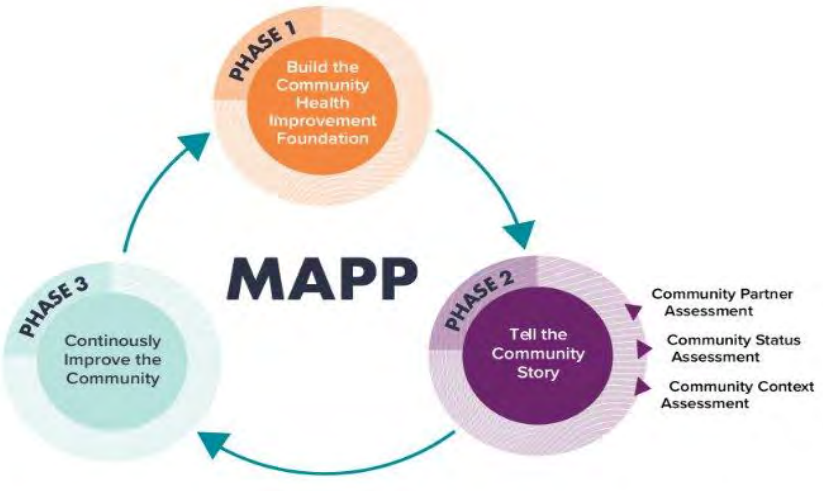
enabling them to customize the assessments to best suit the needs and abilities of their individual counties.

Figure 2 MAPP 2.0 Roadmap to Health Equity

Source: NACCHO

The process implemented by each county followed a three-phased approach noted in Figure 3.

Figure 3 MAPP 2.0 phases



Source: NACCHO

Phase 1: *Build the Community Health Improvement Foundation.*

This phase focuses on creating the leadership, partnerships, and shared commitment necessary to guide the MAPP process. It involves forming or strengthening a community health coalition, establishing clear roles and responsibilities, and developing a shared vision for a healthier community. During this step, partners build trust, set expectations, and ensure that diverse voices

are represented, including residents, community organizations, health systems, and local government.

Phase 2: Tell the Community Story
This phase focuses on gathering and analyzing data to create a comprehensive picture of the community's health using three coordinated assessments: the Community Partner Assessment (CPA), Community Status Assessment (CSA), and Community Context Assessment (CCA). Together, these tools integrate quantitative data with qualitative input from residents and stakeholders to identify key health issues, strengths, and challenges, aligned with the Prevention Agenda social determinants of health domains and equity goals. Partners gain a shared understanding of health needs, disparities, and resources, which provides the evidence base for setting priorities and developing strategies for improvement.

Community Partner Assessment (CPA)
The CPA helps community organizations examine both their own internal processes and abilities, as well as their shared capacity as a community network to tackle health inequities. It is designed to guide partners in determining what actions are needed to address inequities at the individual, system, and structural levels. The CPA is intended to address the following questions:

- What are the capabilities, skills and strengths each participating organization possesses that will contribute to improving community health and advancing MAPP goals?
- Who is currently involved in the MAPP process? Who else needs to be involved?[1]

Each county developed and administered a survey and/or convened focus groups as part of its CPA. Details of the survey development and distribution and focus group administration for each county are noted in the specific county section of this CHA. Responses were then organized qualitatively and quantitatively in an effort to identify strengths, weaknesses, opportunities, and threats as identified by respondents.

Community Status Assessment (CSA)

The CSA provides quantitative information about the community, such as population characteristics, health conditions, and disparities. Its purpose is to help communities understand inequities that go beyond individual behaviors or health outcomes, including how these issues connect to social determinants of health and broader systems of power and privilege. Ultimately, the CSA is a community-centered effort intended to capture and convey the community's narrative. The CSA is intended to address the following questions:

- What does the status of the community look like, including key health, socioeconomic, environmental, and quality-of-life outcomes?
- What populations are experiencing inequities across health, socioeconomic, environmental, and quality-of-life outcomes?
- How do systems influence outcomes?[2]

[1] NACCHO Community Partner Assessment Tool, www.naccho.org
[2] NACCHO Community Status Assessment Tool, www.naccho.org

Data for each county was collected and compiled using Clear Impact performance management software. Data sources included:

- United States Census Bureau (census.gov) and the American Community Survey (5-year estimates)
- New York State Prevention Agenda Dashboard
- New York State Community Health Indicator Dashboard
- County Health Rankings
- Centers for Disease Control and Prevention (CDC)
- Behavioral Risk Factor Surveillance System
- NYSDOH Vital Records (Vital Statistics); New York State Department of Health
- New York State's Statewide Planning and Research Cooperative System (SPARCS)
- Graduation Rate Data, 4-year outcomes; New York State Education Department (NYSED)
- NYS Perinatal Data Profile; Statewide Perinatal Data System
- Healthy People 2020; US Dept of Health and Human Services
- Environmental Protection Agency (EPA) Office of Community Revitalization
- The Neighborhood Atlas | Center for Health Disparities Research
- Local area unemployment Statistics (LAUS); U.S. Bureau of Labor Statistics, Office of Employment and Unemployment Statistics
- Evalumetrics Youth Survey (EYS) Reports
- Wilmot Cancer Institute, Cancer in Focus State Cancer Profiles; National Vital Statistics System | SEER
- NYSIIS Performance Report; New York State Immunization Information System
- Immunization Action Plan (IAP) Baseline Reports

Community Context Assessment (CCA)

The Community Context Assessment is a qualitative and quantitative tool used to assess a community's strengths, weaknesses, assets, and challenges specific to each community. It is based on three areas: Community Strengths and Assets, Built Environment, and Forces of Change. The MAPP 2.0 Framework CCA guiding questions were developed collaboratively by participating health departments to ensure continuity in data collection and analysis. Each county had the option of adding additional questions, but all counties asked the following seven questions:

1. Which health issues have the biggest impact on you and/or your community?
2. What does our community have that helps everyone, no matter their income, background, or language, have a fair chance to be healthy and feel welcome?
3. How do the streets, buildings, and sidewalks in different parts of our community help support the health of people, especially those with low incomes, people of color, limited English speakers, people with different genders or sexual orientations, or those with disabilities?
4. Where in our community is it easier or harder to be healthy, and why?
5. What has occurred recently that may affect the health of our community?
6. What may occur in the future?

7. Based on the above – do these things affect some groups more than others?[3]

Data collected during the Community Context Assessments added residents' voices and care was taken to engage often underrepresented populations, including migrant farm workers, members of the LGBTQ community, males, and low-income individuals. Data enhanced understanding of the unique needs of each community and aided in establishing the priority areas chosen by each county.

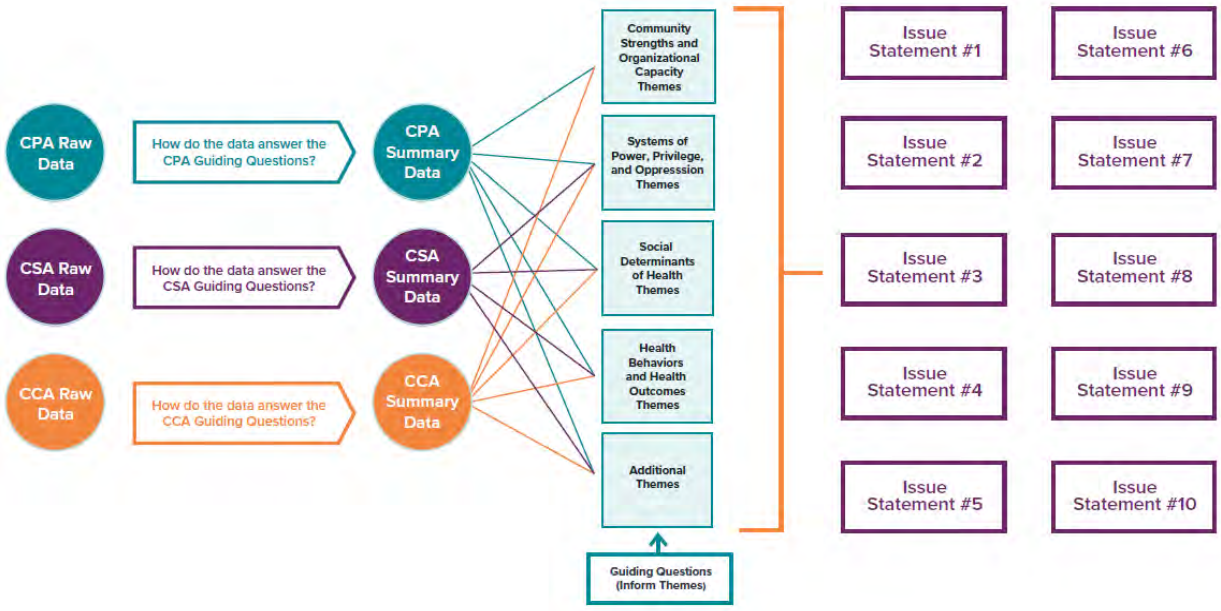
For a description of each county's activities during the CCA, see county-specific chapters in the document.

Data Triangulation

Counties collaborated with Pivital, Common Ground Health, and their county-specific partners and stakeholders to complete the CPA, CSA and CCA.

After each county completed the three assessments, Pivital triangulated the data to develop and propose cross-cutting themes for each county (Figure 4).

Figure 4 Data Triangulation Process

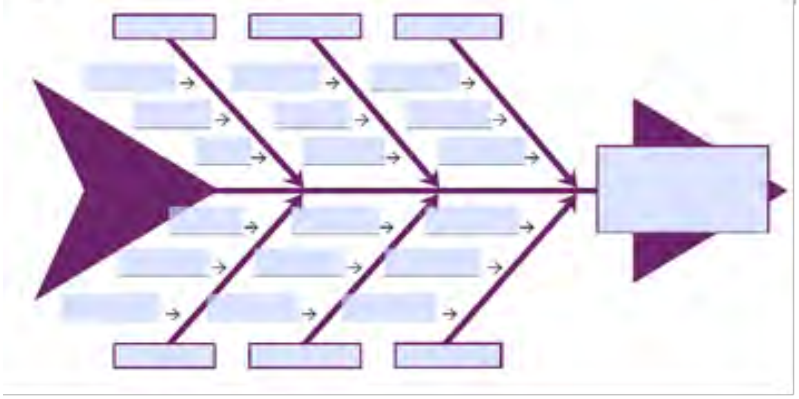


Source: NACCHO

After data was triangulated, counties used Fishbone Diagrams to examine the cause and effect of each identified community issue – Figure 5. Using the *Five Whys* - identifying an issue and asking "why" at least five times to get to the root cause - counties were able to narrow the list of priorities and identify upstream root causes on which to focus. Each county then reviewed findings with their

[3] NACCHO Community Context Assessment Tool, www.naccho.org

Figure 5: Fishbone Diagram



Source: NACCHO

stakeholders and community partners and conducted a Health Assessment Prioritization using a prioritization matrix to rank each theme based on five criteria:

1. Relevance of the issue to community members.
2. Magnitude/severity of the issue.
3. Impact of the issue on communities impacted by inequities.
4. Availability and feasibility of solutions and strategies to address the issue.
5. Availability of resources (time, funding, staffing, equipment) to address the issue.

Each county then identified at least three Prevention Agenda Priorities to address in its CHIP.

Phase 3: Continuously Improve the Community

This phase focuses on using assessment findings and selected priorities to develop, implement, and monitor a Community Health Improvement Plan (CHIP). This phase emphasizes ongoing collaboration, use of evidence-based strategies, and continuous quality improvement to advance health equity and strengthen community conditions over time. After the selection of focused Prevention Agenda priorities to be included in the CHIP, local health departments and community partners will identify evidence-based and promising practices that address the root causes and key drivers of each priority area. Local county committees will then select strategies that are realistic and feasible for implementation, taking into account local capacity, existing and potential partners, and available resources. Following the selection of strategies, partners will identify clear performance measures and selected Prevention Agenda objectives to monitor implementation, track progress, and assess impact over time, supporting a continuous quality improvement approach to community health.

Partner Engagement

Community partners played a key role throughout the CHA and during the development of the CHIP. Each partner completed the Community Partner Assessment (CPA), providing valuable organizational data and insights. They also helped identify and engage community members and organizations for focus groups as part of the Community Context Assessment (CCA), ensuring diverse perspectives were included.

Throughout the process, each county's stakeholders and partners participated in regular meetings where findings from all three assessments were presented. These sessions encouraged questions, feedback, and shared interpretation of the data. These work groups collaboratively reviewed and discussed the triangulated results, allowing partners to validate findings and contribute to identifying key themes.

Finally, partners participated in the prioritization process, ensuring that shared priorities reflected both data and community voice.

Regional Access to Care Report

In addition to the MAPP 2.0 Framework process, Pivital Public Health Partnership, in collaboration with the eight local health departments, administered the Access to Care Survey[4] between July and November 2024 to obtain primary, population-based data on access and barriers to care across the region. The survey, offered in multiple formats and languages, included questions on having a usual source of care, use of routine and preventive services, delays in care due to cost or transportation, experiences with behavioral health care, insurance status, and key demographic characteristics, and yielded more than 1,700 completed responses from residents of the eight counties.

Survey data were cleaned, weighted to reflect the regional population using Census-based distributions, and analyzed using descriptive statistics to characterize access indicators and chi-square tests and logistic regression models to examine differences and disparities by factors such as race, insurance type, geography, and Plain Community status. Findings from this analysis were integrated with MAPP 2.0 assessments and qualitative input from focus groups to identify populations facing the greatest barriers, and were used to inform health issue prioritization.

Key findings from the Survey showed that people in the eight counties still face problems when trying to get health care:

- *Not enough providers*: It is difficult for many people to find a doctor, dentist or mental health provider, especially in rural areas.
- *Transportation issues*: Many people do not have reliable ways to get to appointments, especially if they do not own a car or if they live far away from care.
- *Insurance problems*: People without insurance and those who have Medicaid often have a harder time getting care. They may have to wait longer or travel farther.
- *Unequal access*: Non-White, rural and Plain community (Amish/Mennonite) members face compounded barriers, with reduced routine/preventive care and higher rates of appointment access challenges.
- *Community strength*: People also shared many positive things, like strong local groups, caring volunteers, helpful nonprofit organizations, and local hospitals.

The report also identified emerging issues within the Finger Lakes region:

- *Health care workforce shortages*: Behavioral health, in particular, along with other health care workers are in demand. Rural communities have a difficult time attracting talent because of aging infrastructure and rate of pay.
- *Telehealth expansion*: While telehealth may be expanding in many areas of the country, limited broadband access makes its dissemination problematic in rural areas.
- *Insurance policy changes*: Impending cuts to Medicaid may impact access to care and increase out-of-pocket costs.

[4] Source: Access to Care in the Finger Lakes Region, Collaborative Assessment Report, 2025 https://pivitalphp.org/reports/access-to-care/

- *Supplemental Nutrition Assistance Program (SNAP):* Expected changes to eligibility may mean residents are forced to choose between food and medical care, including prescriptions.
- *Integration of care*: New models of care are being piloted in many areas but face funding and coordination challenges in the Finger Lakes region.
- *Equity gaps*: Mortality rates among minority populations are higher than other groups. Additionally, higher Medicaid-dependence is linked with higher food insecurity issues which impact overall health.
- *Innovative care models*: Social Care Networks and Urgent Care expansion will help to alleviate some rural health concerns and issues.

Comprehensive Regional Community Health Assessment

Demographics

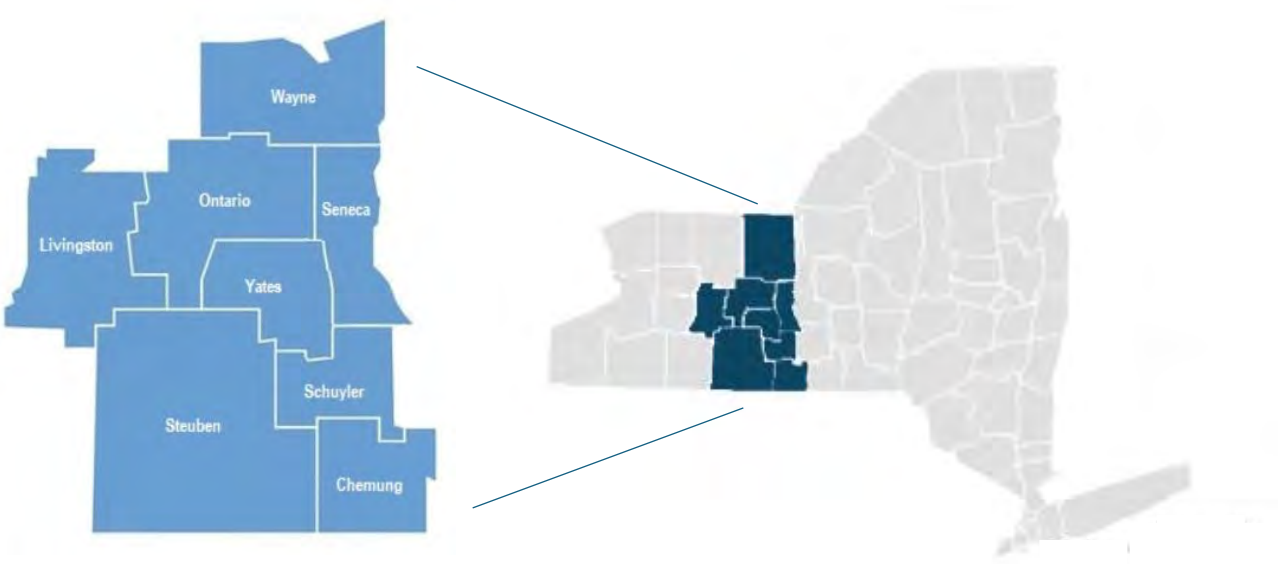
Community Description: The Finger Lakes Region

The Finger Lakes get their name from the series of 11 lakes in central and western New York that resemble the fingers on a hand. Native American lore explains that the lakes were formed when the Great Spirit laid his hand down on the region. The lakes were formed as an impression of his hand blessing the landscape.[5] Scientifically speaking, the lakes were formed by receding glaciers over two million years ago.[6] The area now serves as an idyllic recreational spot with abundant outdoor activities, award-winning wineries, historic and quaint towns, and vast agricultural farmland. While smaller urban areas do exist within the counties, this mostly rural region of New York State shares the health-related issues and illnesses of many rural areas in New York and the United States.

Though the Finger Lakes Region encompasses a larger swath of the state, the eight Finger Lakes counties represented in this Community Health Assessment, include: Chemung, Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne, and Yates. (Map 1)

[5] Source: FingerLakesTravelNY.com: History of the Finger Lakes
[6] "*Ithaca is Gorges: A Guide to the Geology of the Ithaca Area, Fourth Edition*" by Warren D. Allmon and Robert M. Ross, published in 2007 by the Paleontological Research Institution

Map 1: The Finger Lakes Region of New York State

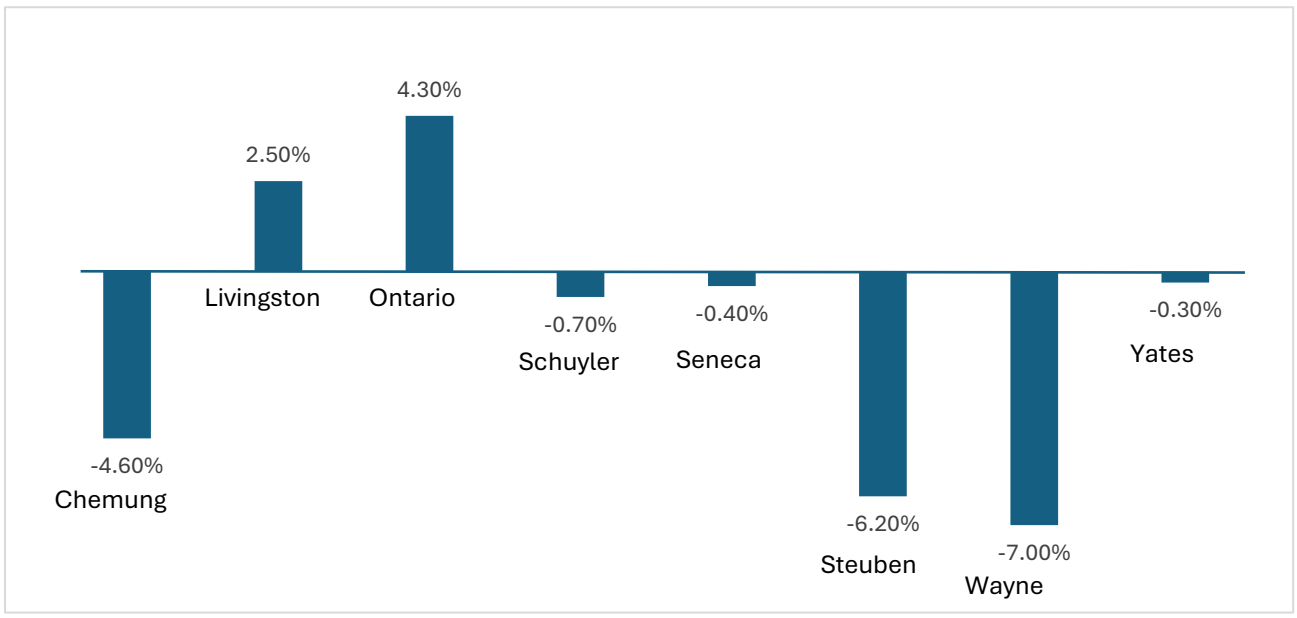


Population Estimates

Overall Population Estimates

There are 515,563 people living in the 8-county Finger Lakes Region. Estimates projecting into the year 2040 demonstrate a slight decrease in the population for most counties, with the exceptions of Livingston and Ontario. Stratified by county, see Figure 6, are the projected population differences

Figure 6: Percent Change in Population from 2020- 2040



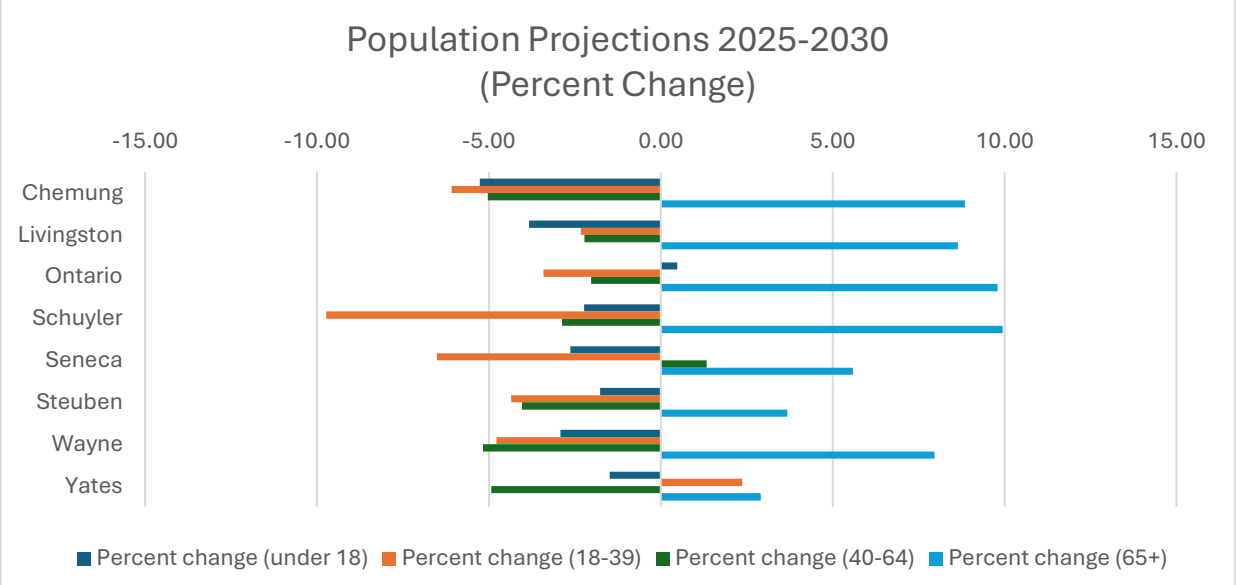
Source: County Health Rankings, Census Population Estimates, Cornell Program on Applied Demographics

over the next 20 years. Some of the largest changes are expected in Chemung, Steuben and Wayne Counties.

Age Group Projections

Over the next five years (2025–2030), the population of residents aged 65 and older is projected to increase in all Finger Lakes counties, while younger age groups (under 18, 18–39, and 40–64) are expected to decline in most counties. Exceptions include: Ontario County, which is projected to see a slight increase in the under-18 population; Seneca County, which is expected to gain residents aged 40–64; and Yates County, which is projected to experience growth in the 18–39 age group. The overall growth in the older adult population will likely increase demand for geriatric care and chronic disease management across the region. Figure 7 illustrates the projected percent change in each age group by county.

Figure 7: Population Projections by Age Group, Finger Lakes Region

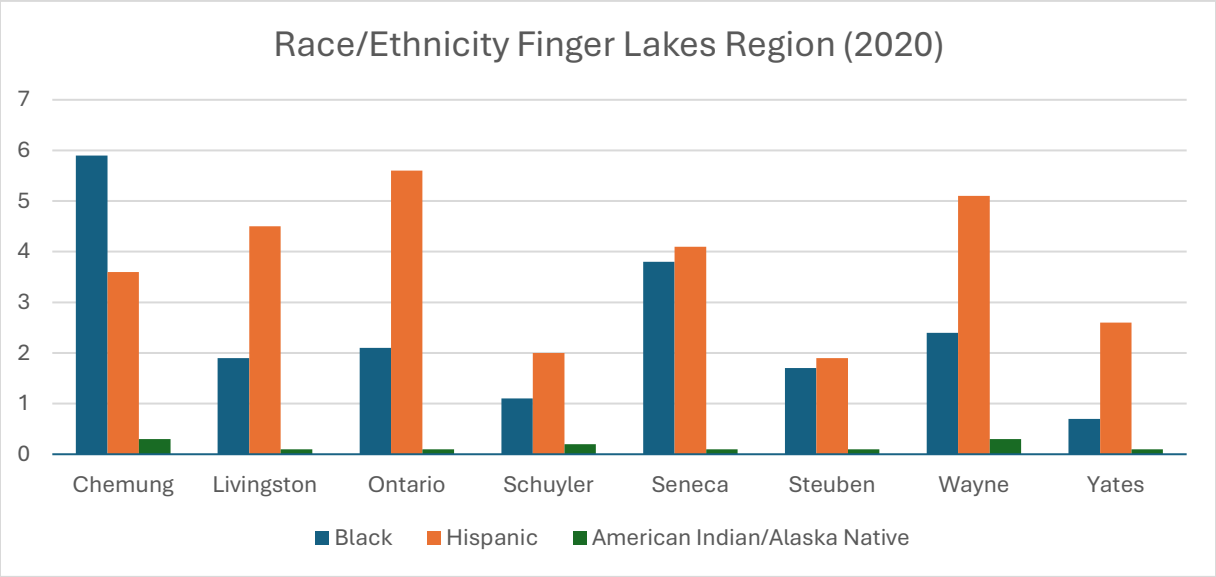


Source: Cornell University Program on Applied Demographics, 2025-2030

Race/Ethnicity

More than 90% of the Finger Lakes Region population is White/Non-Hispanic. Chemung County has the largest non-white population with 5.9% Black, 3.6 % Hispanic, 0.3% American Indian/Alaska Native. (Figure 8)

Figure 8: Race/Ethnicity Finger Lakes Region



Source: An Ecosystem of Minority Health and Health Disparities Resources. National Institute on Minority Health and Health Disparities

Migrant Farm Workers

The 2022 Census of Agriculture reported that there were 22,000 workers on farms in the Finger Lakes region. Just less than one quarter (5,340) were unpaid and probably represented family members or co-op workers. The vast majority (16,600) were paid workers, but not necessarily in full-time or permanent positions. Wayne County had the highest number of migrant workers (3,034) of the eight counties.

Almost 25% of the region's farms contracted with migrant farm workers. Because migrant farm workers move from job to job depending on the season, a single migrant worker may be counted by multiple farms, therefore the total number of migrant workers is potentially an over count of individuals (Table 3).

Table 3: Farms and Farm Workers in the Finger Lakes Region

County	Number of Farms with Hired Workers (2022)	Number of Farms with Migrant Workers (2022)	Hired Farm Labor*		Number of Migrant Workers** (2022)	Number of Unpaid Workers*** (2022)
			Total Workers (2022)	Number of Workers Who Worked <150 days (2022)		
Chemung	48	2	171	90	(D)^	381
Livingston	142	16	998	354	68	477
Ontario	229	32	1,547	718	307	801
Schuyler	108	25	943	547	119	333
Seneca	146	39	1,653	1,212	493	429
Steuben	297	21	1,344	690	66	1,370
Wayne	259	141	3,902	2,590	3,034	677
Yates	250	80	1,625	1,111	390	872
Total Finger Lakes Region	**1,479**	**356**	**12,183**	**7,312**	**4,477**	**5,340**

*Hired farm labor does not include contract/migrant workers.
**Migrant farm workers are workers whose employment requires travel that prevents the worker from returning to his or her permanent place of residence the same day.
***Unpaid workers include agricultural workers not on the payroll who performed activities or work on a farm or ranch.
^Suppressed to avoid disclosing data for individual farms.
Source: US Department of Agriculture, 2022 Census of Agriculture

Migratory and seasonal agricultural workers and their families face distinct barriers that contribute to significant health disparities. Factors such as hazardous working conditions, poverty, inadequate housing, limited clean water, lack of insurance, language and cultural barriers, and fear and mistrust related to immigration status all limit access to consistent, quality care. These challenges increase the risk of serious health issues including diabetes, malnutrition, depression, substance use, infectious diseases, pesticide exposure, and work-related injuries. Migration further heightens these problems by creating isolation and disrupting continuity of care, making it harder to maintain treatment and health records.[7]

A healthy migrant community is essential to the farming industry in the eight-county region and therefore essential to the livelihood of farmers and the economy of the region. Without them, fields may go unplanted, fruit unpicked, and crops unharvested.

Amish/Mennonite

The Plain Community - Amish and Mennonite - is an important part of the Finger Lakes region, contributing substantially to the agricultural sector in many areas. Obtaining reliable, current information about their population size and health outcomes is difficult, particularly at the county

[7] Source: Rural Health Information Hub, 2025: https://www.ruralhealthinfo.org/topics/migrant-health

level, because these groups typically do not participate in surveys like those run by the U.S. Census Bureau.

Elizabethtown College's Young Center for Amish Studies provides annual population estimates that help fill this gap. According to their data, New York State has 60 Amish settlements and 188 districts, totaling roughly 25,220 individuals.[8] Within the Finger Lakes, specifically Livingston, Seneca, Steuben, and Wayne Counties, there are 16 districts with an estimated 3,770 Amish residents.[9] These numbers do not include Mennonite populations. The Young Center also compiles information on various Mennonite groups, often organized by church conference. In New York, the Groffdale Conference Mennonites are estimated at 3,856 people, the Midwest Mennonite Conference at 971, and the Stauffer Mennonite Conference at around 476.[10]

When reviewing data or planning public health efforts, it is important to account for Amish and Mennonite cultural practices. Decision-making about health care is typically influenced by church leaders' guidance. Many families rely on natural or homeopathic health approaches, which can delay lifesaving medical care and affect decisions about family planning, preventive care, dental care, and vaccinations. Home births and delayed prenatal care are relatively common as is breast feeding. Children generally attend school through eighth grade before focusing on farming or learning a trade, increasing exposure to potential injuries. Travel by bicycle or horse-drawn buggy also creates traffic-safety concerns on rural roads shared with faster-moving motor vehicles.

These cultural factors combined with expected population growth are important considerations for public health professionals in the region. Research suggests that when health information is offered by trusted sources and services are easily accessible, Plain families are often receptive to interventions, including certain immunizations. Building cultural understanding and maintaining flexible, consistent outreach can support strong participation in recommended health practices.[11]

American Indian and Alaska Native Population

In 2022, 1,408 residents of the Finger Lakes region identified themselves as American Indian and Alaska Native alone. However, it is important to note that this estimate does not include residents who identify as multiple races.[12]

The Centers for Disease Control and Prevention noted that as of 2023, the average life expectancy for American Indians and Alaska Natives is the lowest of all ethnic groups. American Indians and

[8] "Amish Population Profile, 2025." Young Center for Anabaptist and Pietist Studies, Elizabethtown College. https://groups.etown.edu/amishstudies/statistics/amish-population-profile-2025.
[9] Statistics compiled by Edsel Burdge Jr., Young Center for Anabaptist and Pietist Studies, Elizabethtown College, in cooperation with Joseph F. Donnermeyer, School of Environment and Natural Resources, The Ohio State University, and with assistance from Adam Hershberger, Ohio Amish Library, Millersburg, Ohio.
[10] Compiled from the most recent directories by Edsel Burdge Jr., Young Center for Anabaptist and Pietist Studies, Elizabethtown College, 1 Alpha Drive, Elizabethtown, PA 17022 Updated October 2025
[11] Baillie, K. U. (2018, July 13). *With free vaccinations, ChildProtect program helps Amish communities stay healthy*. *Penn Today*. University of Pennsylvania. https://penntoday.upenn.edu/news/free-vaccinations-childprotect-program-helps-amish-communities-stay-healthy
[12] Source: U.S. Census Bureau Population Estimates Program. Methodology for the United States population estimates: Vintage 2022. 2022. https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2020-2022/methods-statement-v2022.pdf

Alaska Natives can expect to live to 70.1 years as compared with the national estimate of 78.4 years. Further, they also report being in fair or poor health more often than all other racial groups (24.4%). The leading causes of death in this group are heart disease, cancer, unintentional injuries, chronic liver disease, and diabetes.[13]

These disparities exist for a number of reasons but largely correlate back to inadequate educational opportunities, disproportionate rates of poverty, discrimination in the delivery of health services, and the impact of historical intergenerational trauma including centuries of racial discrimination.[14]

Foreign Born Population

The majority of those who are foreign-born living in the Finger Lakes region have become naturalized US Citizens. The naturalization rate varies by county, from as low as 35 percent in Wayne County to 77.9 percent in Yates County (Table 4). Residents coming from other countries may face significant challenges in adapting to the United States' disease prevention and treatment culture and, as such, should be cared for and tended to in a way that is respectful of and collaborative with the customs and beliefs of their heritage.

Table 4: Foreign Born and Citizenship

County	Percent of Population that is Foreign-born (2020)	Percent Naturalized U.S. Citizen (2020)	Percent Not a U.S. Citizen (2020)
Chemung	3.6	58.0	42.0
Livingston	3.5	51.5	48.5
Ontario	5.0	55.8	44.2
Schuyler	1.9	51.8	48.2
Seneca	2.9	54.4	45.6
Steuben	3.3	38.4	61.6
Wayne	5.0	35.0	65.0
Yates	1.6	77.9	22.1

Source: U.S. Census Bureau, 2020 Census.

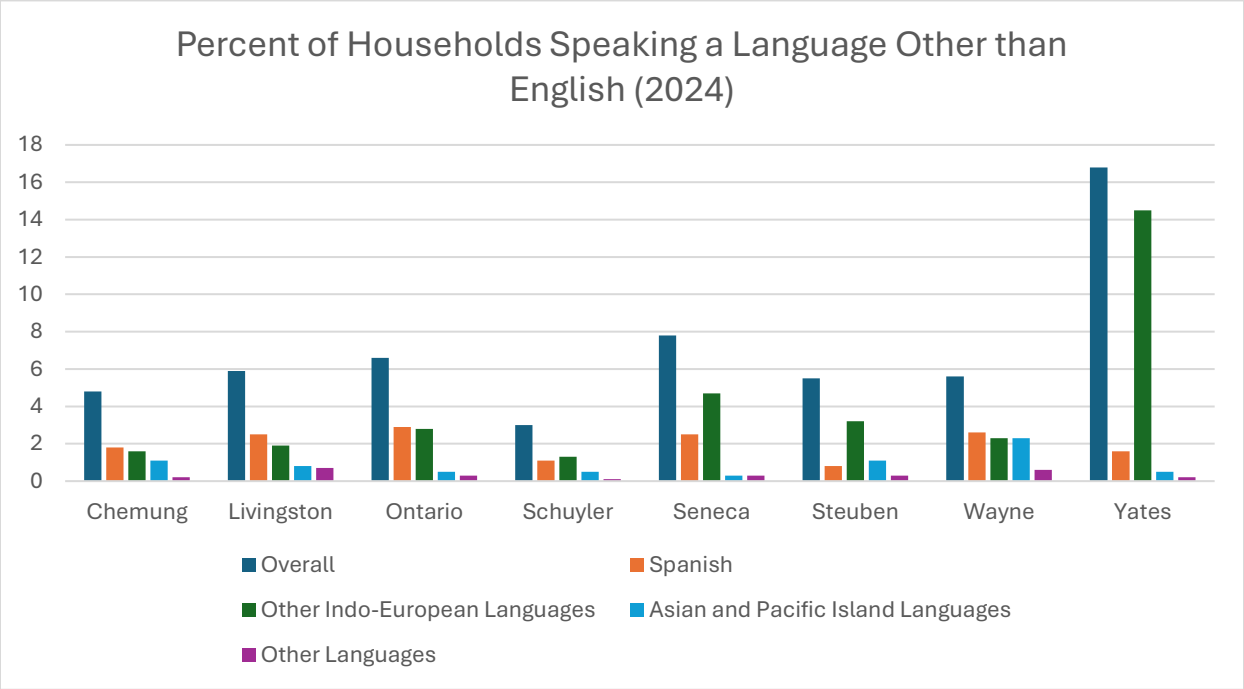
Public health professionals must keep cultural and linguistic differences in mind when collecting and exhibiting data, developing and providing programming, and evaluating the effectiveness of interventions. Demonstrating respect for an individual's national and cultural background fosters trust and strengthens the practitioner–client relationship. Cultural responsiveness enhances the quality of care, supports better health outcomes, and reduces disparities.

[13] Source: CDC, https://minorityhealth.hhs.gov/american-indian-and-alaska-native-health
[14] US Commission on Civil Rights, Broken Promises: Continuing Federal Funding Shortfall for Native Americans, 2018

Household Languages

While most people in the Finger Lakes region primarily use English, a smaller portion of the population speaks other languages at home. These include Spanish, various Asian and Pacific Island languages, and a range of other Indo-European languages (Figure 9). In Yates County, the notable share of Indo-European language speakers is likely influenced by the presence of Amish and Mennonite communities in which some families speak German dialects in the home. Small counties may have no bilingual staff members and few options for obtaining interpreters.

Figure 9: Percent of Households Speaking a Language Other than English



Source: U.S. Census Bureau, 2024 ACS 1or 5-year estimates

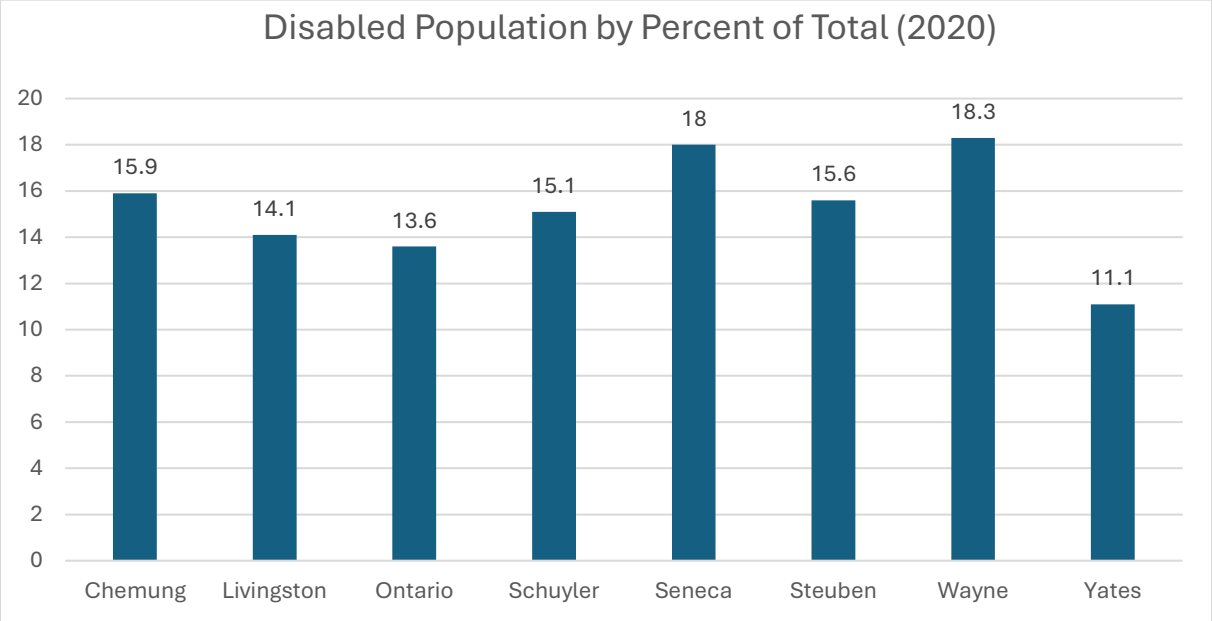
Disability

People with disabilities face a higher likelihood of developing chronic health issues such as obesity, heart disease, and diabetes. Reducing health disparities among this population involves fostering a community culture that supports inclusion and creating welcoming physical spaces free of conditions that might prohibit participation in healthy behaviors. Achieving this requires coordinated efforts across multiple disciplines, including policy, systems, and environments.

Figure 10 shows the disability rate for each county in the Finger Lakes region. The most common disabilities in the region are cognitive, ambulatory and independent living.[15]

[15] Source: U.S. Census Bureau, 2020 Census

Figure 10: Disability Rate by County

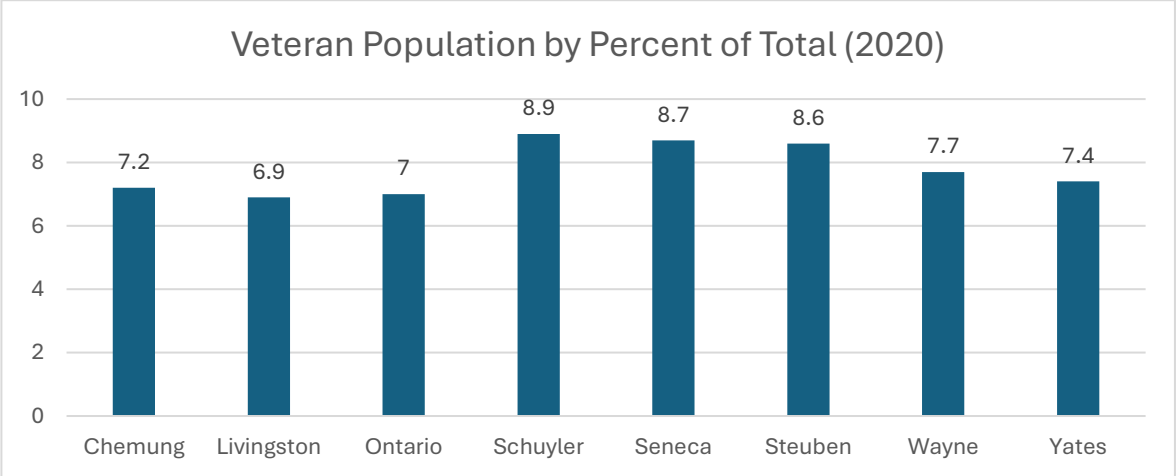


Source: U.S. Census Bureau, 2020 Census

Veterans

The population of veterans in the eight counties of the Finger Lakes is higher than the NYS average of 3.5 percent. Veterans certainly have the same health care needs as others in the community, however, they may also require additional health care services related to mental health, physical health and issues related to environmental exposure during service.[16] Figure 11 details the percentage of veterans in each county.

Figure 11: Veteran Population by Percent of Total Population



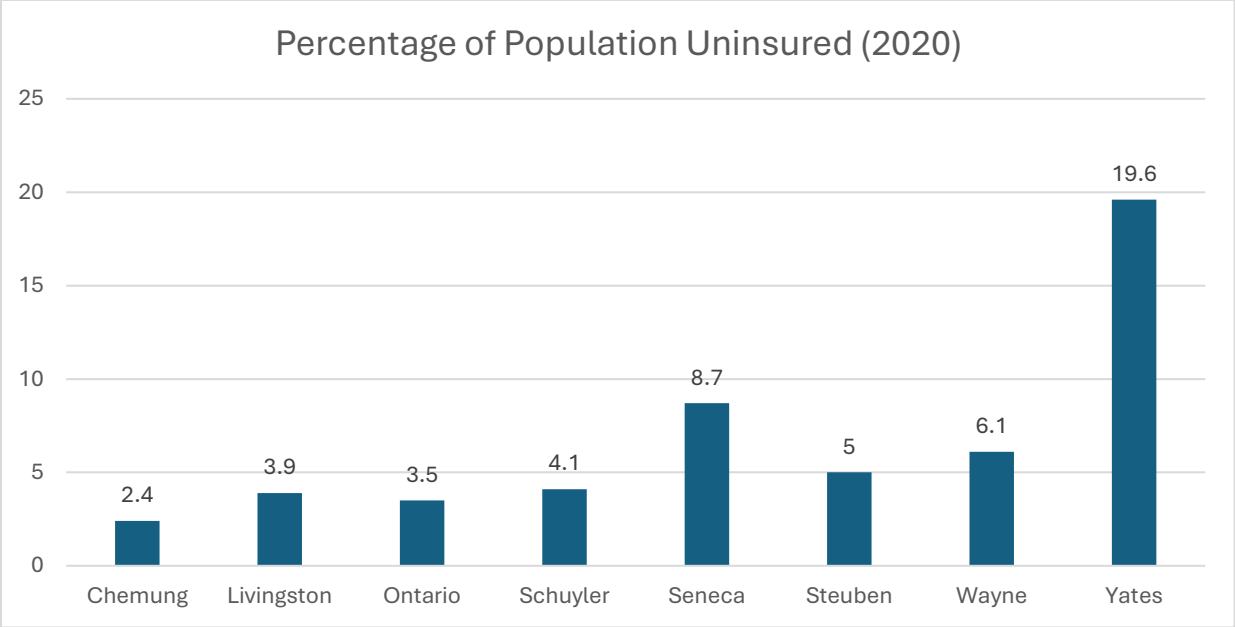
Source: U.S. Census, 2020 Census

[16] Source: Veterans Affairs, https://www.va.gov/health-care/health-needs-conditions/

Health Insurance Status

Health insurance plays an important role in ensuring people can obtain necessary medical services. Like individuals with limited financial resources, those without insurance are less likely to seek routine or preventive care, often lack a consistent healthcare provider, and may rely more heavily on emergency departments for issues that could be managed in primary care. Figure 12 illustrates the share of residents in each county who are uninsured. The notably higher uninsured rate in Yates County is likely influenced by the sizable Amish and Mennonite communities living there.

Figure 12: Health Insurance Status



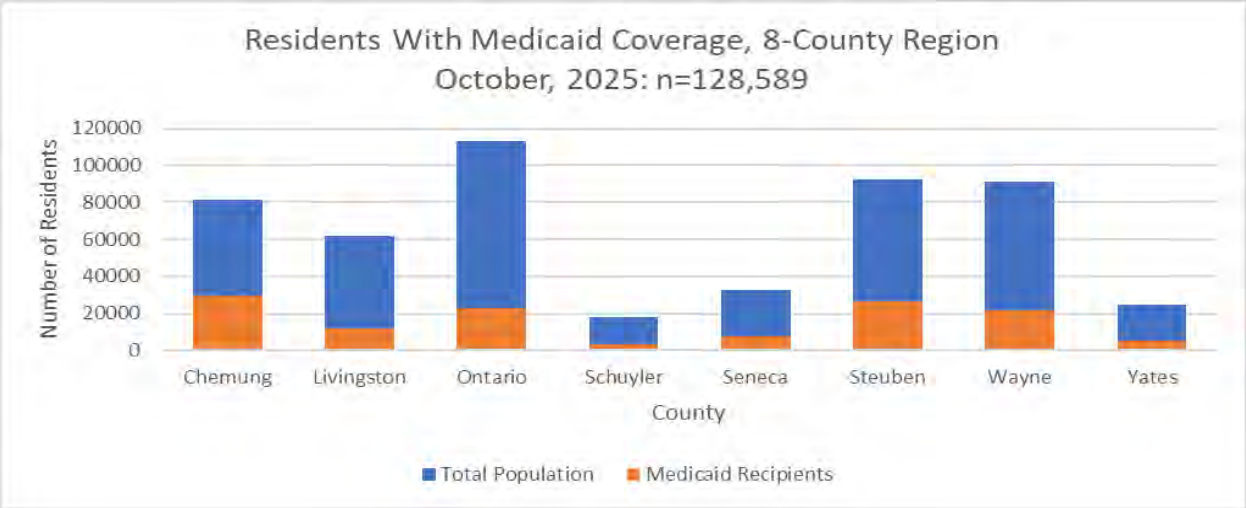
Source: U.S. Census Bureau, 2020 Census

In October of 2025, in New York, 6,812,160 residents were enrolled in Medicaid.[17] Of these, 128,589 are residents of the eight county Finger Lakes Region. According to the NY State of Health, an estimated 1-1.5 million New Yorkers may lose Medicaid coverage in 2026 due to new federal requirements.[18] Using this projection, between 18,774 and 28,290 Finger Lakes residents may lose coverage. Figure 13 highlights the number of residents with Medicaid coverage versus the overall population in each county.

[17]Source: Medicaid Enrollment Databook, October 2025 at https://www.health.ny.gov/health_care/medicaid/enrollment/docs/by_resident_co/current_month.htm

[18] Source: https://info.nystateofhealth.ny.gov/stay-connected

Figure 13: Residents with Medicaid Coverage

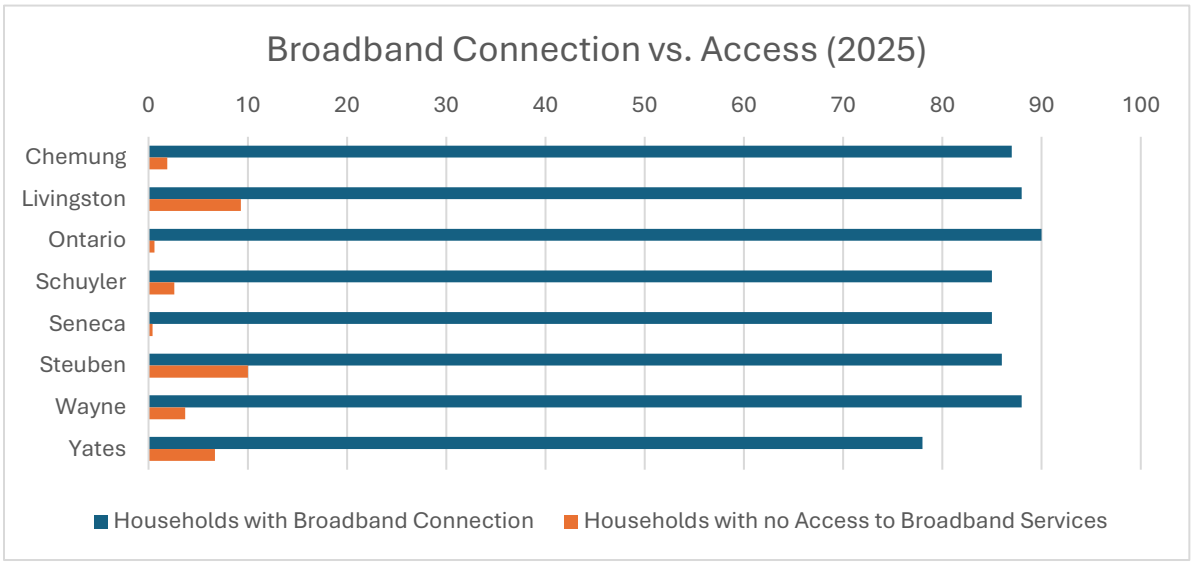


Source: Source: Medicaid Enrollment Databook

Broadband Access

Access to broadband services is considered a necessity. The Covid-19 pandemic elevated the need for broadband access to a new level with remote work and learning and accessible healthcare options. New York State as a whole has extensive broadband access (90%), but not every part of the state has the same access. Figure 14 notes the percentage of households with a broadband connection versus the percentage in the county who have no access to broadband services, meaning broadband service is not available to them to purchase or access.

Figure 14: Broadband Connection vs Broadband Access in each County



Source: Office of the State Comptroller, ACS, County Health Rankings

Transportation

Rural residents lack equitable access to transportation. Low population density often makes public transportation implausible. Access to a personal vehicle can affect an individual's health and wellness in many ways. Unreliable, inconsistent or inconvenient transportation can cause a strain on the ability to access health care services, purchase food and other items, and maintain a job. These can-result in, poor health outcomes, and decreased economic stability.

Figure 15 shows the proportion of households in each Finger Lakes county that do not have access to a vehicle. Yates County's higher percentage is largely due to the Amish and Mennonite communities, who typically use horse-and-buggy travel rather than motor vehicles. This is particularly evident in Map 2.

Map 2: Households without a Vehicle by Zip Code

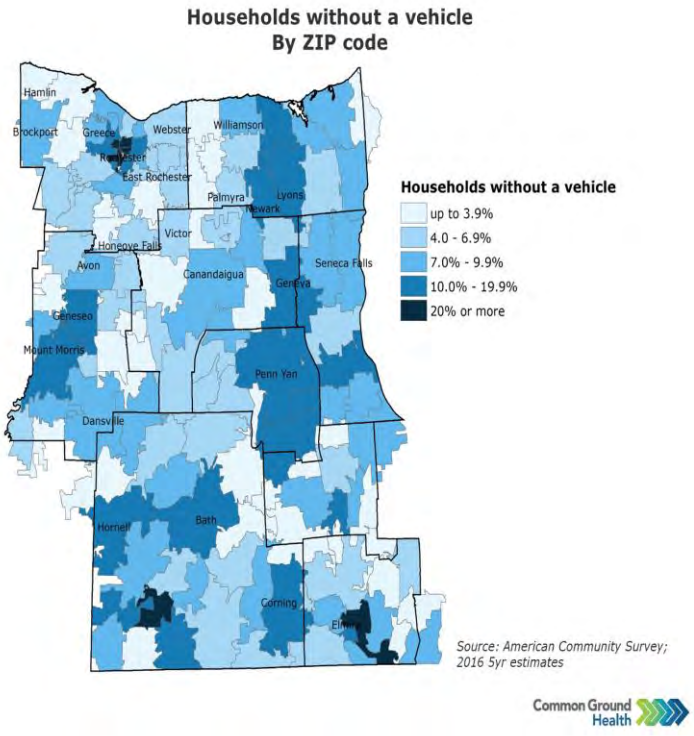
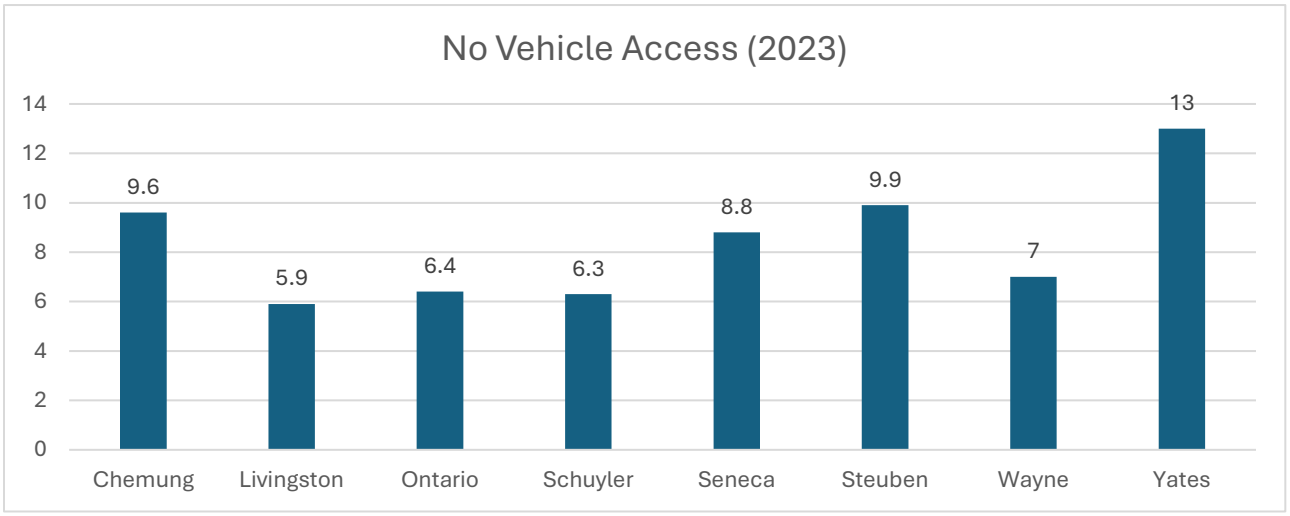


Figure 15: Percent of Households with No Vehicle Access



Source: U.S. Census Bureau 2023 5-year estimates

Life Expectancy

Genetics are not the only indicator of an individual's life expectancy. Social determinants of health impact life expectancy. Table 5 notes the life expectancy in each county in the Finger Lakes region along with the percent change from 2018. Life expectancy is decreasing in most counties and is below the New York State average.

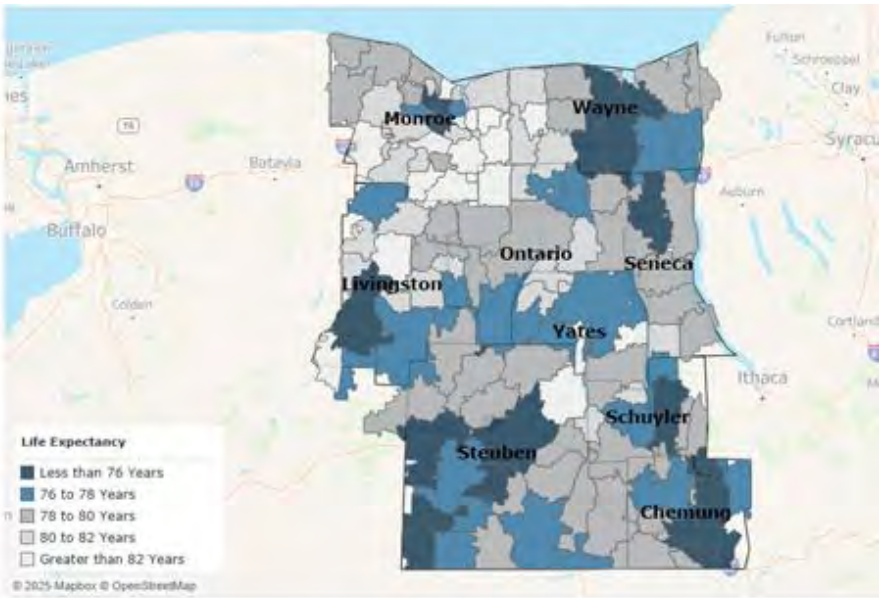
Table 5: Life Expectancy

County	Life Expectancy (2022) (NYS: 79.4)	Percent Change from Baseline (2018)
Chemung	75.0	-3%
Livingston	79.4	-1%
Ontario	79.8	No change
Schuyler	76.5	-2%
Seneca	77.6	No change
Steuben	76.3	-3%
Wayne	77.2	-2%
Yates	78.1	No change

Source: County Health Rankings, National Center for Health Statistics-Mortality Files

In addition, Map 3 further delineates life expectancy by Zip Code. Lower life expectancy by zip code corresponds with increased poverty rates (Maps 6-8), higher preventable hospitalizations (Map 13) and higher Emergency Department visits (Maps 14-18).

Map 3 Life Expectancy by Zip Code, Finger Lakes Region



Source: NYS Vital Statistics; US Census Bureau County Population Estimates and Claritas ZIP Level Estimates; Years 2018-2022 Analysis and Calculations by Common Ground Health (YPLL/Death Rate per 100k population and Life Expectancy)

Courtesy Common Ground Health

Leading Causes of Death

The top causes of death in the counties of the Finger Lakes region may be seen in Table 6 along with the number of deaths per 100,000 population. The top two leading causes of death in all eight counties are heart disease and cancer. All counties except Ontario have a higher death rate per 100,000 population than the New York State average.

The rates shown for Alzheimer's in this table reflect a combined category of "Alzheimer's disease and other dementias" that was age–sex adjusted using local population estimates, whereas the

state Vital Statistics tables report age adjusted rates for “Alzheimer’s disease” alone. As a result, counts for Alzheimer’s disease align with state data, but the inclusion of other dementias and the different adjustment method produce higher overall rates and allow this combined category to appear among the leading causes of death in several counties while still following a trend similar to the state’s Alzheimer's only rates.

Across the region, the most commonly diagnosed cancers reflect patterns seen statewide, with female breast, prostate, and lung cancers appearing most frequently in many counties, alongside colorectal cancer in some areas. These cancers represent a substantial share of the overall cancer burden even when they are not always the leading causes of cancer death, underscoring the importance of continued emphasis on screening, early detection, and treatment.

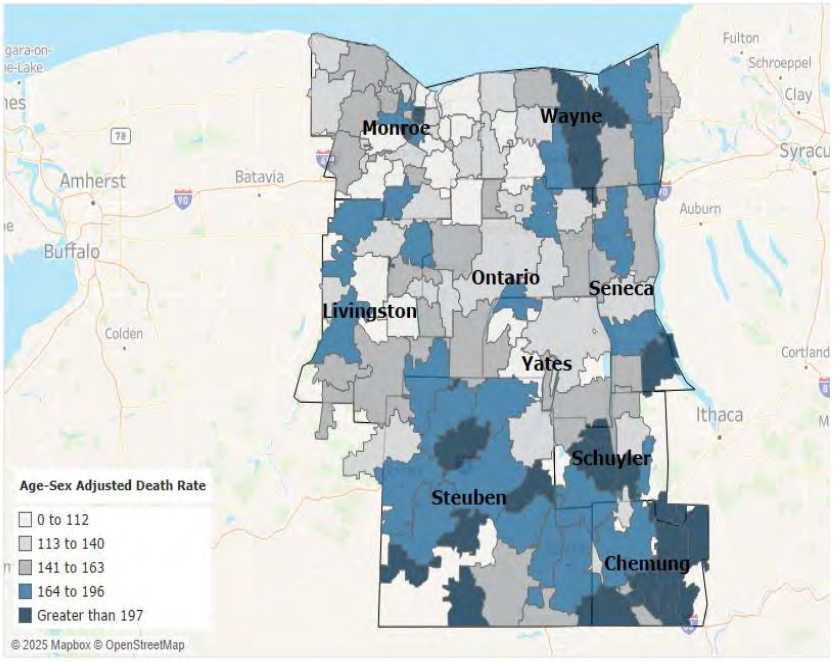
Table 6: Leading Causes of Death 2022

County	First Cause	Second Cause	Third Cause	Death Rate/100,000 (NYS: 744.2/100,000)
Chemung	*Heart Disease* 235.6/100,000	*Cancer* 184.7/100,000	*Alzheimer's and Other Dementias* 87.0 /100,000	1,014
Livingston	*Cancer* 145.1/100,000	*Heart Disease* 122.1/100,000	*Alzheimer's and Other Dementias* 73.1/100,000	763.1
Ontario	*Heart Disease* 141.8/100,000	*Cancer* 128.9/100,000	*Alzheimer's and Other Dementias* 69.8/100,000	716.9
Schuyler	*Cancer* 221.5/100,000	*Heart Disease* 210.8/100,000	*Diabetes* 63.6/100,000	974.3
Seneca	*Heart Disease* 167.6/100,000	*Cancer* 155.8/100,000	*Alzheimer's and Other Dementias* 87.8 /100,000	812.9
Steuben	*Heart Disease* 204.7/100,000	*Cancer* 187.8/100,000	*Alzheimer's and Other Dementias* 71.5/100,000	944.8
Wayne	*Cancer* 151.5/100,000	*Heart Disease* 170.4/100,000	*Alzheimer's and Other Dementias* 78.3/100,000	828.0
Yates	*Cancer* 143.3/100,000	*Heart Disease* 142.6/100,000	*Alzheimer's and Other Dementias* 88.4/100,000	839.3

Source: New York State Department of Health Vital Statistics, 2022

Map 4 highlights the age-adjusted death rate for heart disease per 100,000 population and Map 5 details the age-adjusted death rate for cancer per 100,000 population in each of the counties of the Finger Lakes. Note that the highest death rates for both cancer and heart disease in both maps coincide with the highest poverty rates (Maps 6-8), and lowest life expectancy of the counties. It also coincides with higher preventable hospitalizations (Map 13) and higher Emergency Department visits (Maps 14-18).

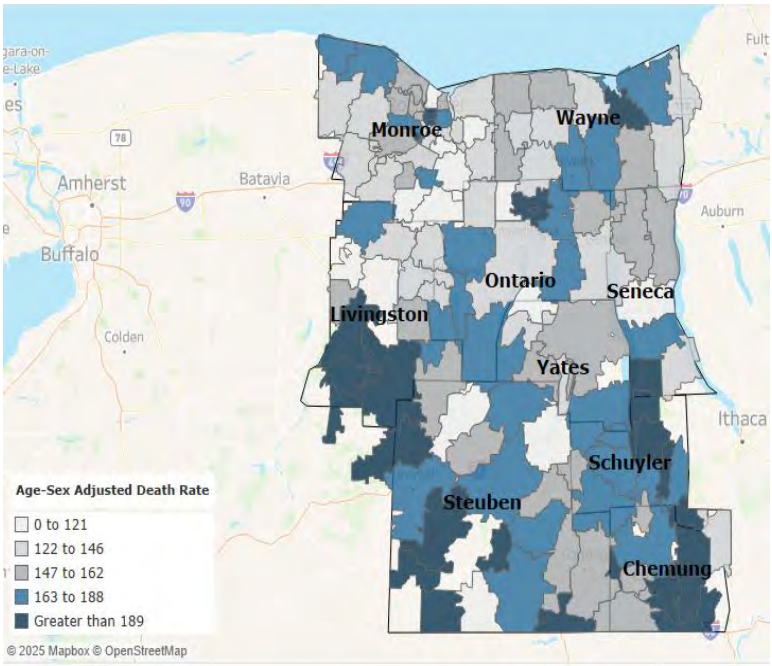
Map 4: Age-Adjusted Death Rate for Heart Disease Rate per 100,000



Courtesy: Common Ground Health

Source: NYS Vital Statistics; US Census Bureau County Population Estimates and Claritas ZIP Level Estimates; Years 2018-2022 Analysis and Calculations by Common Ground Health (YPLL/Death Rate per 100k population and Life Expectancy)

Map 5: Age-adjusted Death Rate for Cancer Rate per 100,000



Courtesy: Common Ground Health

Source: NYS Vital Statistics; US Census Bureau County Population Estimates and Claritas ZIP Level Estimates; Years Analysis and Calculations by Common Ground Health (YPLL/Death Rate per 100k population and Life Expectancy)

Leading Causes of Premature Death

The top causes of premature death in the counties of the Finger Lakes region may be seen in Table 7 with the number of deaths per 100,000 population. Consistent across all eight counties, the top three causes of premature death (before age 75) are cancer, heart disease and unintentional injury. Most counties also exceed the New York State average rate for premature death.

Unintentional injury deaths in Yates County may be due in part to its Mennonite population. There are many family-owned farms on which children assist parents with chores. Transportation by horse and buggy and bicycle further increases the risks for injuries on roadways.

Table 7: Leading Causes of Premature Death 2022

County	First Cause	Second Cause	Third Cause	Premature Death Rate (NYS: 326.8/100,000)
Chemung	*Cancer* 111.7/100,000	*Heart Disease* 88.3/100,000	*Unintentional Injury* 75.4/100,000	496.2
Livingston	*Cancer* 80.8/100,000	*Unintentional Injury* 43.6/100,000	*Heart Disease* 33.4/100,000	324.1
Ontario	*Cancer* 60.5/100,000	*Heart Disease* 60.7/100,000	*Unintentional Injury* 38.1/100,000	304.6
Schuyler	*Cancer* 123.0/100,000	*Heart Disease* 65.8/100,000	*Unintentional Injury* 62.0/100,000	420.2
Seneca	*Cancer* 91.5/100,000	*Heart Disease* 50.8/100,000	*Unintentional Injury* 36.7/100,000)	369.6
Steuben	*Cancer* 97.1/100,000	*Heart Disease* 62.6/100,000	*Unintentional Injury* 48.9/100,000	423.5
Wayne	*Cancer* 93.6/100,000	*Unintentional Injury* 58.1/100,000	*Heart Disease* 65.6/100,000	398.4
Yates	*Unintentional Injury* 63.4/100,000	*Cancer* 61.4/100,000	*Heart Disease* 46.0/100,000	334.4

Source: New York State Department of Health Vital Statistics, 2022

County Health Rankings

The University of Wisconsin Population Health Institute has created the County Health Rankings & Roadmaps, a program that works to improve health outcomes for all and to close the health disparities gap between those with the most and least opportunities for good health.[19]

As the county health rankings model has evolved, so have the measures. Table 8 demonstrates how each county in the Finger Lakes ranks compared with New York State and the nation as a whole. Two categories are referenced: Health and Well-being describes health as "more than being free from disease and pain; health is the ability to thrive. Well-being covers both quality of life and the

[19] County Health Rankings, https://www.countyhealthrankings.org/about-us

ability of people and communities to contribute to the world."[20] Community Conditions refer to the social determinants of health. Generally, the Finger Lakes region is better than or equal to New York State and the nation in terms of health and well-being and community conditions.

Table 8: County Health Rankings (2025)

County	Health and Well-being		Community Conditions	
	New York State	U.S.	New York State	U.S.
Chemung	Worse	Better	Worse	About Equal To
Livingston	Better	Better	Better	Better
Ontario	Better	Better	Better	Better
Schuyler	About Equal To	Better	Worse	About Equal To
Seneca	Better	Better	Worse	About Equal To
Steuben	About Equal To	Better	About Equal To	Better
Wayne	About Equal To	Better	About Equal To	Better
Yates	Better	Better	Worse	About Equal To

Source: County Health Rankings

Courtesy Ontario County

[20] County Health Rankings, https://www.countyhealthrankings.org/health-data

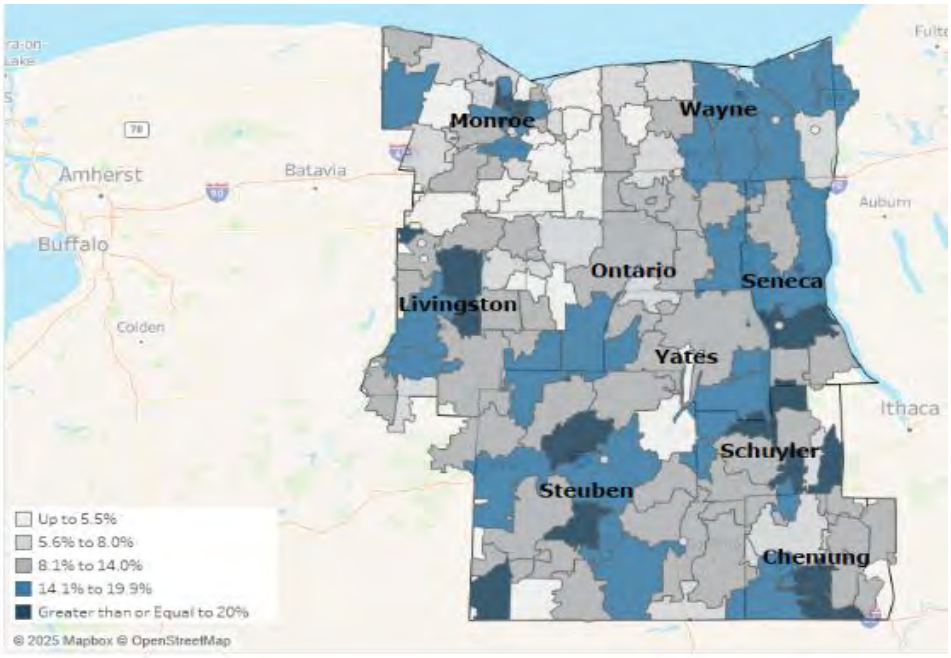
New York State 2025-2030 Prevention Agenda Domains and Priorities

This section details the New York State Prevention Agenda domains and their associated priorities by exploring region-wide data.

Economic Stability

Poverty and Unemployment

Map 6 Overall Poverty in the Finger Lakes Region



U.S. Census Bureau, 2019-2023 ACS 5-yr Estimates. Table S1701 (Poverty Status in the Past 12 Months)

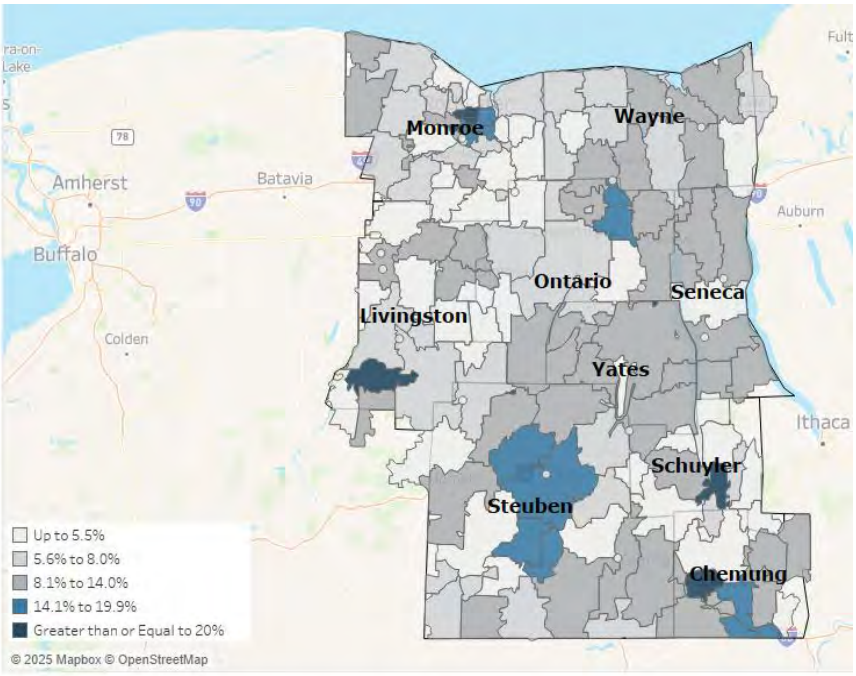
Courtesy Common Ground Health

The socio-economic status of communities greatly impacts the health outcomes of the individuals residing there. Higher rates of poverty have been linked to increased anxiety and mental illness, higher mortality rates and increased risk of chronic disease. Additionally, communities with increased rates of poverty have more limited access to necessities such as food, shelter, healthcare, education, and employment. Rural poverty is often characterized by isolation and lack of access to resources rather than overcrowded housing and crime, which are more prevalent in urban communities. Map 6 notes poverty rates by zip code in the Finger Lakes region.

The population of those 65 years of age and older is expected to increase through at least 2040. Map 7 shows the poverty rate by zip code in this age group. Older Americans living in poverty are at risk for experiencing earlier mortality, higher rates of disability, loneliness, depression and anxiety.[21] These patterns indicate that poverty is not evenly distributed, with older adults in rural and higher-deprivation ZIP codes facing disproportionate financial and health burdens, which can widen existing health inequities.

[21] Source: Thornton, M., Bowers, K., (January 31, 2024) "Poverty in Older Adulthood: A Health and Social Crisis" OJIN: The Online Journal of Issues in Nursing Vol. 29, No. 1, Manuscript 3

Map 7: Poverty rates by Zip Code for those Over 65 Years of Age



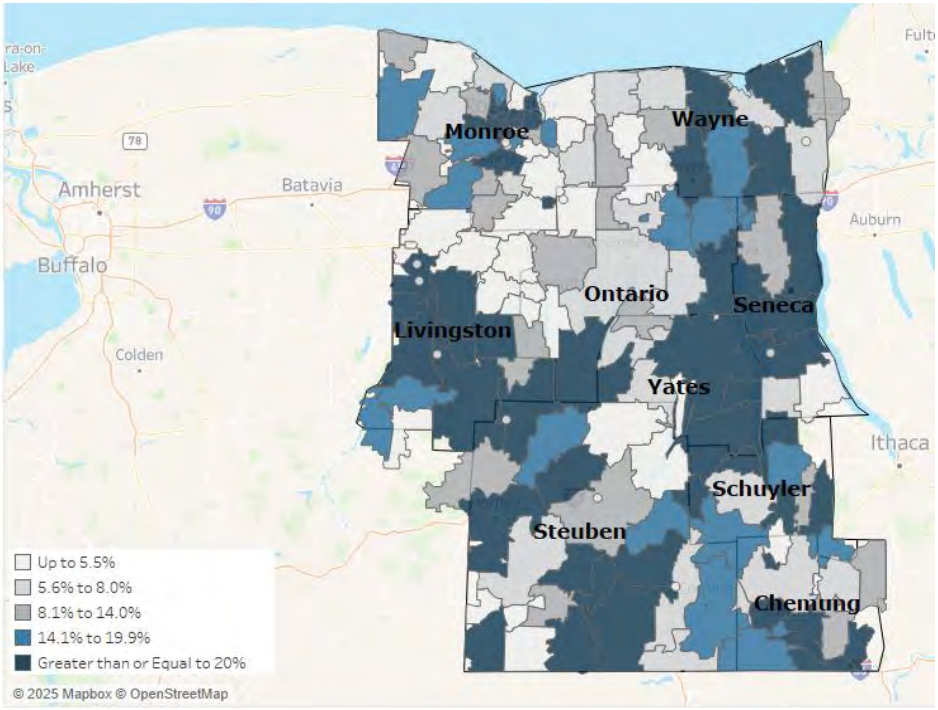
U.S. Census Bureau, 2019-2023 ACS 5-yr Estimates. Table S1701 (Poverty Status in the Past 12 Months)

Courtesy Common Ground Health

Map 8 shows the poverty rate by zip code in each county for those under age 18. According to the American Psychological Association,[22] childhood poverty is significant and can be long lasting. It is associated with subpar housing and homelessness, poor nutrition and hunger, less safe neighborhoods, educational lags, and substandard childcare. All of these affect the ability of children to be successful and to be mentally and physically healthy.

The societal costs of poverty are significant, not just to individuals, but to the community at large. They include affordable housing shortages, increased homelessness, workforce shortages, increased crime, and more reliance on social sectors such as temporary housing, the justice system, food banks, Medicaid and SNAP. New York Counties share Medicaid and SNAP benefit costs with the federal government. When poverty rates increase, local contributions to these programs increase, as well, straining already strapped county budgets.

Map 8: Poverty Rate by Zip Code for those Under 18 Years of Age



U.S. Census Bureau, 2019-2023 ACS 5-yr Estimates. Table S1701 (Poverty Status in the Past 12 Months)

Courtesy Common Ground Health

[22] Source: https://www.apa.org/topics/socioeconomic-status/poverty-hunger-homelessness-children

Table 9 notes the poverty rates, median household income, living wage requirement, and unemployment rate for the eight counties compared with the NYS average and the prevention agenda (PA) target. The living wage requirement refers to the amount of money one person would need to earn to cover basic household expenses including taxes for one adult and two children. The percent change from the baseline year is also noted. For several counties, the poverty rate exceeds the NYS average and, in many cases, is increasing. The population of those over age 65 living in poverty, though it does not exceed the NYS average, is particularly alarming as it has increased in all counties. The average household income has increased, but it has not kept pace with the living wage requirement.

Table 9 Poverty Rates in the Finger Lakes Region

County	% Poverty 2023 NYS: 13.7 PA:12.5*	% Change from 2018*	% Poverty ages <18 2023 NYS: 19*	% Change from 2018*	% Poverty ages >65 2023 NYS: 12.7 PA=11*	% Change from 2018*
Chemung	15.8	+7.0	22.0	+10.0	10.1	+15.0
Livingston	11.6	-14.0	12.0	-14.0	6.9	+17.0
Ontario	9.2	-4.0	10.0	-9.0	7.6	+27.0
Schuyler	15.1	+9.0	19.0	-10.0	8.9	+75.0
Seneca	13.3	+7.0	21.0	+5.0	9.0	+25.0
Steuben	13.7	-2.0	19.0	0.0	11.1	+63.0
Wayne	11.3	0.0	14.0	-7.0	8.3	+9.0
Yates	14.1	+24	18.0	-14.0	12.5	+51
	Median Household Inc. 2023 NYS: $82,100**	% Change from 2019**	Living Wage Required 2023 NYS: $61.75***	% Change from 2021***	%Unemployed (January 2025)****	% change from January 2019****
Chemung	$60,500	+4.0	$50.73	+30.0	4.4	-2.2
Livingston	$70,200	+16.0	$51.12	+29.0	4.6	-9.8
Ontario	$79,400	+19.0	$56.94	+37.0	6.1	+29.8
Schuyler	$65,200	+25.0	$49.95	+31.0	6.1	-1.6
Seneca	$58,600	+15.0	$48.77	+26.0	3.6	-5.2
Steuben	$64,300	+21.0	$49.08	+29.0	5.0	+8.7
Wayne	$73,000	+18.0	$51.24	+29.0	4.6	-9.8
Yates	$66,200	+9.0	$51.14	+33.0	4.5	+4.7

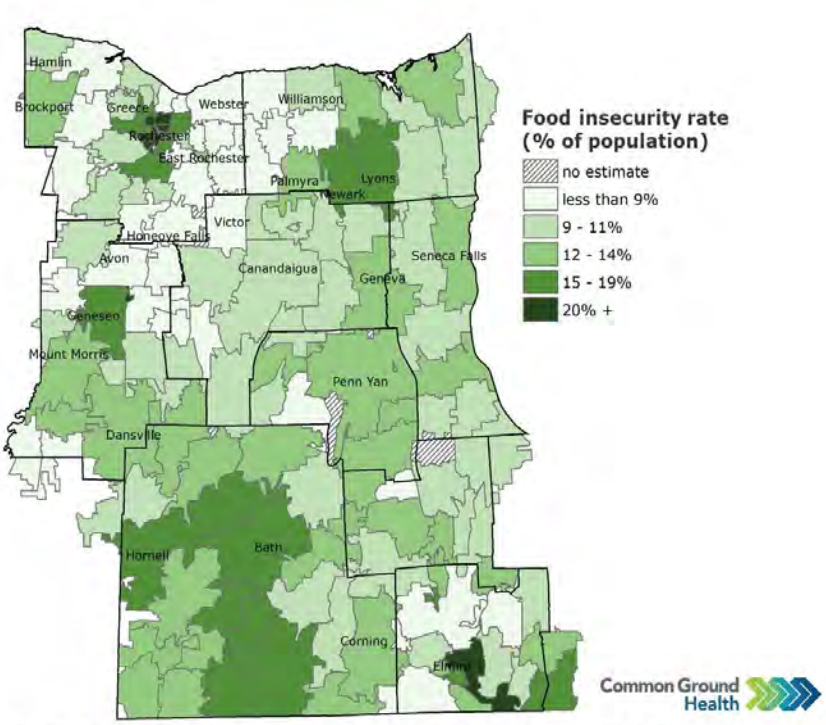
*Source: *Poverty Rates: American Community Survey (2018-2023)*
**Average Household Income: Small Area Income and Poverty Estimates, U.S. Census (2019-2023)*
****Living Wage Requirement: The Living Wage Calculator (2021-2024)*
*****Unemployment Rate: U.S. Department of Labor (2019-2025)*

Nutrition Security

The Food Environment Index (FEI) measures how easily residents can access healthy, affordable foods. The score is based on both the rate of food insecurity and the percentage of low-income residents who live far from a grocery store. Scores range from 0 (worst) to 10 (best). Lack of access to healthy foods is strongly associated with increased rates of obesity, chronic disease (such as diabetes and heart disease), and early death.

The Food Insecurity Rate highlights the economic disparities that may contribute to increases in poverty rates. The Food Insecurity Rate, expressed as a percentage of the total population, measures the share of households that lack consistent access to enough food for an active, healthy life. Map 9 shows the Food Insecurity Rate by Zip Code in the Finger Lakes region.

Map 9: Food Insecurity Rate by Zip Code



Source: Gundersen, C., A. Dewey, A. Crumbaugh, M. Kato & E. Engelhard. Map the Meal Gap 2018: A Report on County and Congressional District Food Insecurity and County Food Cost in the United States in 2016. Feeding America, 2018.

A strong food environment is important because limited access to healthy food is linked to higher rates of chronic diseases (like obesity and diabetes), premature death, and poorer overall community health, especially in low-income and rural communities.

Over the past three years, cross-sectional community surveys conducted by the Pivital Public Health Partnership in Chemung, Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne, and Yates counties show that food insecurity is both common and worsening. Using the validated two-item Hunger Vital Sign screener, the share of surveyed households reporting food insecurity increased from 26% in 2019–2020 to 67% in 2023–2024, indicating that more than two in three responding households now experience concern about having enough food or difficulty affording balanced meals. During the same period, the proportion of respondents who reported knowing someone struggling with food insecurity rose from 45% to 65%, underscoring that food hardship is widely visible within residents' social networks and community life.

A total of 1,289 responses were collected across the eight counties (Chemung 76, Livingston 209, Ontario 380, Schuyler 80, Seneca 164, Steuben 52, Wayne 126, and Yates 202), providing community input to inform assessment and planning. These survey findings complement secondary indicators such as FEI, food insecurity rate, and SNAP eligibility, reinforcing that many

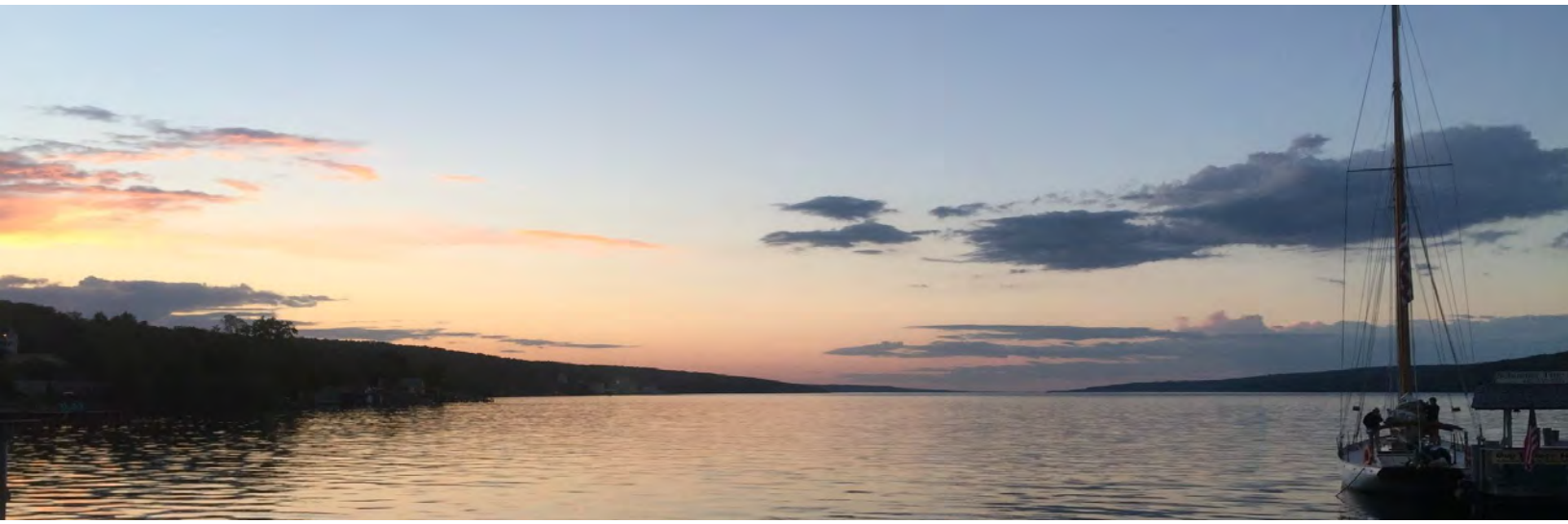
rural residents face both geographic and economic barriers to healthy food and that targeted strategies to improve nutrition security are needed across the region. Taken together, these findings show that food insecurity disproportionately affects residents in lower-income and more remote ZIP codes, contributing to avoidable gaps in diet-related health outcomes and reinforcing existing inequities.

Table 10 compares each county's Food Environment Index (FEI) with its estimated food insecurity rate to illustrate ongoing challenges with nutrition security in the region. Counties with FEI scores below the New York State value of 8.7, such as Chemung, Schuyler, Seneca, and Steuben, face relatively greater barriers to healthy food access, including affordability and proximity to grocery stores. At the same time, food insecurity affects roughly one in eight to one in seven residents across the counties, with the highest rates generally observed in more rural areas, indicating that many households continue to struggle to afford enough nutritious food.

Table 10 Food Environment Index in the Finger Lakes Region

County	Food Environment Index (2022) (NYS: 8.7)*	% Change from 2018*	Food Insecurity Rate (2023)**
Chemung	7.9	0.0	14.4
Livingston	8.7	+4.0	11.8
Ontario	8.8	+2.0	11.8
Schuyler	8.4	+2.0	13.9
Seneca	8.4	+2.0	14.0
Steuben	8.1	-1.0	13.6
Wayne	8.7	+4.0	11.9
Yates	8.8	-1.0	12.4

*Source: *County Health Rankings, USDA, **Feeding America: Map the Meal*



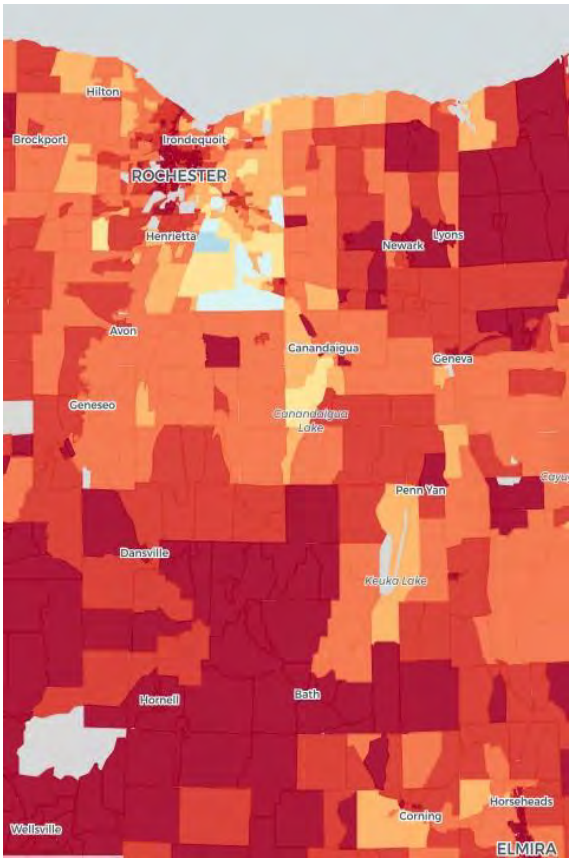
Seneca Harbor, Courtesy Seneca County

Housing Stability and Affordability

Poor housing conditions are closely linked to health risks, influencing everything from chronic disease rates to mental well-being. Access to safe, stable, and affordable housing remains a top priority for residents across the region. A high housing cost burden -when households spend a large share of their income on housing - can signal financial strain and potential housing instability, which in turn may affect health outcomes and access to other basic needs.

The Area Deprivation Index (ADI) provides additional context by measuring the level of socioeconomic disadvantage in a community based on factors such as income, education, employment, and housing quality. Higher ADI scores indicate greater disadvantages, which can often be associated with poorer housing conditions and elevated health risks. Map 10 notes the ADI by zip code in the Finger Lakes. The ADI is measured from 1 (blue - least deprived) to 10 (red - most deprived). Most deprived areas of the region also coincide with higher poverty rates as can be seen in Maps 6-8.

Map 10: Area Deprivation Index by Area



Source: University of Wisconsin School of Medicine and Public Health. Area Deprivation Index.

Table 11 compares both the housing cost burden and the Area Deprivation Index (ADI) across the counties of the Finger Lakes region, with New York State averages. The data suggest that, while housing cost burdens in most Finger Lakes counties fall below the state average of 19 percent, ADI scores are higher across all counties, indicating that many areas experience greater socioeconomic disadvantage than the state overall. This contrast underscores the complex relationship between housing affordability, neighborhood conditions, and community health.

Table 11 Housing Cost Burden and Area Deprivation Index in the Finger Lakes Region

County	Housing Cost Burden (2023) (NYS: 19%)*	% Change from 2015*	Area Deprivation Index (ADI) (2023) (NYS: 5.5)**	% Change from 2019**
Chemung	15%	+25	9.3	+3
Livingston	10%	-23	8.7	0
Ontario	11%	+10	8.2	-1
Schuyler	11%	-8	8.9	-2
Seneca	12%	+9	9.0	0
Steuben	11%	+10	9.4	+1
Wayne	11%	+10	9.0	0
Yates	12%	-8	8.5	+1

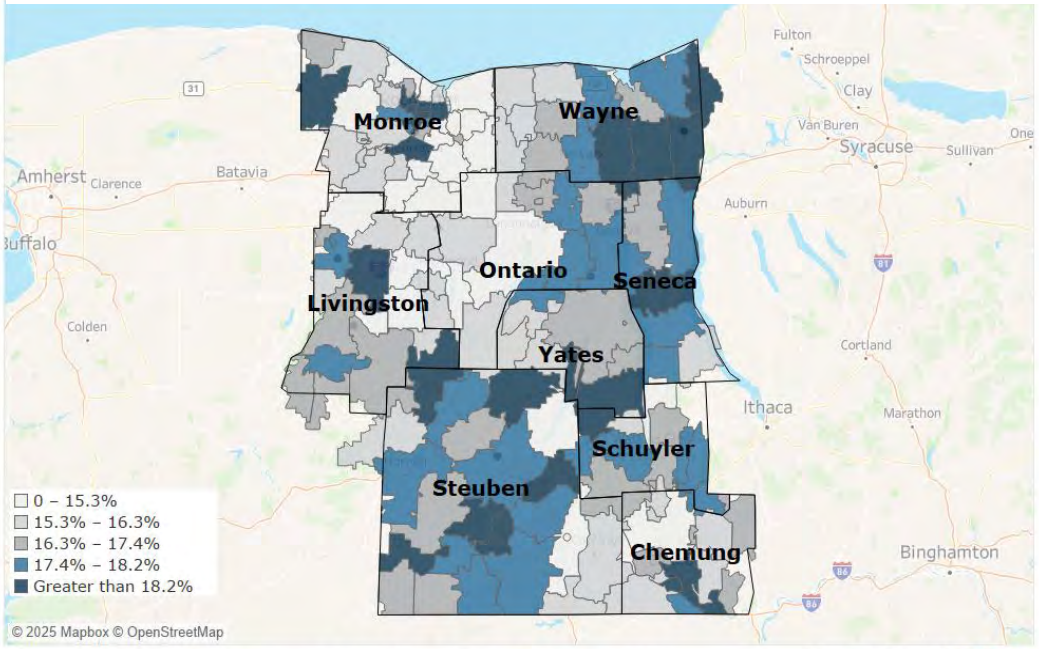
Source: *Housing Cost Burden: American Community Survey (2015-2023)

**ADI: Kind AJH, Buckingham W. Making Neighborhood Disadvantage Metrics Accessible: The Neighborhood Atlas. New England Journal of Medicine, 2018. 378: 2456-2458. DOI: 10.1056/NEJMp1802313. PMCID: PMC6051533. (2019-2023)

Social and Community Context

Anxiety and Stress

Map 11: Frequent Mental Distress Among Adults (Mental Health Not Good for 14+ of past 30 days)



Centers for Disease Control and Prevention. PLACES: Local Data for Better Health. (2022)

The rate of depressive disorders and the percentage of adults reporting 14 or more days of poor mental health in a month increased significantly across the counties of the Finger Lakes between 2018 and 2022. (Table 12). Map 11 highlights those reporting 14 or more days of poor mental health in the past 30 days by zip code in the Finger Lakes region. Because county estimates are based on survey samples, some of the larger percentage changes - especially in smaller counties - may reflect statistical variability and should be interpreted with caution rather than as exact shifts in prevalence.

The map illustrates that frequent mental distress (14 or more days of poor mental health in the past month) is elevated in many ZIP codes across the region, reinforcing county-level survey data showing rising rates of depressive disorders and frequent poor mental health among adults.

In 2021, all eight counties reported higher percentages of adults with a depressive disorder than in 2016, with increases ranging from about 5% to more than 75%. Similarly, the share of adults reporting 14 or more days of poor mental health in the past month was higher than in 2018 in every county, indicating a broad rise in mental distress.

Many factors influence rates of anxiety and stress, including economic stability, chronic health conditions, and adverse childhood experiences. Lack of access to mental health providers in rural areas is a factor that makes receiving treatment for anxiety and stress challenging.

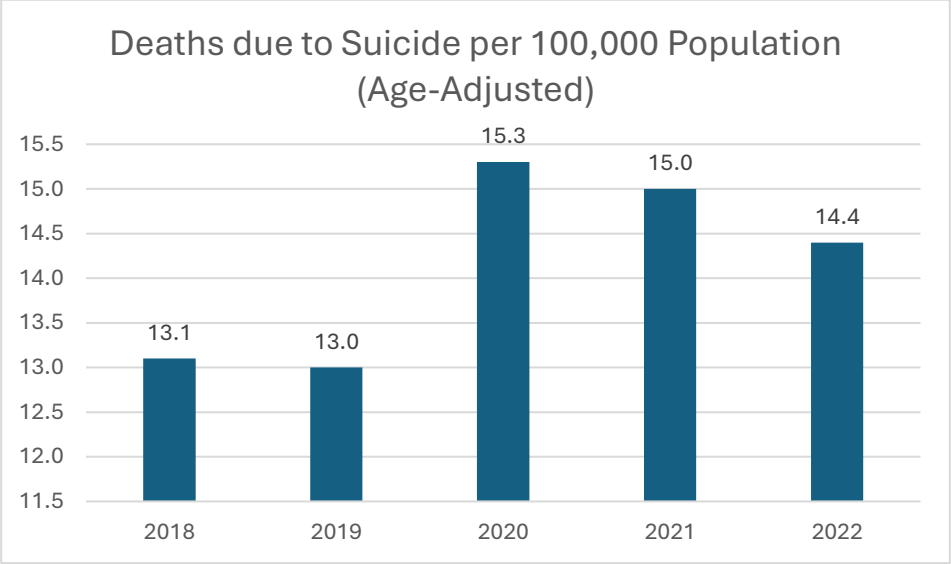
Table 12: Rate of Depressive Disorders and Percentage of Adults Reporting 14 or more days of Poor Mental Health in a Month

County	Percent of Adults Reporting a Depressive Disorder (2021) (NYS=18.7)	Percent Change from 2018 Baseline	Percent of Adults Reporting 14 or more Days of Poor Mental Health Per Month (2021) (NYS=16)	Percent Change from 2018 Baseline
Chemung	35.4	+36	18	+20
Livingston	24.9	-15	18	+29
Ontario	27.9	+64	18	+38
Schuyler	24.1	-18	20	+33
Seneca	18.3	-16	18	+20
Steuben	29.5	+7	19	+27
Wayne	20.3	-23	18	+20
Yates	24.3	+40	19	+36

Source: New York Expanded Behavioral Risk Factor Surveillance System

Suicide Rate

Figure16 Suicide Rates for the Finger Lakes Region (age-adjusted)



Source: County Health Rankings; National Center for Health Statistics – Mortality Files

Adult suicide mortality in the eight-county region has remained elevated over the past five years, increasing from 13.1 deaths per 100,000 residents in 2018 to a peak of 15.3 in 2020 and remaining above the 2018 baseline through 2022 at 14.4 per 100,000. These values represent age-adjusted rates based on 5-year County Health Rankings data (2014–2018 for the 2018 baseline and 2018–2022 for the most recent point), demonstrating that suicide continues to be a persistent and significant cause of premature death across the region. Because these rates are calculated from very small numbers of deaths, even one additional death can cause large percentage changes, so trends should be interpreted cautiously.

Youth suicide rates for the region, drawn from the New York State Prevention Agenda dashboard for ages 10–19, are based on small numbers of deaths (fewer than 10 events per 5-year period) and are therefore considered statistically unstable. Because of this instability, youth suicide rates are

flagged as unreliable in official reporting and should be interpreted with extreme caution, emphasizing the need for ongoing monitoring rather than firm conclusions about trends.

Overdose Deaths by Drugs

Overdose deaths related to opioids and any drug show an alarming increase in most counties exceeding NYS averages. Overdose deaths may be indicative of substance use problems within a community. Table 13 presents regional overdose mortality rates for opioids and all drugs combined, alongside New York State averages and Prevention Agenda targets, to illustrate the extent to which the Finger Lakes Region is above desired levels. Because the regional rates draw on small numbers of deaths in some counties, relatively few additional deaths can result in large percentage changes over time, so trends should be interpreted with caution rather than as precise shifts in riskFocus group participants in several counties noted the increase in drug use as problems within their counties. Several counties have developed partnerships with organizations that deal directly with drug use and misuse.

Table 13: Overdose Deaths

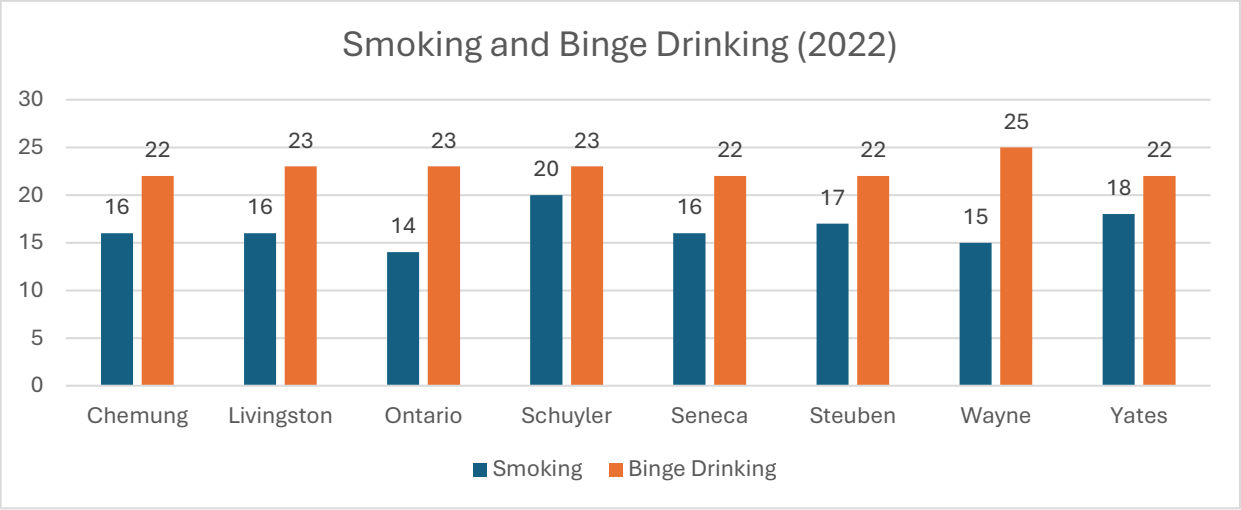
County	Age-Adjusted Rate of Opioid Overdose Deaths per 100,000 (2022) (NYS=27)	Percent Change from 2013 Baseline	Age-Adjusted Rate of Overdose Deaths Involving any Drug per 100,000 (2022) (NYS=31.3 PA=22.6)	Percent Change from 2013 Baseline
Chemung	40.9	+605	46.5	+489
Livingston	22.3	+829	24.5	+433
Ontario	12	+500	16	+332
Schuyler	21.4	+2,040	39.8	+3,880
Seneca	14.4	+700	24.6	+779
Steuben	30.7	+708	31.3	+341
Wayne	29.8	+645	35.2	+314
Yates	0	0	8.2	+720

Source: NYS Opioid Data Dashboard

Smoking and Binge Drinking

Smoking rates have decreased in each county from 2018 to 2022, while the rates of reported binge drinking have increased, with the exception of Schuyler which remained unchanged (Figure 17). All rates exceed the New York State averages of 12 percent for smoking and 20 percent for binge drinking.

Figure 17: Smoking and Binge Drinking

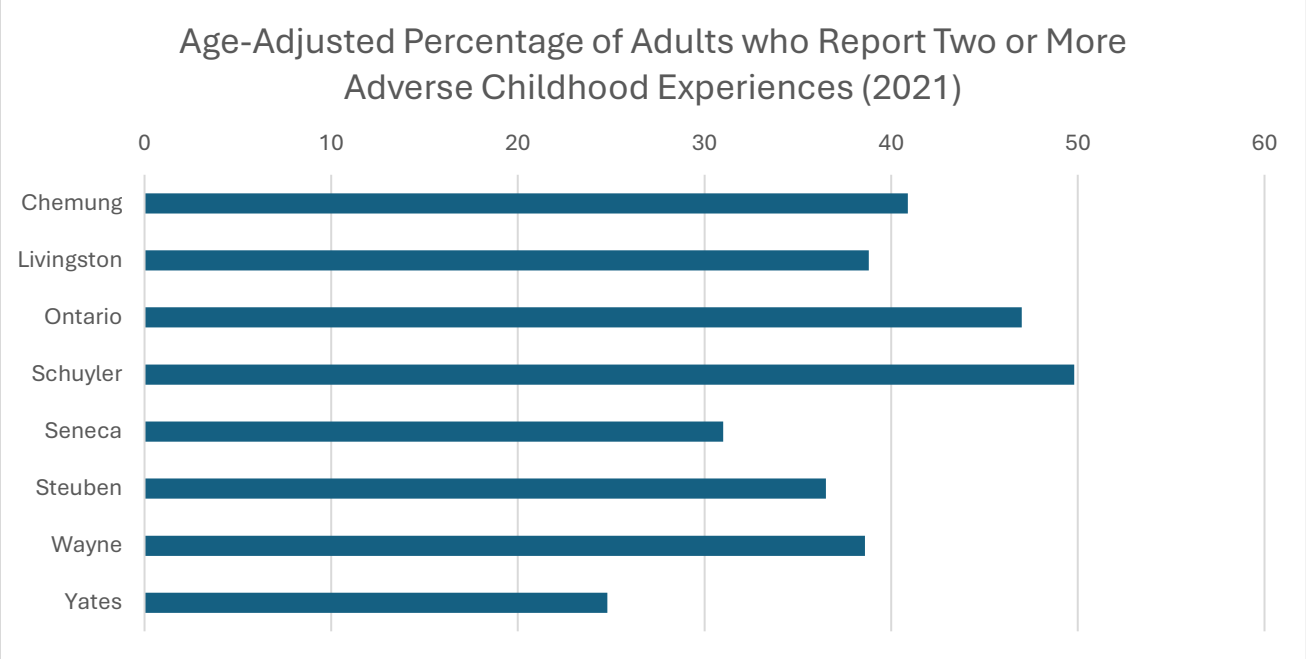


Source: Behavioral Risk Factor Surveillance System

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are those negative emotional and physical circumstances one experiences before age 18. They may include neglect, sexual abuse, parental divorce, mental illness and/or substance abuse in the home, and exposure to violence. ACEs impact individuals well into adulthood and may include physical and mental long-term health problems. The age-adjusted percentage of adults with two or more ACEs may be seen in Figure 18.

Figure 18: Adverse Childhood Experiences



Source: National Center for Health Statistics

Healthy Eating

The Finger Lakes Region is largely rural with hundreds of farms and farm stands, during harvest season. Unfortunately, the number of people without access to a vehicle and/or who live far from a grocery store is substantial. The cost of healthy foods is also a factor in whether or not families are able to purchase fruits and vegetables.

The percentage of adults who eat fruits daily is under 50% for most of the counties but is trending upward, which is a promising sign. More people eat vegetables each day, but that percentage decreased for each county between 2016 and 2021. The number of people who drink one or more sugary drinks each day is below the NYS average in all but three counties (Livingston, Ontario, Schuyler). (Table 14)

Focus group respondents noted that though healthy eating is a priority, it is difficult for many to afford healthy foods. While dollar stores, convenience stores and fast-food restaurants are prolific across the region, grocery stores are less common in many communities.

Table 14: Healthy Eating

County	Percentage of Adults who Eat Fruit Daily (2021)	Percent change from 2016 baseline	Percentage of Adults who Eat Vegetables Daily (2021)	Percent change from 2016 baseline	Percentage of Adults with an Annual Household Income <$25,000 who drink one or more sugary drinks every day (2021) (NYS = 34.1)	Percent change from 2016 baseline
Chemung	41.7	No change	46.9	-25	25.5	-47
Livingston	49	-9	56.5	-2	37.5	-14
Ontario	49	-9	52.1	-24	45.2	+71
Schuyler	45.6	+17	60.3	-3	42.4	+18
Seneca	57.3	+13	71.3	-6	28.1	-25
Steuben	44.7	+9	52	-21	20.5	-42
Wayne	42.3	+20	57.2	-7	20.3	-40
Yates	63.4	+16	70.2	-4	17.1	+60

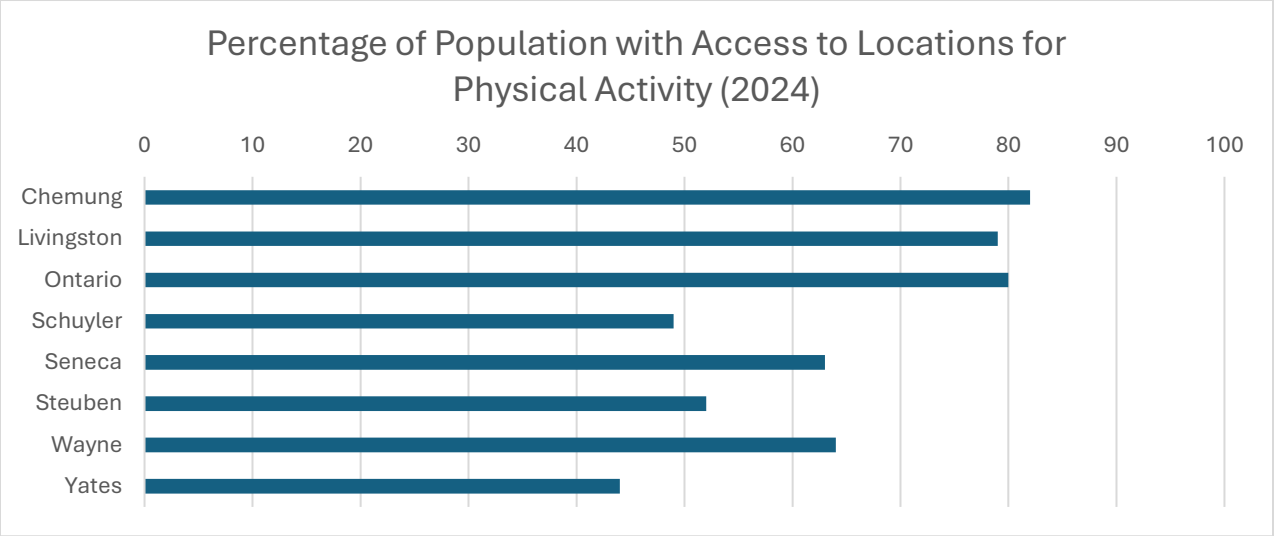
Source: Behavioral Risk Factor Surveillance System

Neighborhood and Built Environment

Opportunities for Active Transportation and Physical Activity

While healthy eating is a major component of preventing and managing chronic diseases, so is physical activity and exercise. More than 50 percent of the population in several counties have access to locations for physical activity (Figure 19). Livingston, Steuben, and Wayne counties all increased the share of residents with access to physical activity resources between 2021 and 2024, with Steuben showing a particularly notable rise of 940 percent.

Figure 19: Access to Locations for Physical Activity.

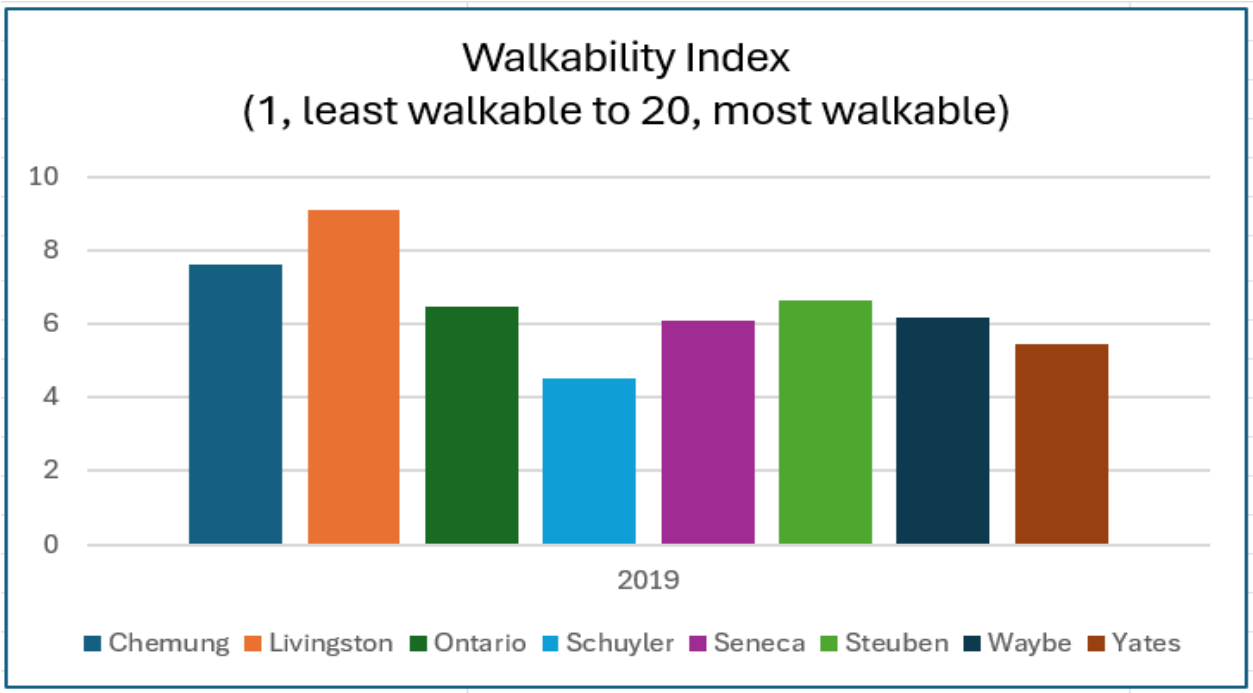


Source: ArcGIS Business Analyst and Living Atlas of the World; YMCA; US Census TIGER/Line Shapefiles

The Walkability Index measures how walkable a county is on a scale from 1 (least walkable) to 20 (most walkable). Overall, the Finger Lakes counties included in this chart have relatively low walkability scores, ranging from about 4.5 to just over 9 on the 20-point scale. The 2019 Walkability Index scores are: Chemung 7.6, Livingston 9.12, Ontario 6.49, Schuyler 4.53, Seneca 6.11, Steuben 6.66, Wayne 6.16, and Yates 5.46 (Figure 20).

Walking or biking for exercise in rural upstate communities can be dangerous due to roads that often lack sidewalks, shoulders, and streetlights, especially outside village centers. Between October and April, roadways and any existing sidewalks may be icy or snow-covered, and higher speed limits on county and town roads can discourage walking and biking for recreation or transportation. Although there are YMCA facilities and other indoor exercise options in parts of the region, many residents face barriers such as membership costs, limited hours, and lack of reliable transportation, which can reduce access to safe places for physical activity.

Figure 20: Walkability Index

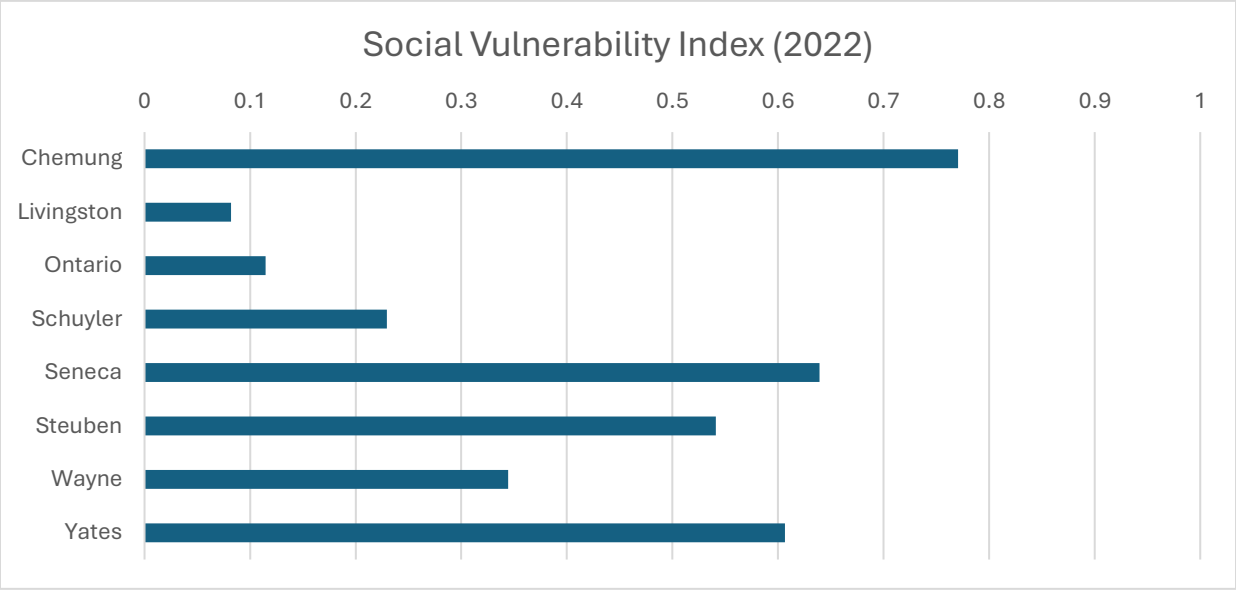


Source: EPA Office of Community Revitalization

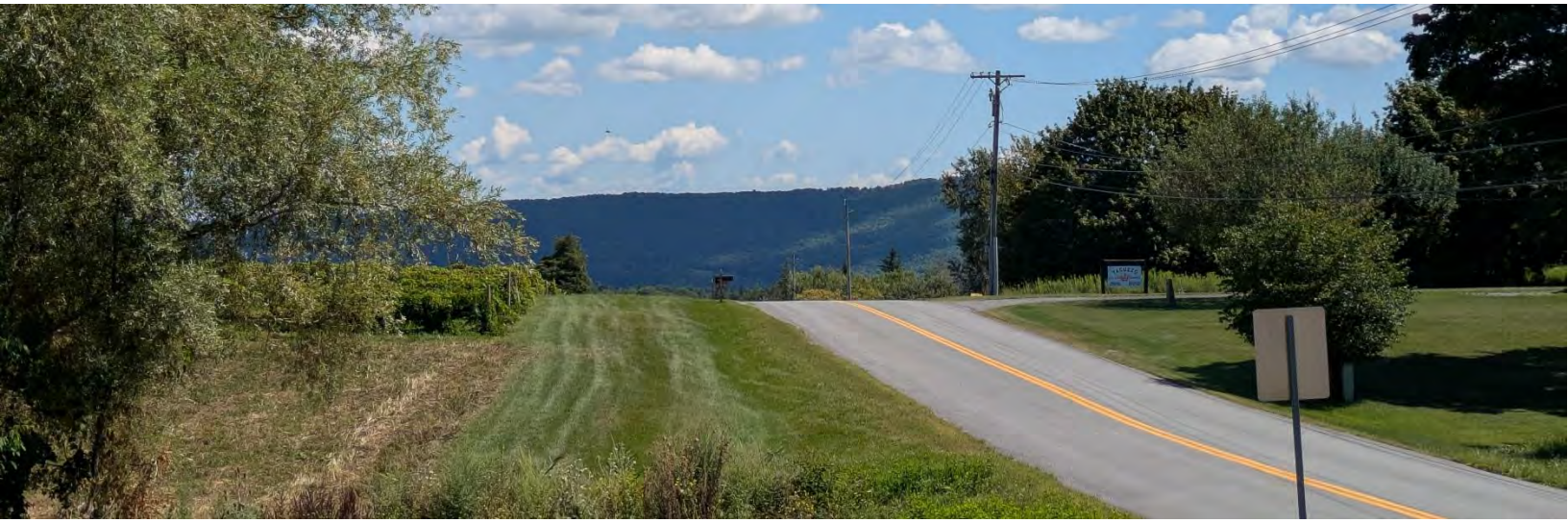
Access to Community Services and Support

The Social Vulnerability Index was developed to measure the level of access to community services and support in the wake of emergencies. It is a useful tool for public health programming and outreach as it considers poverty, unemployment, income, high school graduation rate, single parent homes, individuals with disabilities, those over 65, minority status, spoken language, housing and transportation. It is measured on a scale from 0 (lowest vulnerability) to 1 (highest vulnerability). While no county is considered highest vulnerability, Chemung, Seneca, Steuben and Yates are above the 0.5 midpoint. (Figure 21)

Figure 21: Social Vulnerability Index



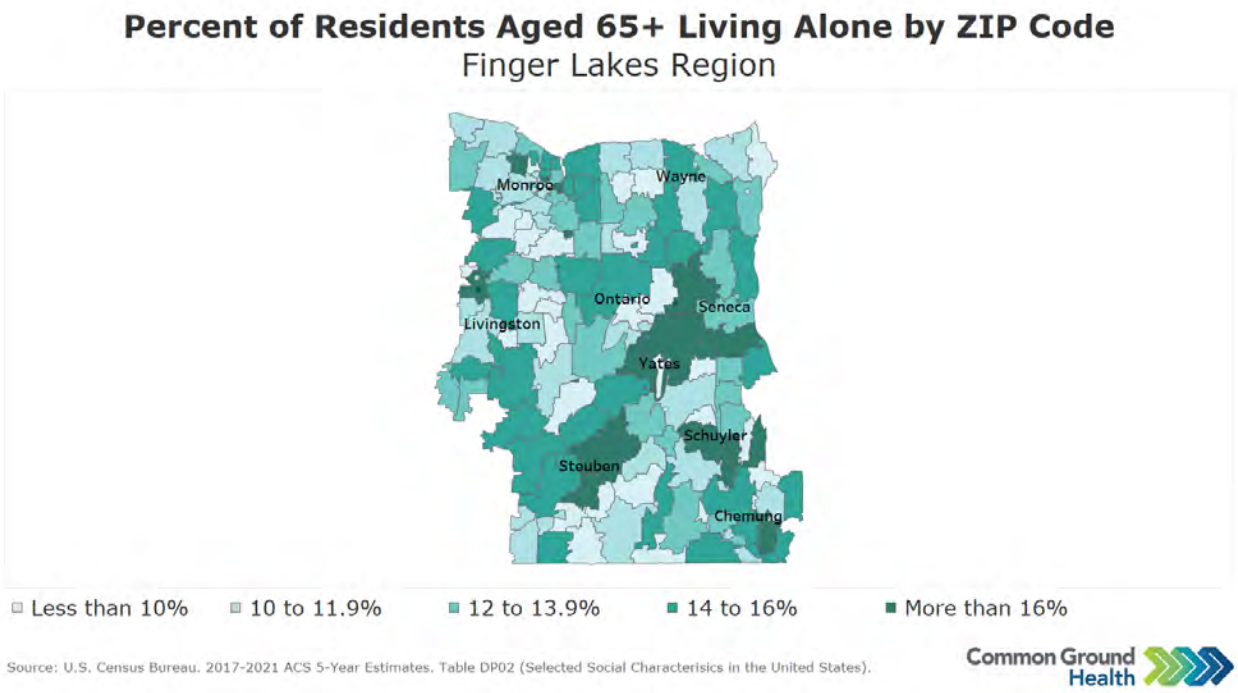
Source: Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry/Geospatial Research, Analysis, and Services Program. CDC/ATSDR Social Vulnerability Index Interactive



Source: Ontario County

The Finger Lakes Region is aging and people over the age of 65 who live alone may lack access to community services and support. Map 12 highlights the distribution of this population. Loneliness and social isolation among adults over 65 can create serious physical, mental, and social health challenges. Physical challenges include increased risk of chronic diseases, higher mortality risk, and poor nutrition and sleep. Mental health impacts include depression and anxiety, cognitive decline and lower resilience in coping with mental and physical challenges. Social isolation may make it difficult to access services and supports, particularly during emergencies like a fall. Social isolation may also cause a loss of purpose and can perpetuate elder abuse by allowing it to go undetected.[23]

Map 12: Percentage of the population of those 65 years and older living alone by zip code



Injuries and Violence

Injuries and violence are a major and growing concern across the eight-county Finger Lakes region. Because "injuries and violence" in this assessment includes several distinct indicators (unintentional injury, violent crime, and firearm-related deaths), each measure uses a different baseline year based on data availability. For example, unintentional injury trends use a 2015 baseline, firearm-related deaths use 2018, and violent crime uses 2013. As a result, rates and trends should be interpreted within the context of each indicator's specific baseline year rather than as a single combined trend for injuries and violence.

[23] Perissinotto CM, Stijacic Cenzer I, Covinsky KE. Loneliness in older persons: a predictor of functional decline and death. Arch Intern Med. 2012 Jul 23;172(14):1078-83. doi: 10.1001/archinternmed.2012.1993. PMID: 22710744; PMCID: PMC4383762.

Unintentional injuries in NYS Vital Statistics include deaths from external causes that are not intentionally self-inflicted or due to assault, such as motor vehicle crashes, falls, drownings, fires and burns, accidental poisonings (including many drug overdoses coded as unintentional), and other accidental injuries.

Unintentional Injuries in the eight counties of the Finger Lakes region have increased since 2015 and in many cases, alarmingly. The exception is Seneca County which decreased in age-adjusted death rate for unintentional injury in 2015 from 2022. Three counties are below the New York State average for age-adjusted death rate for unintentional injury. Conversely, five counties exceed the New York State average for age-adjusted death rate (death before age 75) for unintentional injury. All counties have increased in this indicator from baseline. (Table 15)

Table 15: Injuries and Violence

County	Age-Adjusted Death Rate for Unintentional Injury per 100,000 (2022) (NYS = 54.1)	Percent Change from Baseline of 2015	Age-Adjusted Premature Death Rate (Death Before Age 75) for Unintentional Injury per 100,000 (2022) (NYS = 46.9)	Percent Change from Baseline of 2015
Chemung	88.2	+102	75.4	+144
Livingston	50.7	+14	43.6	+46
Ontario	48.1	+26	38.1	+32
Schuyler	66.3	+46	62	+57
Seneca	43.5	-2	36.7	+27
Steuben	58.6	+99	48.9	+136
Wayne	64.3	+60	58.1	+61
Yates	80.3	+267	63.4	+424

Source: New York State Department of Health - Office of Quality and Patient Safety - Division of Information and Statistics - Bureau of Health Informatics - Vital Statistics Unit

Violence related harms show similar concern in the region and require clear definitions. Violent crime refers to reported offenses of murder, rape, robbery, and aggravated assault, compiled from local law enforcement data by state and federal justice agencies and expressed as a rate per 100,000 residents. Firearm related deaths are measured as the number of deaths due to firearms per 100,000 population over a five year period, based on national mortality data and Census population estimates; this measure includes suicides, homicides, and other firearm fatalities defined by specific ICD10 codes, and values are suppressed for counties with fewer than 10 deaths. Because recent changes in population estimation methods affect the denominator for firearm fatality rates, comparisons across years should be made with caution. In the Finger Lakes region, the violent crime rate has risen from about 120.9 per 100,000 in 2013 to approximately 154.5 per 100,000 in 2022, and firearm related deaths have also increased since 2018 and now exceed the statewide rate, although they remain concentrated in specific communities. Together,

these patterns indicate that many residents face elevated risks of both accidental and intentional injury, underscoring the need for coordinated prevention strategies focused on traffic safety, fall and poisoning prevention, firearm safety, and community violence reduction.

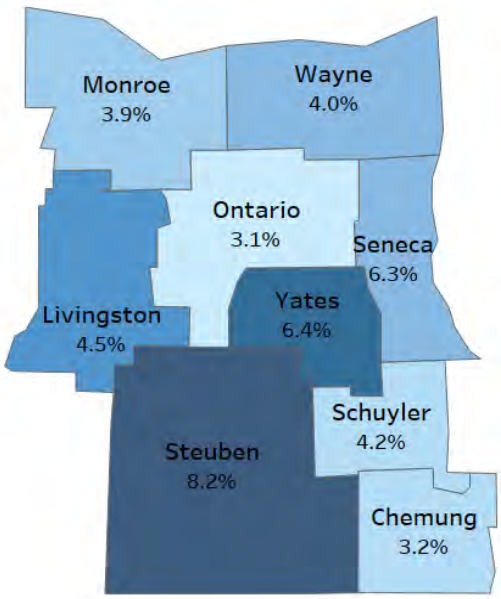
Health Care Access and Quality

Access to and Use of Prenatal Care

Maternal and child health have been areas of focus for the Finger Lakes Region counties in several past Community Health Improvement Plans. According to Healthy People 2030, "improving the well-being of mothers, infants, and children is an important public health goal for the United States. Their well-being determines the health of the next generation and can impact future public health challenges for families, communities, and the health care system."[24]

Receiving early and adequate prenatal care is important for ensuring a healthy pregnancy. At prenatal visits, health care providers screen for diseases, provide vaccinations, and manage maternal chronic diseases that may be exacerbated by or have a negative impact on their pregnancy. In addition, health care providers educate pregnant persons about labor, delivery, postpartum depression, and early warning signs of complications. Ensuring timely prenatal care is obtained can lower the incidence of premature birth, low birth weight babies and infant mortality.[18]

Map 13: Percentage of births with late (3rd trimester) or no prenatal care (2019-2021)



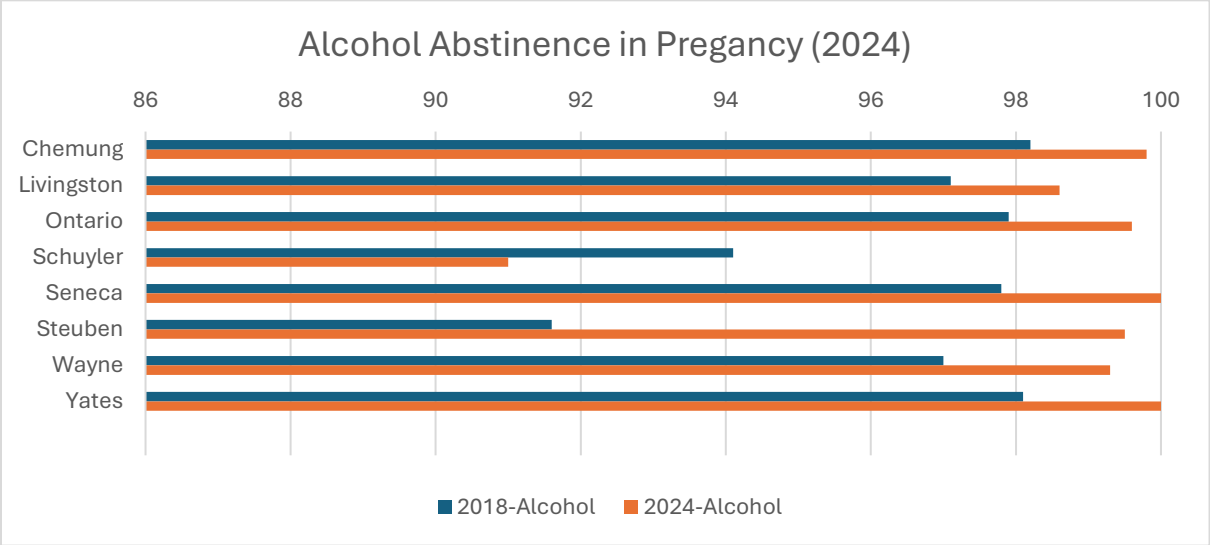
Source: NYS Perinatal Data Profile 2019-2021

Despite regional efforts, some pregnant residents still begin care late in pregnancy or receive no prenatal care at all. Map 13 shows that, while most births occur with timely prenatal care, a notable minority in several counties receive care in the third trimester or not at all, highlighting persistent geographic disparities in early access that can contribute to preterm birth, low birth weight, and higher infant and maternal risks.

Prenatal care may also be measured using three abstinence indicators – alcohol (Figure 22), smoking (Figure 23), and illegal drugs (Figure 24). All counties have improved in each indicator from 2018 to 2024 with the exception of alcohol abstinence in Schuyler County.

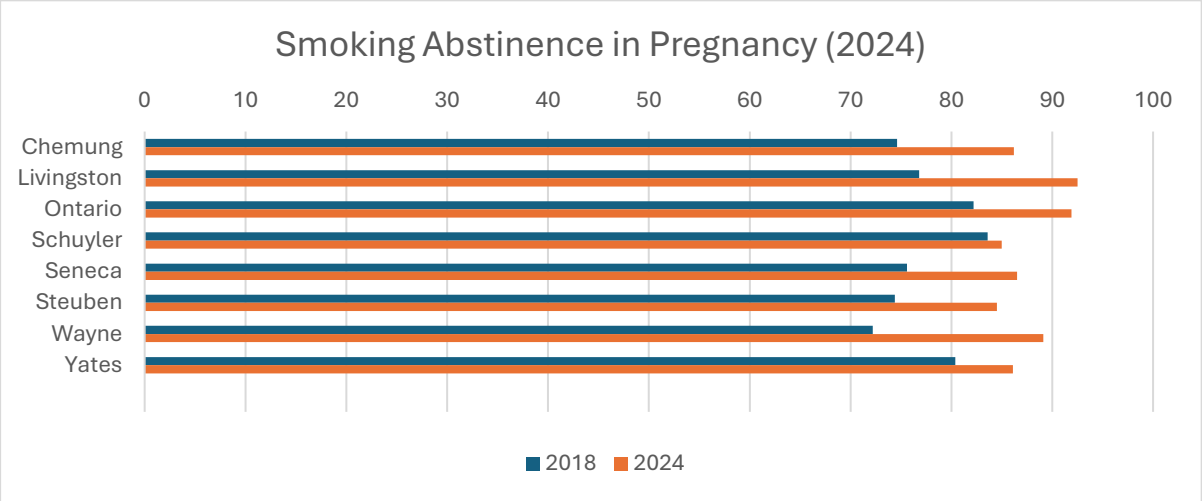
[24] Source: Healthy People 2030 https://odphp.health.gov/healthypeople/about/workgroups/maternal-infant-and-child-health-workgroup

Figure 22: Alcohol Abstinence in Pregnancy



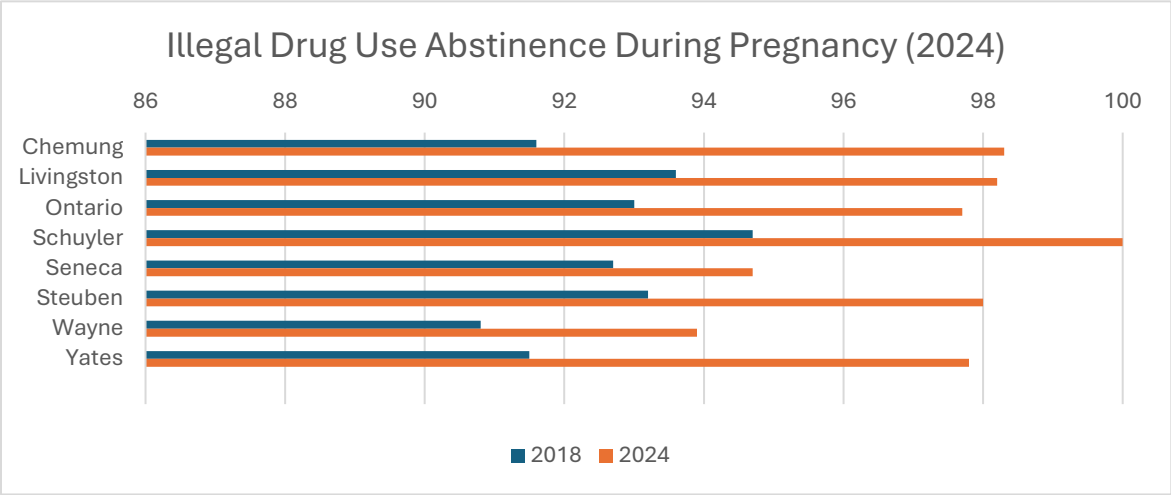
Source: Healthy People 2020; US Department of Health and Human Services.

Figure 23: Smoking Abstinence in Pregnancy



Source: Healthy People 2020; US Department of Health and Human Services.

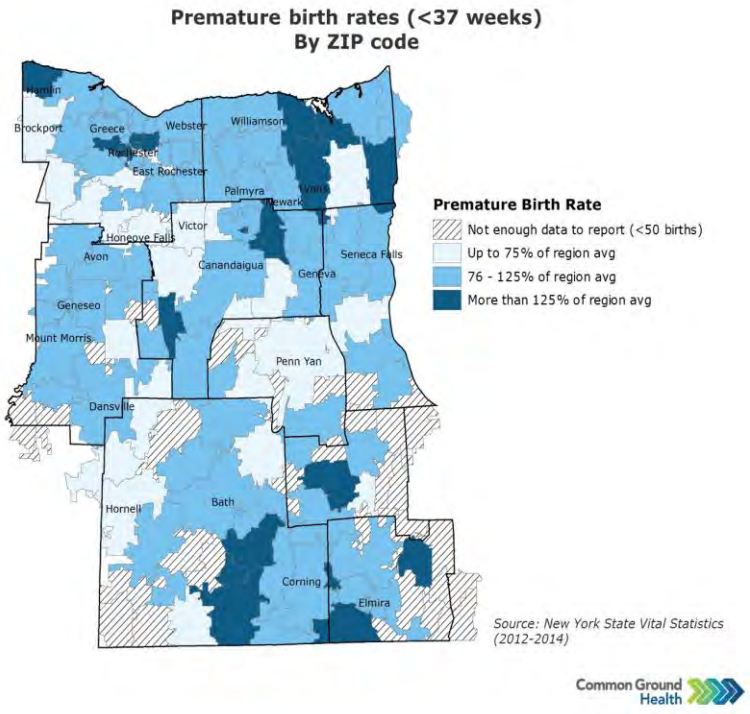
Figure 24: Illegal Drug Abstinence in Pregnancy



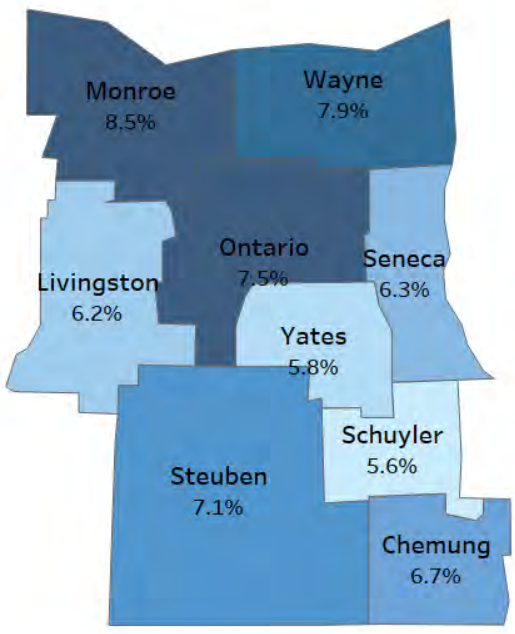
Source: Healthy People 2020; US Department of Health and Human Services.

Additionally, lack of access to prenatal care may be manifested by low live birth weights (<2,500 grams or about 5 lbs., 8 oz.) and premature births (live births before 37 weeks) (Figure 25 and Maps 14, 15, 16).

Map 14: Premature birth Rates



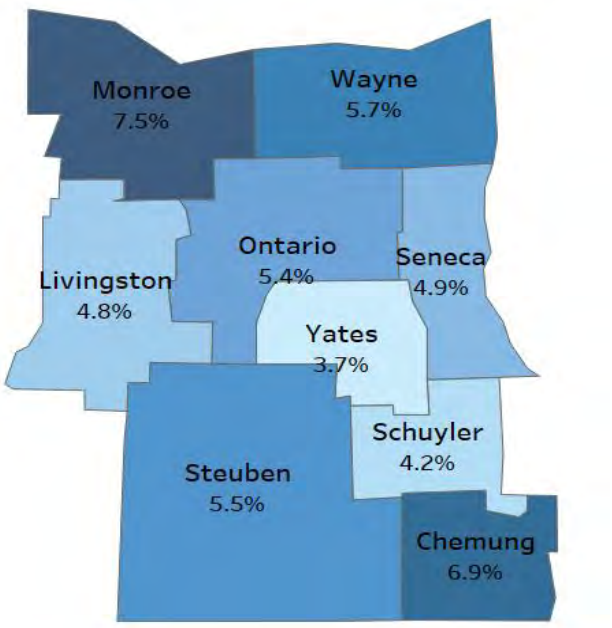
Map 15: Percentage of Premature Births with 32 - < 37 Weeks Gestation (2019-2021)



Source: NYS Perinatal Data Profile 2019-2021

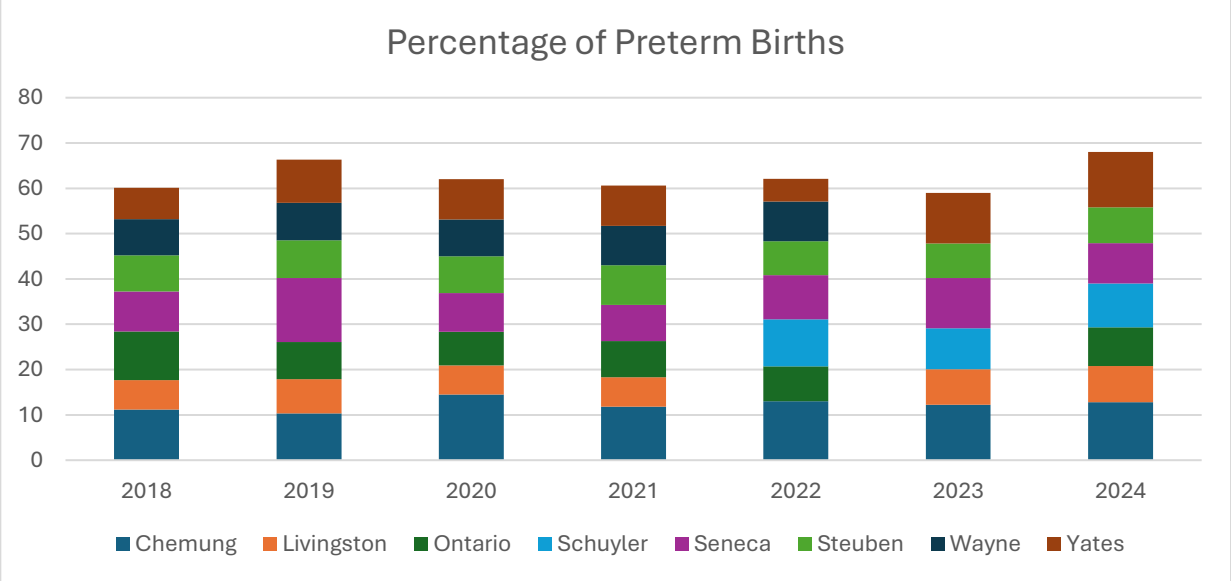
A baby born prematurely is immediately at risk for complications including jaundice, anemia, feeding and airway issues, and apnea. The earlier in pregnancy a baby is delivered, the more likely it is that the baby will need to spend time in the neonatal intensive care unit (NICU). Long-term health complications associated with premature birth include vision and hearing deficits, neurological delays, delays in speech and language development and deficits in social and emotional regulation. Of note, premature birth is the primary cause of low birth weight.[25]The percent of live births with low birth weight has remained relatively unchanged in the region from 2018 (6.4%) to 2023 (also 6.4%). A missing value is reported for counties with fewer than 10 low birthweight births in the time frame was the case in 2021.[26]

Map 16: Percentage Low Birth Weight (<2.5 kg) Singleton Births (2019-2021)



Source: NYS Perinatal Data Profile 2029-2021

Figure 25: Percentage of Preterm Births in the Region from 2018-2024



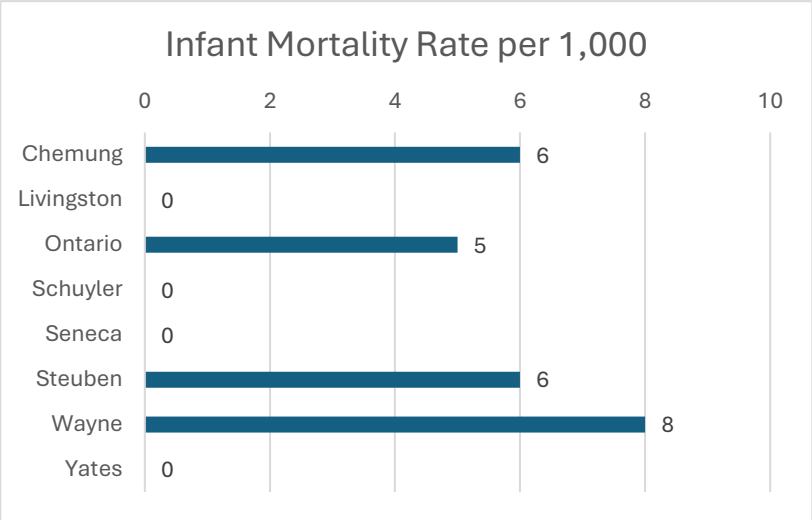
Source: National Center for Health Statistics

[25] Stanford Children's Health, Low Birthweight
[26] Stanford Children's Health, Low Birthweight

Prevention of Infant and Maternal Mortality

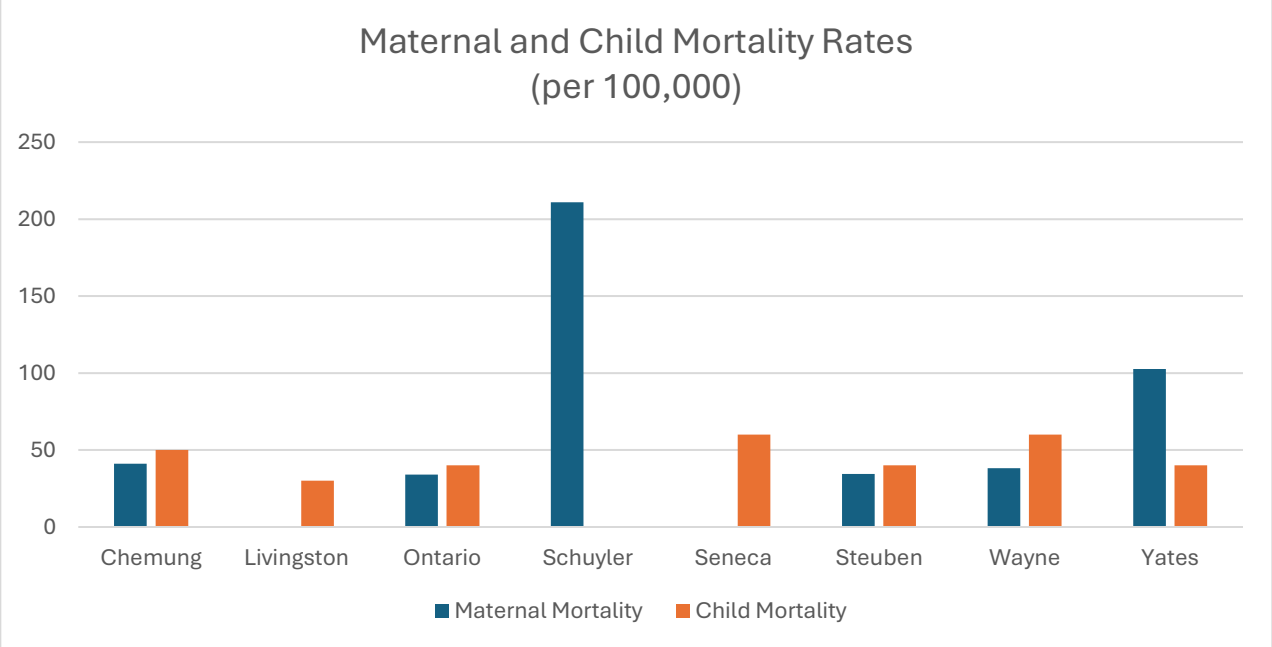
Prematurity and its related conditions are the leading causes of infant mortality. Reducing rates of preterm births, therefore should decrease infant mortality. (Figure 26). Figure 27 shows maternal (per 100,000), child (per 100,000) mortality rates while Figure 26 shows infant (per 1,000) mortality rates in the Finger Lakes region. If data are expressed as 0, it may not indicate that there was no mortality. Data may not be available or the number may be too small as not to be reportable. The New York State average maternal mortality rate is 22 per 100,000. More than half of the counties exceed that rate. The New York State average for child mortality is 40. More than half of the counties are at or above that rate.

Figure 26: Infant Mortality Rate per 1,000 (2022)



Source: National Center for Health Statistics

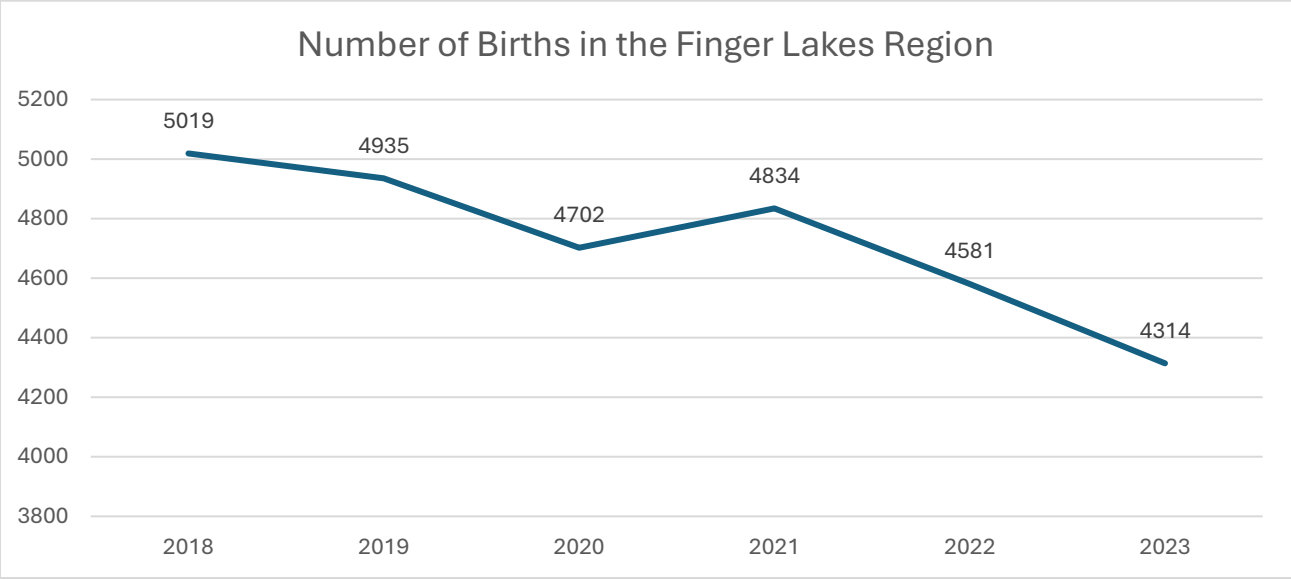
Figure 27: Maternal and Child Mortality Rates per 100,000 (2022)



Source: National Center for Health Statistics

Total births in the Finger Lakes region have been on a steady decline until a precipitous drop in 2024 (Figure 28).

Figure 28: Number of Births in the Finger Lakes Region



Source: Statewide Planning and Delivery System (SPDS)

Preventive Services for Chronic Disease Prevention and Control

Most chronic diseases are preventable and are closely tied to modifiable behaviors, including poor diet, limited physical activity, tobacco use, and heavy alcohol consumption. These conditions significantly drive up health care costs and place substantial pressure on the health care system. In New York State, chronic illnesses - such as heart disease, stroke, cancer, COPD, diabetes, and obesity - are the primary causes of disability and death. They create a considerable health burden and greatly diminish overall quality of life, contributing to six in ten deaths.[27]

Many New Yorkers also experience multiple chronic conditions at the same time. Expanding early screening and detection, strengthening self-management skills, and improving access to health care providers and referral services can play a major role in reducing both the occurrence and severity of chronic diseases.[28]

Access to care is a widespread barrier, especially for those on Medicaid or living in poverty. Even when primary care, dental care, and mental health care are available, access may be inequitable across populations and places. Cost, insurance limitations, scheduling practices, and a lack of transportation continue to be barriers to access. These barriers may prevent people from seeking acute care, as well as preventive measures such as dental exams, yearly physicals, and cancer screenings.

[27] Source: NYS Prevention Agenda
[28] Source: NYS Prevention Agenda

A look at practitioner access in Table 16 provides insight into the problem of obtaining both acute and preventive health care in the region as well as insights into the problem of chronic disease management.

Table 16 Provider Access in the Finger Lakes Region

County	Primary Care Physicians – Number of residents to one physician (2021) (NYS: 1,240)	Mental Health Providers Number of residents to one provider (2024) (NYS: 260)	Dentists Number of residents to one dentist (2022) (NYS: 1,200)	Primary Care Providers Other than Physicians Number of residents to one provider (2024) (NYS: 610)
Chemung	1,280	290	1,540	560
Livingston	2,200	640	1,980	1,130
Ontario	1,210	330	1,660	680
Schuyler	1,610	430	3,530	1,590
Seneca	3,740	410	3,290	1,120
Steuben	1,790	400	2,810	930
Wayne	4,300	800	2030	1,420
Yates	2,050	840	2,220	1,220

Sources: County Health Rankings & Roadmaps, using data from the Area Health Resources Files (primary care physicians), CMS National Provider Identifier and NPPES files (mental health providers, dentists, and other primary care providers).

Courtesy Ontario County

Access to and use of preventive services may also be measured by the percentage of residents who have undergone diagnostic testing such as mammograms and colorectal screenings. Additionally, those who have been tested for and diagnosed with high blood pressure or diabetes as detailed in Table 17. A large percentage of residents receive mammography services, and those on Medicare doing so exceed the New York State average.

Table 17: Preventive Services

County	Percentage of those 50-74 years who have gotten a Mammogram (2022)	Percentage of those on Medicare who have gotten a Mammogram (NYS = 44%) (2022)	Percentage of Those Receiving Colorectal Screening (2022)	Percentage of Those who have had a test for High Blood Sugar/ Diabetes Test (2021)	Percentage of those with an income < $25,000 who have had a test for High Blood Sugar/ Diabetes (2018) (NYS = 62.2%)	Percentage of those Diagnosed with High Blood Pressure (18+) (2021)
Chemung	74.4	51	61.3	66.9	52.8	29.7
Livingston	79	51	62	61.6	75.4	28.8
Ontario	75.9	52	65.3	63.2	56.6	28.9
Schuyler	73.7	50	61.4	62.9	63.4	28.8
Seneca	73	47	61.3	63.3	64.3	31.9
Steuben	76.9	50	59.9	59.4	49.5	29.8
Wayne	79.6	43	62.3	65	51.4	29.1
Yates	75.5	55	63.2	69.6	48.7	30.1

Sources: County Health Rankings, American Medical Association, National Provider Identifier, Healthy People 2020, NYS Prevention Agenda, Statewide Perinatal Data System, National Center for Health Statistics, CDC, Vital Records, Behavioral Risk Factor Surveillance System, NYS Medicaid Program, IAP Baseline Report, NYSIIS Performance Report, Child Health Plus.

Oral Care

Oral care is important to overall health. Lack of dental insurance, insufficient provider numbers, and lack of dentists willing to see Medicaid clients-contribute to residents' inability to access preventive and acute dental care. Table 17 describes the state of dental care in the region. All data points demonstrate room for improvement, particularly Medicaid preventive visits for those ages 2-20 as early preventive care prevents future chronic conditions. (Table 18)

Table 18: Oral Care

County	Adult Dental Visits (%) (2019)	Medicaid Visits (age 2-20) (%) (2023)	Medicaid Visits (%) (2023)	Medicaid Preventive Visit (%) (2023)	Medicaid Preventive Visit (age 2-20) (%) (2023)
Chemung	65.4	43.3	25.2	21.4	40.8
Livingston	69.9	41.3	26.7	22.7	38.7
Ontario	74.5	40	25	21.1	37.1
Schuyler	58.4	43.6	24.3	20.6	40.5
Seneca	69.1	34.8	21.6	17.4	30.9
Steuben	59.5	41.1	23.9	20.2	38.5
Wayne	66.6	39.4	25.1	20.6	36.2
Yates	62.6	41.2	25.1	21.1	37.2

Sources: County Health Rankings, American Medical Association, National Provider Identifier, Healthy People 2020, NYS Prevention Agenda, Statewide Perinatal Data System, National Center for Health Statistics, CDC, Vital Records, Behavioral Risk Factor Surveillance System, NYS Medicaid Program, IAP Baseline Report, NYSIIS Performance Report, Child Health Plus.

Lack of access to dental care, the use of non-fluorinated well water by many rural residents, and an emerging trend of municipalities removing fluoride from public water systems leave Finger Lakes residents at risk for oral diseases and disorders.

Emergency Department Visits and Preventable Hospitalizations

Emergency Departments may serve as the source of primary care for those who are underinsured or lack health insurance. In addition, lack of provider access may contribute to increased reliance on emergency rooms and may cause preventable hospitalizations. Migrant populations fearing deportation may defer medical care until an emergency room visit and subsequent hospitalization is necessary. Mennonite community members often self-treat common maladies and wait until they are experiencing advanced illnesses which require the use of an emergency room.

Many Finger Lakes counties exceed New York State averages for emergency department visits and preventable hospitalizations. Four counties exceed the state rate for behavioral health ED visits; four exceed the state rate for all preventable hospitalizations; and all but one county exceeds the state rate for all emergency department visits. The number of emergency department visits related to behavioral (suicidal thoughts, substance use, psychiatric disorders), and mental health (depressive disorders) are areas that may be improved. (Table 19)

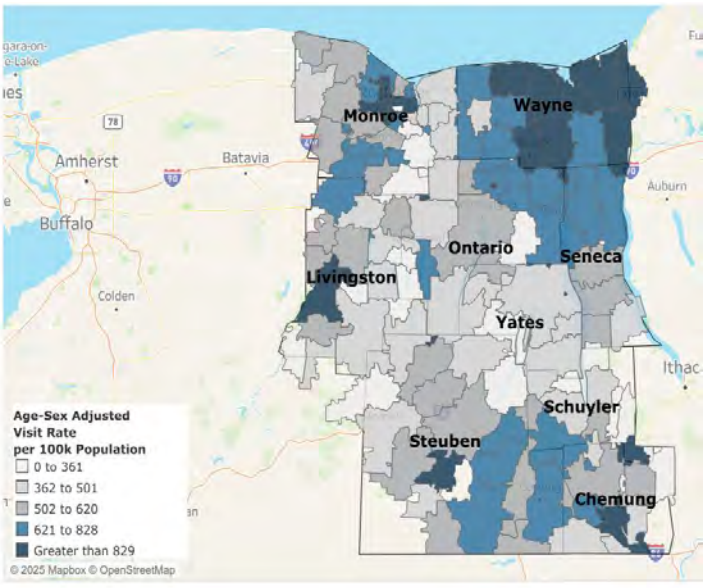
Table 19: Emergency Department Visits and Preventable Hospitalizations

County	All Emergency Department Visits (2023) (NYS = 29,809)	All Behavioral Health Conditions ED Visits (2023) (NYS = 6,872)	All Mental Health ED Visits (2023) (NYS = 3,370)	All Preventable Hospitalizations (2023) (NYS = 808)
Chemung	43,624	8,622	4,204	1,046
Livingston	27,323	5,798	2,470	723
Ontario	33,756	6,132	2,645	780
Schuyler	52,967	7,108	3,523	954
Seneca	38,723	6,873	3,014	885
Steuben	44,043	8,215	3,292	720
Wayne	31,387	8,617	3,423	1,072
Yates	41,443	4,935	2,303	604

Source: SPARCS

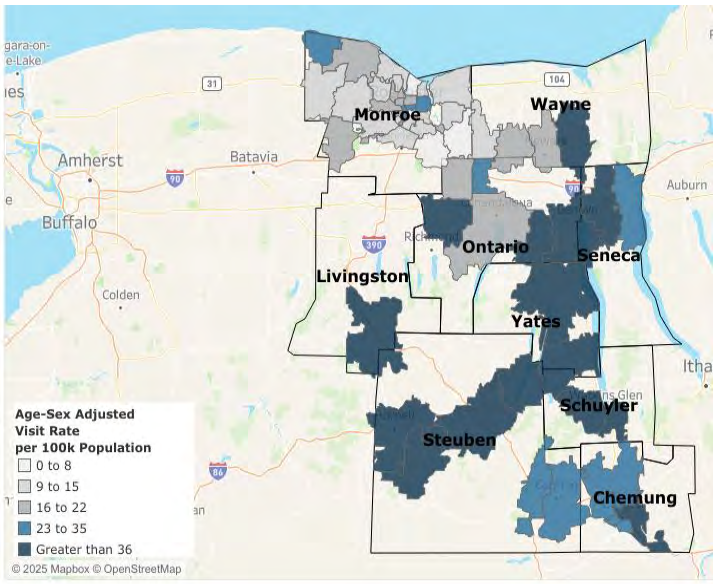
Map 14 highlights the potentially preventable hospitalizations by zip code in the Finger Lakes region. This map corresponds with maps highlighting life expectancy as well as emergency department visits for heart disease, cancer, hypertension, depressive disorders, and anxiety and panic disorders (Maps 17-22) as well as poverty (Maps 6-8). Note that the concentrations of potentially preventable hospitalizations as well as the emergency department visits cluster in similar areas of the region. This corresponds with higher poverty rates as well as decreased life expectancy. Higher rates of emergency department use and preventable hospitalizations in certain counties and populations—especially people living in poverty, on Medicaid, or in rural areas—signal inequitable access to timely, high-quality outpatient care and contribute to widening health disparities.

Map 17: Potentially Preventable Hospitalizations



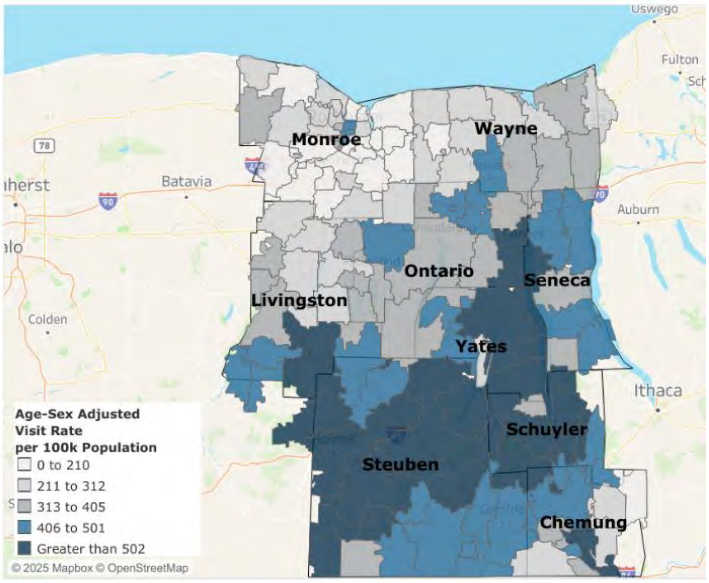
Source: Statewide Planning and Research Cooperative System (SPARCS), 2019-2023
Analysis by Common Ground Health

Map 18: ED Visits for Cancer by Zip Code



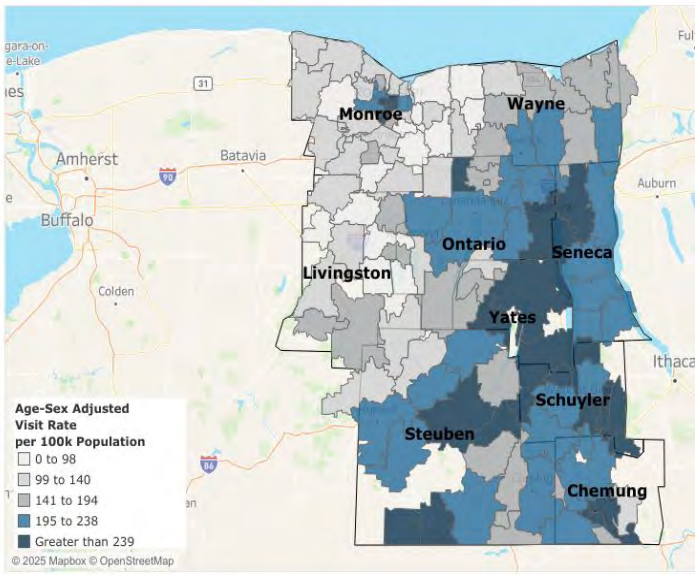
Source: Statewide Planning and Research Cooperative System (SPARCS), 2019-2023
Analysis by Common Ground Health

Map 96: ED Visits Related to Heart Disease by Zip Code



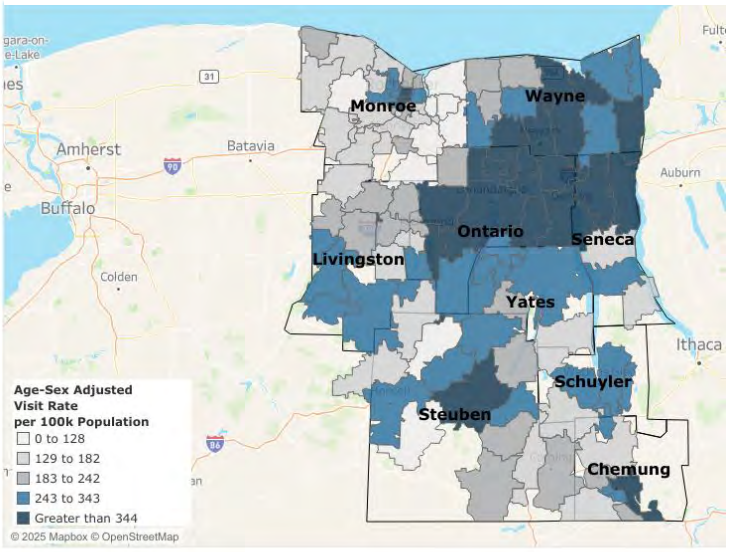
Source: Statewide Planning and Research Cooperative System (SPARCS), 2019-2023
Analysis by Common Ground Health

Map 20: ED Visits for Hypertension by Zip Code



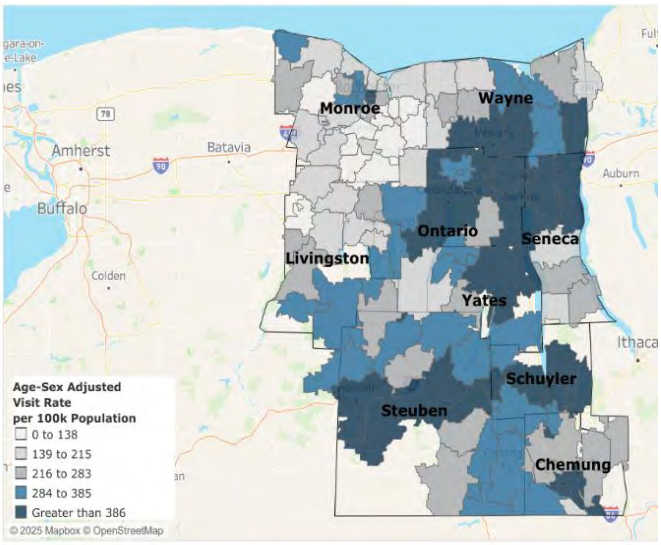
Source: Statewide Planning and Research Cooperative System (SPARCS), 2019-2023
Analysis by Common Ground Health

Map 21: ED Visits for Depressive Disorders by Zip Code



Source: Statewide Planning and Research Cooperative System (SPARCS), 2019-2023
Analysis by Common Ground Health

Map 22: ED Visits for Anxiety and Panic Disorders by Zip Code

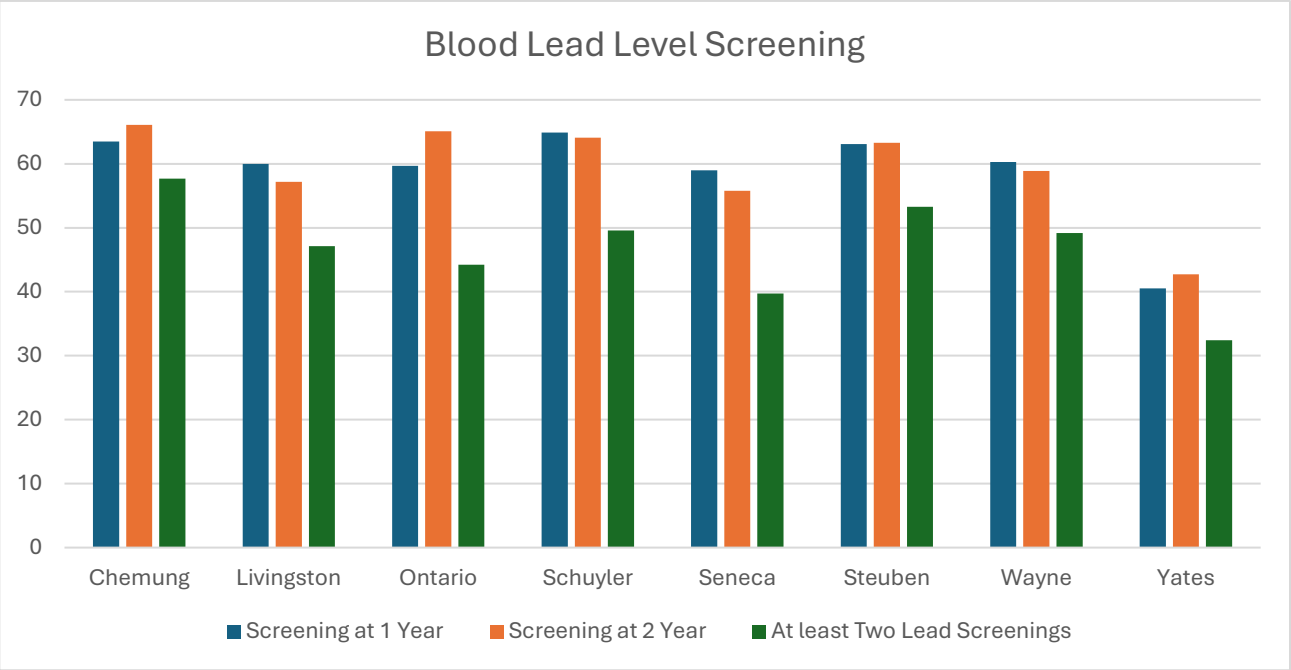


Source: Statewide Planning and Research Cooperative System (SPARCS), 2019-2023
Analysis by Common Ground Health

Blood Lead Level Screening and Vaccinations

One important screening that happens during well-child visits is a blood lead level test. "Asymptomatic lead poisoning has become more common in children. Blood lead levels of greater than 5 ug per dL are associated with impairments in neurocognitive and behavioral development that are irreversible."[29] It is required that children to have at least two screenings in the first 36 months of life – one at age one and one at age 2. (Figure 29) In addition, the 4:3:1:3:1:4 (four doses of DTaP (Diphtheria, Tetanus, and Pertussis), three doses of polio (IPV), one dose of MMR ((Measles, Mumps, and Rubella)), three doses of Hib ((Haemophilus influenzae type b)), three doses of Hepatitis B, one dose of Varicella, and four doses of pneumococcal vaccine (PCV)) childhood vaccination series are key to keeping not just children, but the overall population free of vaccine preventable diseases. (Figure 30)

Figure 29: Blood Lead Level Screening in the Finger Lakes Region

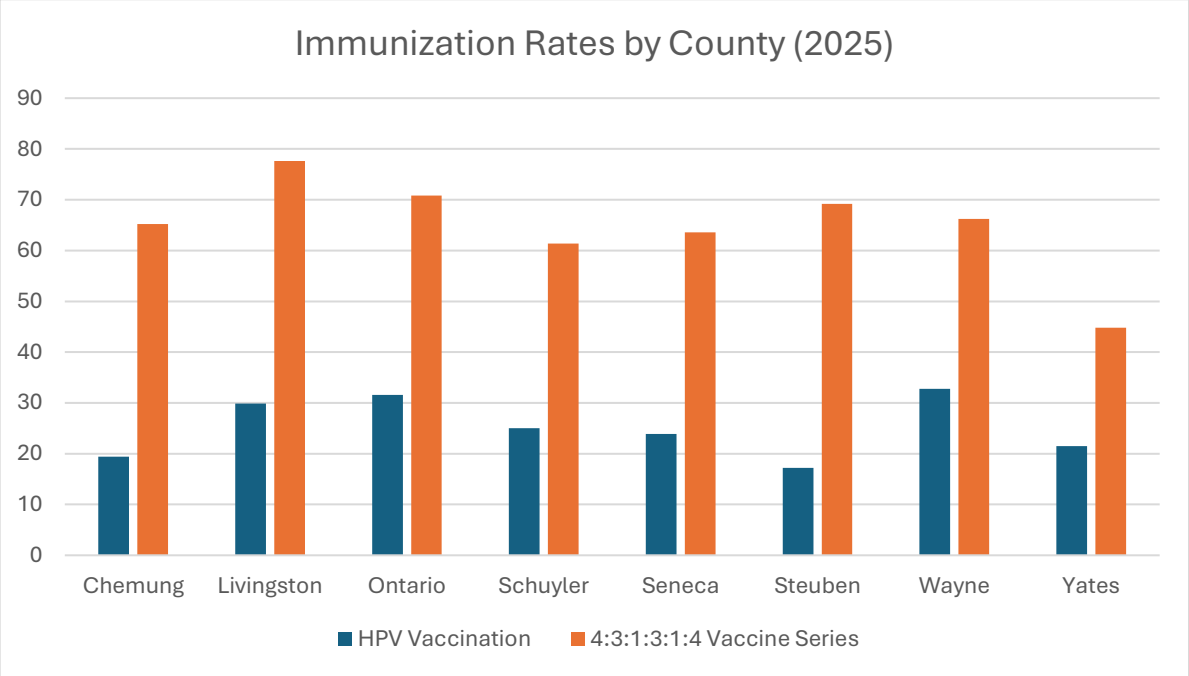


Source: NYSIIS Performance Report

[29] Mayans, L. (2019). Lead poisoning in children. American family physician, 100(1), 24-30.

The Finger Lakes region shows persistent gaps in key pediatric and adolescent preventive services, despite relatively strong early-childhood immunization rates. Across the eight counties, completion of the 4:3:1:3:1:4 vaccine series consistently exceeds both lead screening by age two and adolescent HPV vaccination, indicating that standard early-childhood vaccines are delivered more reliably than other preventive services. HPV vaccination is the lowest measure in every county, and lead-screening completion remains only moderate, signaling missed opportunities for cancer prevention and early detection of environmental hazards affecting low-income and rural children.

Figure 30: Immunization Rates by County in the Finger Lakes



Source: NYSIIP

Education Access and Quality

Health and Wellness Promoting Schools

Health and wellness promoting schools refers to the non-academic factors that impact whether a student is set up for success. These may include the prevalence of healthy food choices and ability to participate in physical activity.

One important indicator of how well schools are supporting students is chronic absenteeism, defined as missing at least 10 percent of school days in a year. State-level data from the 2022–2023 school year show that nearly one in three New York students is chronically absent, with rates varying by region, race and ethnicity, and socioeconomic status. Chronic absenteeism has increased sharply in rural districts, reaching 13.4 percent in low-need rural areas, 25.2 percent in average-need rural areas, and 33.0 percent in high-need rural areas. Economically disadvantaged students, students with disabilities, and English language learners experience the highest

absenteeism rates, highlighting the need for school-based strategies that address health, transportation, and other non-academic barriers to attendance.[30]

Additional indicators include the percentage of teens and young adults who were neither working nor in school (disconnected youth), the number of school age students eligible for free or reduced lunch and the number of childcare centers per 100,000 children under age 5 as highlighted in Table 20.

Table 20: Education-related Socio-economic factors

County	% teens and young adults (age 16-19) neither working nor in school (2025) (NYS: 7%)	% school age children eligible for free or reduced lunch (2025) (NYS: 57%)	Number of childcare centers per 1,000 children under age 5 (2025) (NYC: 6)
Chemung	11	53	6
Livingston	5	44	7
Ontario	5	43	6
Schuyler	Not available	43	5
Seneca	14	56	3
Steuben	9	50	8
Wayne	9	50	4
Yates	Not available	55	3

Source: County Health Rankings

Three measures of opportunities for continued education are the high school graduation rate, the average spending per student, and the high school graduation rate of economically disadvantaged students. All counties except Seneca and Yates exceed the New York State average percent of adults over age 25 with a high school diploma or equivalent. A quality education may improve the economic prosperity of residents by allowing them to obtain better compensated employment which increases their economic stability. (Table 21)

Table 21: Education Indicators

County	Percent of adults over age 25 with a high school diploma or equivalent (2023) (NYS = 88)	Average gap ($) between actual and required spending in public school districts (2022) (NYS = $12,754)	Graduation rate of economically disadvantaged students (2023) (NYS = 82)
Chemung	91	9,909	75
Livingston	93	11,626	87
Ontario	93	12,784	85
Schuyler	91	11,955	80

[30] Source: New York's Stubbornly High Rates of Chronic Absenteeism. October 2024. https://www.osc.ny.gov/files/reports/pdf/missing-school-ny-chronic-absenteeism.pdf

Seneca	85	13,399	80
Steuben	92	12,721	85
Wayne	91	12,785	81
Yates	84	9,915	81

Source: U.S. Census Bureau, ACS, NYSED

The findings in this Community Health Assessment show that health in the Finger Lakes region is shaped by intersecting social and economic conditions, including poverty, food and housing insecurity, transportation barriers, provider shortages, and educational opportunity. These challenges are not experienced equally: older adults, children, people living in rural and higher deprivation ZIP codes, and residents from historically marginalized groups often face higher risks and fewer resources, leading to persistent health inequities across the region. At the same time, strong community assets—including collaborative public health and health care systems, engaged community organizations, and dedicated residents—provide a foundation for collective action.

The accompanying county chapter build on this regional picture by highlighting the county's specific strengths, challenges, and priority populations. Together, the regional and county-level assessment will guide the development of Community Health Improvement Plans that focus on advancing health equity, strengthening the conditions where people live, learn, work, and age, and improving health outcomes for all residents of the Finger Lakes region.

Farm overlooking Keuka Lake, Courtesy of Steuben County

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Chemung River, Steuben County

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Participating Partners and Community Representation

A diverse coalition of organizations and community members participated in the Steuben County Community Health Assessment process to ensure broad stakeholder input and representation from populations experiencing health disparities. The following partners contributed:

Organization	Sector	Population
Steuben County Public Health	Public	All Steuben County residents
Arnot Health – Ira Davenport Hospital	Hospital	Residents of the Southern Tier and Twin Tiers region (Chemung, Steuben, Schuyler counties)
Corning Hospital (Guthrie Corning)	Hospital	Eastern Steuben County and surrounding areas
Steuben Rural Health Network	Community Organization	Serves healthcare providers, community organizations, and residents of Steuben County and nearby rural counties.
Oak Orchard Health Center	Nonprofit - FQHC	Underserved and uninsured individuals and families in Steuben and surrounding counties.
Steuben County Alcoholism and Substance Abuse Services (SCASAS)	Public	County residents struggling with substance use disorders and co-occurring mental health needs
Steuben County Opioid Committee	Public / Multi-sector Coalition	Residents affected by opioid and substance use across Steuben County.
St. James Hospital	Hospital	Western Steuben County and surrounding areas
ProAction Steuben & Yates	Nonprofit	Low-income individuals and families, children (through Head Start/Early Head Start), seniors (through aging services), and those facing barriers to employment, housing, or food security.

Corning Wegmans	Private (Grocery Store)	General public in Corning and surrounding areas
Steuben County Department of Social Services	Public	Steuben County residents needing social supports
Steuben County Community Services	Public	Residents of Steuben County who access public assistance programs
Foodbank of the Southern Tier	Nonprofit	Food-insecure individuals and families across the Southern Tier (Chemung, Steuben, Schuyler, Tioga, Tompkins, and Broome Counties)
Pivital Public Health Partnership	Nonprofit	Local health departments and their communities in the Finger Lakes and Southern Tier regions
Common Ground Health	Nonprofit	Residents of the Finger Lakes and Southern Tier regions, with emphasis on populations experiencing health disparities
STTAC Advancing Tobacco-Free Communities - Roswell Park	Public (State-Affiliated)	Patients from across New York State and beyond, especially those affected by or at risk for cancer.
NAMI Steuben	Nonprofit	Residents in Steuben County with or are at risk for mental illness(es)

Keuka Lake, Hammondsport, Courtesy Steuben County

Executive Summary

For the 2025–2030 Prevention Agenda cycle, Steuben County has identified three priority areas in this Community Health Assessment. These include:

- Housing Stability and Affordability
- Poverty
- Primary Prevention, and Substance Misuse and Overdose Prevention

Disparity Groups

In Steuben County, health disparities are most pronounced among low-income individuals and families, who face higher rates of food insecurity, housing cost burdens, and barriers to preventive care. Older adults, particularly those experiencing poverty, are at greater risk for chronic disease and limited access to services. Youth and adolescents face increasing mental health challenges, high rates of suicide, and obesity, compounded by exposure to adverse childhood experiences. Residents with mental health or substance use issues, those living in rural areas or without reliable transportation, and Medicaid enrollees also experience reduced access to healthcare and preventive services. Households facing housing instability further contend with stress and health risks, highlighting the need to focus interventions on these vulnerable populations.

Data Sources

These priorities were selected based on a comprehensive review of quantitative and qualitative data sources, including the County Health Assessment, NYSDOH Prevention Agenda dashboards, BRFSS indicators, SPARCS data, and community input gathered through surveys, focus groups, and partner consultations. This review confirmed persistent inequities disproportionately affecting residents with low income, individuals living in rural areas, older adults, people experiencing homelessness, individuals with limited health literacy, and those with substance use disorders or re-entering the community following incarceration.

Partners and Roles

Steuben County's CHIP development and implementation are supported by the SMART Steuben coalition, working alongside hospitals, federally qualified health centers, behavioral health providers, human service agencies, schools, libraries, and community-based organizations. Partners play critical roles in data sharing, assessment validation, priority-setting, intervention planning, and implementation. Community members are engaged through multiple participatory approaches, including outreach events, public forums, and structured surveys, to ensure that priority populations are meaningfully represented throughout the assessment and planning processes.

Summary of Findings

Steuben County faces a range of public health challenges influenced by social, economic, and environmental factors. While the overall poverty rate decreased slightly to 13.7% in 2025, child poverty remains at 19% and poverty among adults over 65 has risen sharply to 11.1%. Employment and income disparities contribute to financial instability, with unemployment at 3.9% and a median household income of $64,300. Access to nutritious food remains a concern for some residents, particularly low-income households, although the percentage of adults who are food secure has improved to 77.9%, exceeding state targets. Housing stability and affordability are relatively strong, with 74% of housing units owner-occupied, yet 11% of households still face major housing challenges or spend over half their income on housing.

Mental health is a critical area of concern, with 19% of adults reporting 14 or more days of poor mental health per month, above the state average, and a high prevalence of depression at 29.5%. Suicide rates, especially among youth, are rising sharply, highlighting unmet behavioral health needs. Substance use is an increasing issue, with overdose rates rising dramatically since 2014, and tobacco and heavy alcohol use remain higher than state averages. Adverse childhood experiences continue to affect a substantial portion of the population, contributing to long-term health risks and social challenges.

Health behaviors such as diet and physical activity show mixed trends. While access to physical activity locations increased significantly, only 52% of residents have adequate access, and 24% report no leisure-time physical activity. Daily fruit and vegetable consumption is moderate, and sugary drink consumption has decreased among lower-income residents. Social conditions, including transportation limitations and community vulnerabilities, affect residents' ability to maintain healthy lifestyles, though civic engagement and community networks remain relatively strong.

Maternal and child health indicators demonstrate improvements in prenatal care, substance abstinence, and breastfeeding rates, but infant mortality remains above the state average, and maternal mortality has increased. Preventive care shows mixed results, with high mammogram rates but lower colorectal screening, blood sugar, and blood pressure monitoring, particularly among low-income adults. Oral health access is limited, especially for Medicaid-enrolled children and adults, while childhood immunization and lead screening rates have improved but remain areas for continued focus.

Education and youth engagement are positive contributors to community health, with high school graduation rates above state averages and strong post-secondary participation among adults, although disparities in post-secondary attainment persist. Steuben County's health profile reflects a community performing comparably to New York State and above national averages in overall health and social determinants, yet persistent disparities in mental health, substance use, economic stability, and access to preventive care highlight the need for targeted interventions to improve health equity and outcomes across the county.

Intervention and Strategies

To address the identified priorities, partners have committed to a coordinated set of evidence-informed strategies designed to reduce disparities and improve outcomes for populations most affected by local inequities. Planned interventions include structured tracking of housing support for unhoused patients; routine screening and referral for social needs; public awareness campaigns promoting assistance programs; school-based nutrition education paired with produce incentive initiatives; older adult–focused resource guides and Veggie Van distribution; provider education on opioid stewardship; expanded naloxone training and distribution; and development of public data dashboards to improve transparency and community awareness. These interventions were selected based on their alignment with evidence-based state and national best practices, feasibility within rural settings, and strong partner and community support.

Progress Measures and Evaluation

Progress will be monitored through a formal CHIP Progress Reporting and Revision Plan, which includes quarterly submission of process measures from partner organizations, regular SMART Steuben meetings to assess implementation progress and identify barriers, annual reviews of strategy performance, and multi-year evaluations of outcome trends. Performance measures will include indicators such as screening and referral rates, voucher distribution and redemption, naloxone kit distribution, participation in education and support programs, and related service utilization metrics. As new evidence, policy changes, or resource shifts emerge, interventions will be revised to ensure continued relevance, feasibility, and impact. Through this structured and responsive approach, Steuben County and its partners aim to strengthen health, address disparities, and advance equity across the community over the 2025–2030 period.

Community Description

Service Area

Steuben County is located in the Southern Tier of New York State and serves a diverse population with varying healthcare needs across its rural and small-city communities. Local health services are delivered through a network of hospitals, primary care practices, behavioral health providers, community clinics, and public health programs that operate throughout the county. Residents commonly access care in key population centers such as Corning, Bath, and Hornell, where medical facilities and specialty services are concentrated. This local healthcare landscape shapes how public health initiatives are developed to support prevention, chronic disease management, and overall community well-being.

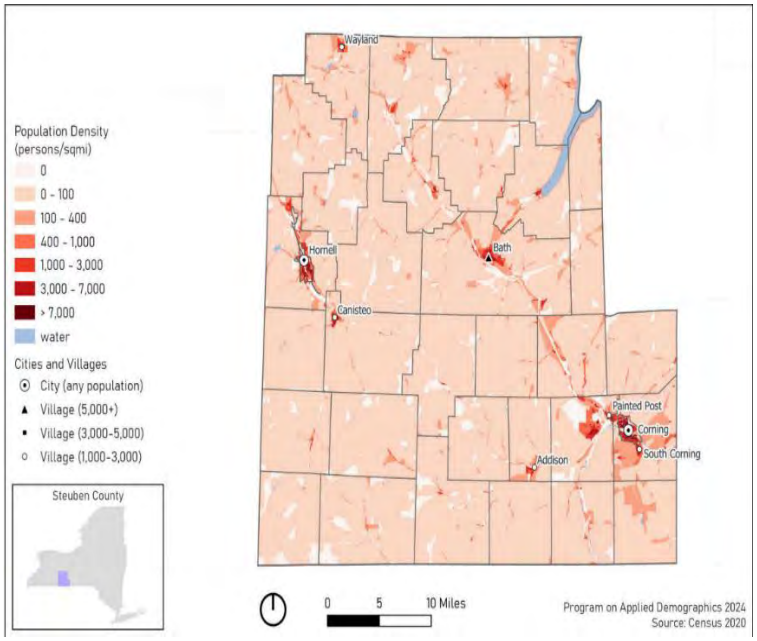
Geographically, Steuben County spans roughly 1,400 square miles, making it one of the largest counties in New York. It is characterized by rural terrain, agricultural areas, and small towns alongside more urbanized hubs. Its position along the Pennsylvania border, coupled with its extensive rural road network, influences travel patterns for healthcare, emergency response, and

social services. Many residents also seek services in nearby communities such as Elmira, creating a regional flow of healthcare utilization that public health planning must consider.

Demographic Summary

Demographic information is essential in public and community health because it helps identify who lives in a community, how their needs differ, and where health disparities exist. By understanding factors such as age, race, income, education, and poverty, organizations can target resources, design effective programs, and allocate funding where it will have the greatest impact. In short, demographic data provides the foundation for equitable planning, informed decision-making, and improved health outcomes for all community members.

Map ST1: Population Density of Steuben County

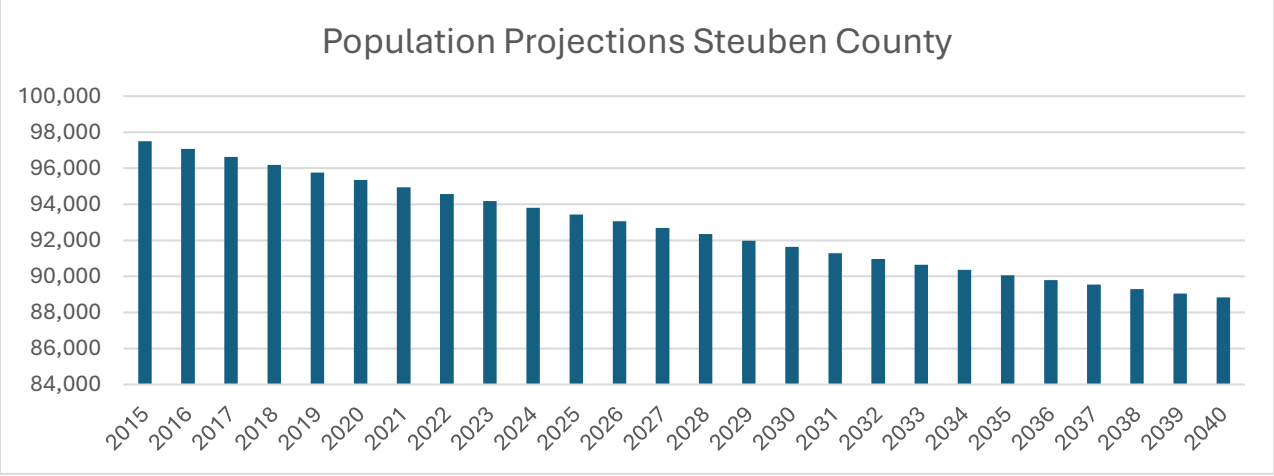


Source: Cornell Program on Applied Demographics

Population

Steuben County is located in north central New York State along the Pennsylvania border. Several small cities, comprise the county including Bath (11,424), Corning (10,551) and Hornell (8,263). Map ST1 depicts the population density throughout Steuben County where 59.8% is considered rural. Figure ST1 depicts Steuben County's population decline expected through 2040. The county has an overall population of 91,162. Small population densities may be seen in municipalities referenced as part of our service area and are scattered across the county landscape.

Figure ST1: Population Projections in Steuben County

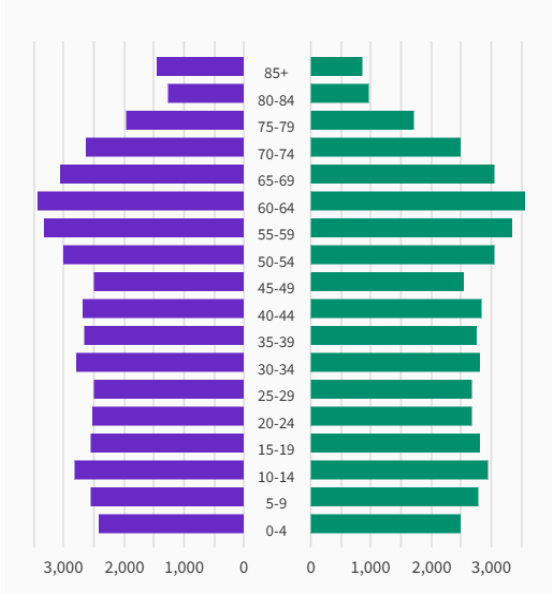


Source: Cornell Program on Applied Demographics

Age and Sex

To better understand the health needs of a community, it is important to know the sex and age breakdown. Figure ST2 shows the number of county residents by sex and age. The median age in Steuben County is 43.7, while the percentage of the population that is female is 49.9% and those identifying as LGBTQ+ is 5.8%. The county has one larger population group from 50-79 but is relatively evenly split between male and female.

Figure ST2: Population by Age and Sex (Female = Purple)



Source: USA Facts 2022 per U.S. Census

Race and Ethnicity

Steuben County is largely White (91%) followed by Black or African American (1.5%), Hispanic or Latino (1.89%), and Asian (1%).[31] The regional section of this CHA denotes additional population considerations including Amish/Mennonite and farmworkers.

Veterans and Disabled

Veterans often have distinct health needs, including higher rates of chronic conditions, mental health challenges, and service-related injuries. Steuben County has an office of Veteran's Administration centrally located in the town of Bath. 2023 Census figures indicate the veteran population in Steuben County accounts for 8.6%, higher than the state average of 3.9%. Of that number, 95% are male and 5% are female.

Disabled persons may face heightened barriers to care, transportation, employment, housing, and healthy living. The disabled population in Steuben County is 15.6% compared with 13.5 in the state as a whole. The most common disabilities are cognitive, independent living and ambulatory difficulty.

Language Spoken at Home

In Steuben County, per the U.S. Census, the percentage of people who speak a language other than English at home is 5.5%. The percentage of those who speak Spanish is 0.8%; those who speak Indo-European languages is 3.2%; those who speak Asian and Pacific Island languages is 1.1%; and 0.3% percent speak other languages. English language proficiency is one factor in ensuring residents are able to communicate their needs and understand their options, particularly related to health care.

[31] An Ecosystem of Minority Health and Health Disparities Resources. National Institute on Minority Health and Health Disparities.

Broadband Access

Broadband access is important because it enables residents to use essential services such as telehealth, online health information, appointment scheduling, and remote monitoring, tools that are especially vital for rural communities and those with limited transportation. Reliable internet also supports health education, emergency communication, social connection, and access to benefits and resources, helping reduce disparities and improve overall community well-being. Broadband access in Steuben County, as measured in the 2025 County Health Rankings, is 86%, while NYS is 90%. The percentage of the population with no access to broadband services meaning broadband is simply not available in their area is 10% in Steuben County.

Health Status Description

Specific Methodology

The CHA provides a comprehensive picture of a community's current health status, including factors that contribute to health risks and challenges, and identifies priority health needs by analyzing local data and community input. Community partners played a key role throughout the development of the CHA. Each partner completed the Community Partner Assessment (CPA), providing valuable organizational data and insights. They also helped identify and engage community members and organizations for focus groups as part of the Community Context Assessment (CCA), ensuring diverse perspectives were included.

Throughout the process, partners participated in regular meetings where findings from all three assessments were presented. These sessions encouraged questions, feedback, and shared interpretation of the data. The full committee collaboratively reviewed and discussed the triangulated results, allowing partners to validate findings and contribute to identifying key themes.

Finally, partners actively participated in reviewing issue profiles and in the prioritization process, ensuring that shared priorities reflected both data and community voice.

Partners participated in a discussion about the issue profiles, identifying root causes for the cross-cutting themes that were identified through data triangulation. The discussion led to the creation of a fishbone diagram for each priority detailing the factors that contribute to the issue such as environment, processes, people, and policies.

Members of the SMART Steuben workgroup participated in the prioritization process. A prioritization matrix was developed with drop-down menus numbered 1 to 5 (one being most important; 5 being least important) to rank each identified issue based on five criteria to determine which three issues would be developed as priority areas for this CHA. A similar, but appropriately adjusted, survey was shared with the general public via social media and partner contacts. The SMART Steuben results were then analyzed with the public's responses to reveal the top three priorities shared between both groups.

The county used CHA data and triangulated findings to inform a community survey that supported development of the Community Health Improvement Plan. This survey, disseminated through partner networks and social media, asked residents to react to the priority issues emerging from the CHA and to identify which areas they felt were most important to address. Community input from this CHIP survey was incorporated into the final prioritization process alongside partner feedback, ensuring that the public had an opportunity to respond to and shape the issues identified through the CHA.

The cross-cutting themes discovered via data triangulation to be ranked in Steuben County were:

- Mental Well-Being and Substance Use
- Economic Well-Being
- Health Insurance Coverage and Access to Care
- Safe and Health Communities

The five criteria used to prioritize issues were:

- Relevance of the issue to community members
- Magnitude/severity of the issue
- Impact of the issue on communities impacted by inequalities
- Availability and feasibility of solutions and strategies to address the issue
- Availability of resources (time, funding, staffing, equipment) to address the issue

New York State Prevention Agenda 2025-2030

Table ST1 identifies the NYSDOH Prevention Agenda Domains and Priorities. The domains and priorities shown in bold are those selected by Steuben County for targeted action in the Community Health Assessment (CHA). The Community Partners column lists organizations that participated in the Community Partner Assessment (CPA) demonstrating a diverse mix of partner organizations engaged in activities covering every major social determinant of health, indicating strong capacity for cross-sector health improvement efforts and broad representation across local priorities.

Table ST1: NYS Prevention Agenda

Prevention Agenda Domain	Priorities	Community Partners (from CPA)	Demonstrated Capacity / Role
Economic Stability	**Poverty** **Housing Stability & Affordability**	**ProAction of Steuben & Yates; Steuben County Community Services; Foodbank of the Southern Tier; Oak Orchard Health; Corning Wegmans; Steuben Rural Health Network; Common Ground Health; Steuben County Public Health**	**Providing financial stability supports; housing navigation; food access and distribution; social needs screening and referral; community resource coordination; employment and workforce supports;**

			rural health systems planning
Social and Community Context	**Primary Prevention, Substance Misuse & Overdose Prevention**	**Steuben County Public Health; SCASAS; Steuben County Mental Health; Steuben County Opioid Committee; NAMI Steuben; Arnot Health – Ira Davenport; Corning Hospital (Guthrie); St. James Hospital; Steuben Rural Health Network; STTAC – Advancing Tobacco-Free Communities**	**Substance use prevention and treatment; harm reduction; mental health counseling and crisis services; provider-to-provider coordination; overdose surveillance; recovery support; tobacco cessation and policy work; community mobilization; supportive services for individuals and families**
Neighborhood and Built Environment	Healthy food access; housing quality; safe environments; transportation & land use	Foodbank of the Southern Tier; Corning Wegmans; Steuben Rural Health Network; Common Ground Health; ProAction ; Steuben County Public Health	Improving food distribution and affordability; coordinating local transportation and access issues; supporting housing stability programs; analyzing built environment and walkability factors; community safety and environmental health supports

Health Care Access and Quality	Access to care; preventive services; chronic disease prevention; oral health	Arnot Health – Ira Davenport Hospital; Corning Hospital (Guthrie Corning); St. James Hospital; Oak Orchard Health; Steuben County Public Health; Steuben Rural Health Network; Pivital Public Health Partnership; Common Ground Health; SCASAS; Steuben County Mental Health	Delivering medical, behavioral health, and oral health services; preventive screenings; chronic disease management; care coordination; health planning and assessment; quality improvement; data analytics; treatment for mental health and substance use disorders
Education Access and Quality	Early childhood development; literacy; health-promoting schools; youth development	ProAction (Head Start/Early Head Start); Common Ground Health; Steuben Rural Health Network; Steuben County Public Health	Early childhood education; family support services; youth programming; literacy and school readiness; school-based wellness initiatives; data-driven school health assessments
Cross-cutting / Other	Inclusion; accessibility; support for diverse populations	NAMI Steuben; ProAction (aging services); Steuben County Mental Health; Pivital Public Health Partnership; Common Ground Health; Steuben Rural Health Network	Mental health advocacy and peer support; aging services and caregiver supports; disability services; regional training and technical assistance; population health data; partnerships that connect multiple sectors

The following section details Steuben County's health status related to the Prevention Agenda domains and priorities.

Domain: Economic Stability

Socioeconomic disparities have a profound impact on health, influencing physical and mental well-being as well as educational outcomes. Children and older adults are particularly vulnerable, as limited resources and reduced access to support services heighten their risk for adverse health conditions.

Unemployment and underemployment further drive inequities. Individuals without stable employment often face significant barriers to health care, and their health tends to decline the

longer they remain unemployed. These challenges are shaped by shifts in the labor market, stagnant wages, and weakening labor protections, all of which limit opportunities for stable, well-paying work.

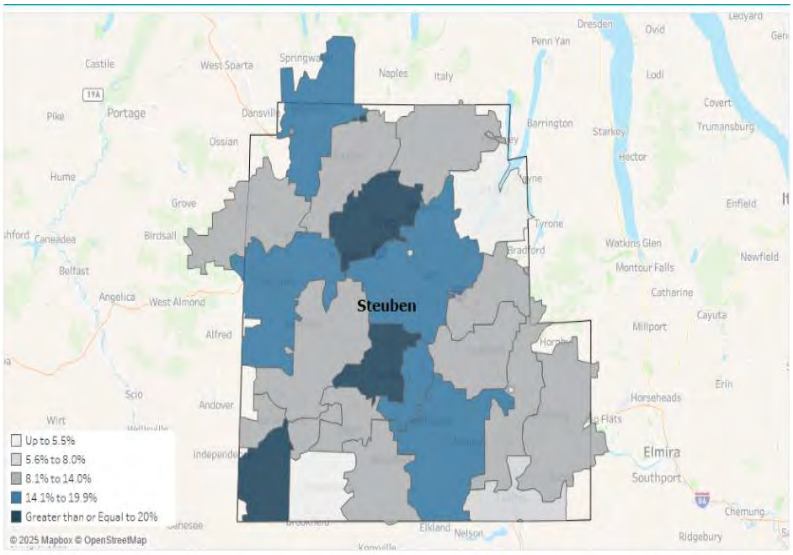
Reliable access to affordable, nutritious food is essential for preventing chronic disease and promoting healthy development. Food insecurity disproportionately affects low-income households, people with lower educational attainment, and those experiencing unemployment. Many rural and economically disadvantaged communities lack full-service grocery stores and instead depend on higher-cost convenience stores with few healthy options.

Housing instability also contributes to poorer overall health and well-being. Low-income families and older adults experience the greatest housing-related burdens, which can lead to increased exposure to environmental hazards, stress, and unsafe living conditions.

Priority: Poverty

Poverty can strain nearly every aspect of community life, from housing stability to access to healthcare, transportation, and nutritious food. Families facing financial hardship often struggle to meet basic needs, and limited local resources can make it difficult for them to find sustainable pathways out of poverty.

Map ST2: Overall Poverty Rate in Steuben County



U.S. Census Bureau, 2019-2023 ACS 5-yr Estimates. Table S1701 (Poverty Status in the Past 12 Months)

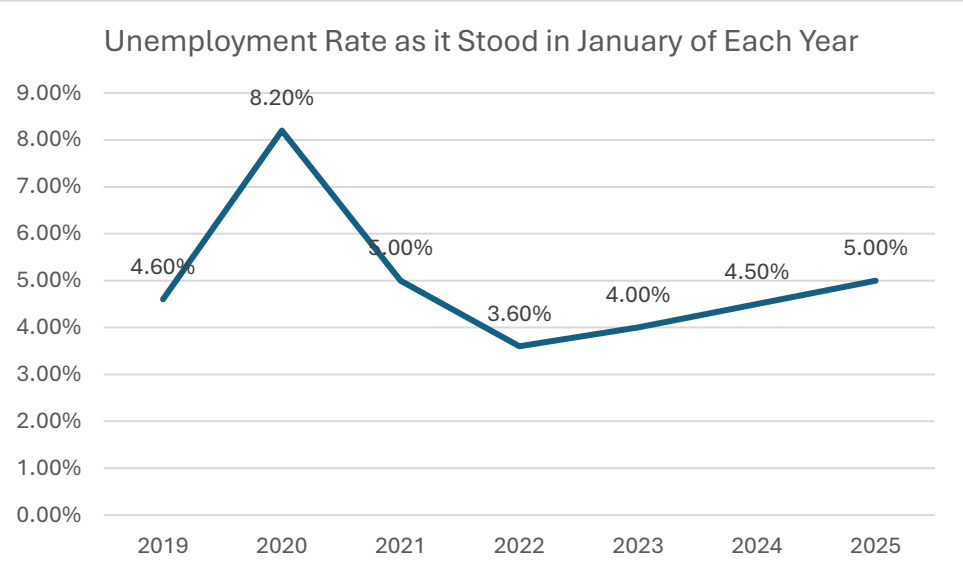
Common Ground Health

Steuben County's overall population poverty rate, per 2023 U.S. Census figures, decreased 2% to 13.7% from 2018 (even with the state average of 13.7%). The percentage of children under 18 years-of-age living in poverty remained unchanged at 19% (with the state average of 19%). The percentage of the population over 65 years-of-age living in poverty increased 63% to 11.1% (lower than the NYS average of 12.7%) but increasing sharply. Map ST2 notes the percentage of those living in poverty in different areas of the county.

Priority: Employment

Unemployment can lead to financial instability for families and reduced economic vitality for the community as a whole. High unemployment often strains social services, limits consumer spending, and can contribute to long-term challenges such as housing insecurity, poor health outcomes, and decreased quality of life.

Figure ST3: Unemployment Rate



Source: Bureau of Labor Statistics

The unemployment rate was 3.9% in August 2025. The median household income in the county is $64,300. Figure ST3 notes the unemployment rate as it stood in January of each year from 2019 to the present.

The primary employment sectors are manufacturing followed by health care and social assistance, educational services and others.

Priority: Nutrition Security

Nutrition insecurity can lead to higher rates of chronic disease, poor child development, and overall diminished health and well-being. When families lack consistent access to affordable, nutritious food, community systems, from healthcare to schools, feel the strain, and long-term inequities in health outcomes deepen.

Nutrition security data from the Behavioral Risk Factor Surveillance System were used to determine food security in Steuben County. Most recent data from 2019 note that 4% of the population of Steuben County does not live close to a grocery store which is above the state average of 2% and an increase of 33% from 2015. Data on perceived food security among adults with an annual household income of less than $25,000 is available for 2016. In that year, 49.1% of individuals in this income group reported being food secure, above the state average of 50.8% and decrease of 24%. From 2018 to 2021, the percentage of adults aged 18 and older who were food secure increased 3% to 77.9%, exceeding the PA target value of 75.9%. The NYS rate was 75.1% in 2021.

The Food Environment Index measures how easy it is for residents to access healthy, affordable food, combining rates of food insecurity and the percentage of low-income people living far from a grocery store. Scores range from 0 (worst) to 10 (best). Steuben County's score decreased 1% to 8.1 and is just below the New York State average of 8.7.

Priority: Housing Stability and Affordability

Housing instability and a lack of affordable options can leave families struggling to meet basic needs, often forcing them to choose between rent, food, and healthcare. When stable housing is out of reach, communities experience higher rates of homelessness, overcrowding, and financial stress, which can undermine overall health, safety, and economic growth.

In 2021, 11% of households had at least one major housing problem—overcrowding, high housing costs, or lack of kitchen or plumbing facilities. This is well below the New York State average of 23% and represents an 8% decrease since 2017. In 2023, 74% of occupied housing units were owner-occupied, higher than the statewide rate of 54% and up slightly (1%) from 2019. In 2023, 11% of households spent half or more of their income on housing, a 10% increase since 2019 but still below the state average of 19%.

Economic Stability Domain Summary: Steuben County faces economic and social challenges that impact health and well-being. Overall poverty is 13.7%, child poverty is 19%, and poverty among adults over 65 has risen to 11.1%. The unemployment rate is 3.9%, with key sectors in manufacturing, healthcare, and education.

Nutrition security is improving, with 77.9% of adults food secure, but access challenges remain, and the Food Environment Index is slightly below the state average. Housing is generally stable, though 11% of households spend half or more of their income on housing. These factors underscore the need to address economic stability, nutrition, and housing to support community health.

Domain: Social and Community Context

Mental health is a core component of overall well-being, influencing daily functioning, healthy relationships, and an individual's ability to cope with challenges. Persistent stress and anxiety can contribute to conditions such as depression and substance misuse and are associated with increased risks of long-term health problems and premature mortality.

Suicide remains a significant public health concern. It continues to be one of the leading causes of death among young people, and many high school students report experiencing suicidal thoughts or attempting suicide. These trends highlight ongoing gaps in prevention, early intervention, and access to mental health supports.

Depression affects more than one in five New Yorkers each year and can severely disrupt daily life. Certain populations are at greater risk due to chronic stress, exposure to trauma, and systemic inequities. Stigma, limited availability of services, and challenges with affordability or transportation continue to prevent many individuals from seeking or receiving timely care.

Substance use and overdose deaths continue to create serious challenges across the state. Early initiation of alcohol or drug use, widespread availability of substances, and community norms all influence risk. Commercial tobacco use also remains a major driver of preventable illness and death, with longstanding disparities fueled by targeted marketing in low-income and minority communities. Excessive alcohol use is common and contributes to thousands of deaths and

billions of dollars in economic costs annually. Factors such as availability, low pricing, and targeted marketing contribute to heavier burdens among specific populations.

Adverse childhood experiences (ACEs) are strongly associated with increased risks of chronic disease, mental health disorders, and substance misuse later in life. Addressing early trauma and supporting protective factors are essential to improving long-term outcomes.

Healthy eating is another important factor in chronic disease prevention. However, many New Yorkers do not consume recommended amounts of fruits and vegetables, reflecting ongoing challenges with affordability, availability, and nutrition-related behaviors.

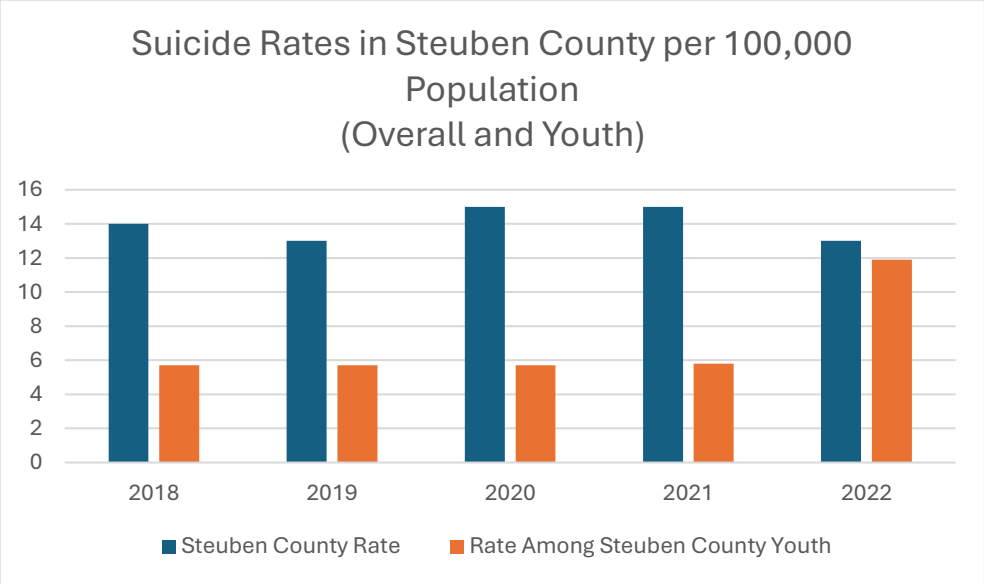
Priority: Anxiety and Stress

In 2022 reporting in the Behavioral Risk Factor Surveillance System, the percentage of adults reporting 14 or more days or more days of poor mental health per month (age-adjusted) increased 27% from 2018 to 19% above the NYS average of 16%. Experiencing 14 or more days of poor mental health in a month is strongly linked to worse overall health outcomes. When this percentage rises - as it has in Steuben County - it can signal increasing stress, depression, or anxiety in the community, which may lead to higher rates of chronic disease, substance use, reduced productivity, and greater demand for mental health and medical services. An elevated rate also suggests that residents may struggle more with daily functioning, decision-making, and maintaining healthy behaviors, ultimately affecting both individual well-being and community health.[32]

Priority: Suicide

The National Center for Health Statistics, notes the suicide rate in the county was 13 per 100,000 in 2022, a decrease of 7% as shown in Figure ST4; higher than the NYS average of 8. The suicide rate among youth (15-19 years-of-age) per 100,000 is 11.9 which is higher than the NYS average of 5.6 and an increase

Figure ST4: Suicide Rate per 100,000 Population



Source: County Health Rankings, National Center for Health Statistics

[32] Source: Strine TW, Balluz L, Chapman DP, Moriarty DG, Owens M, Mokdad AH. Risk behaviors and healthcare coverage among adults by frequent mental distress status, 2001. Am J Prev Med. 2004 Apr;26(3):213-6. doi: 10.1016/j.amepre.2003.11.002. PMID: 15026100.

of 120% from 2021 as shown in figure ST4.

Rising suicide rates signal worsening mental health and increasing levels of stress, trauma, or unmet behavioral-health needs in the community. When the county's overall suicide rate, and especially its youth suicide rate, exceeds the state average, it suggests that residents may face greater barriers to timely mental-health care, social support, or crisis intervention. Higher suicide rates also have wide-reaching impacts: they strain families, schools, healthcare systems, and communities, and often indicate deeper issues such as isolation, substance use, economic stress, or limited access to mental-health services.[33]

Priority: Depression

The age-adjusted rate of adults reporting a depressive disorder in 2021 is 29.5%, higher than the NYS average of 18.7% and an increase of 7%. This is a significant public health concern because a high prevalence of depressive disorders in the community can lead to widespread impacts on physical health, productivity, and overall well-being. Elevated rates of depression are associated with increased risk of chronic diseases, substance use, social isolation, and suicide, as well as greater demand for mental health services. When the county's rate is both higher than the state average and rising, it indicates that many residents may not be receiving adequate treatment or support, contributing to long-term health disparities and strain on local healthcare and social services.[34]

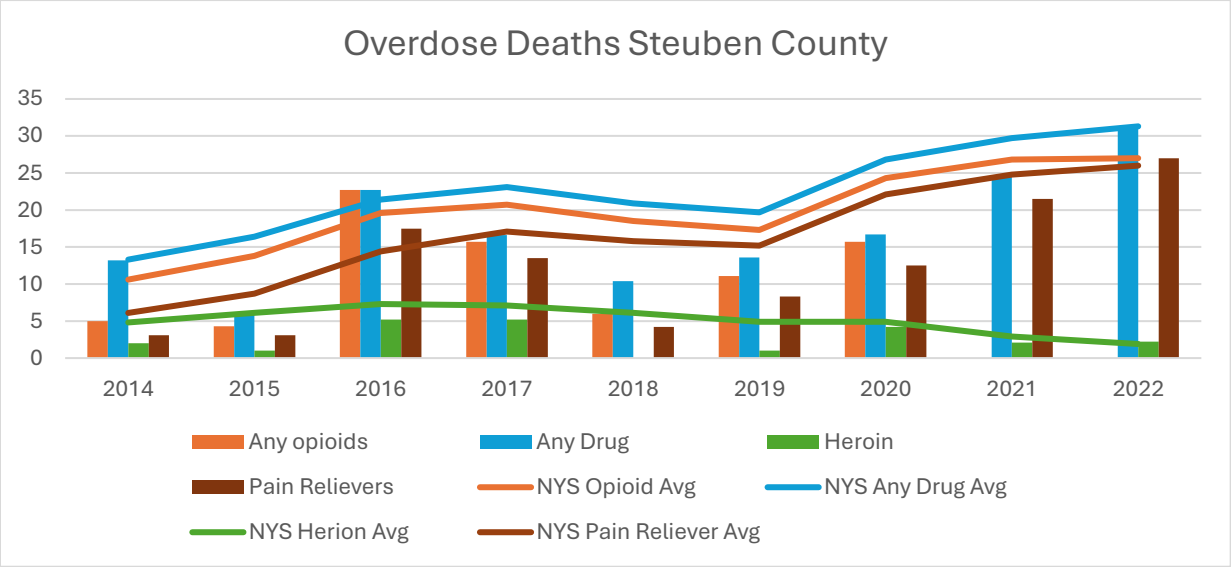
Priority: Drug Misuse and Overdoses Including Primary Prevention

Overdose deaths, as reported in 2022, continue to trend upward from 2014 with the exception of heroin as noted in Figure ST5. Overdoses involving any opioids have increased 708% from 2014; involving any drug have increased 341%; involving heroin have increased 120%; and involving pain relievers have increased 800%. All overdose deaths are below state averages and are measured per 100,000 population.

This is a serious public health problem because rising overdose rates reflect increasing substance use and related harms in the community, which can lead to preventable deaths, long-term health complications, and social and economic consequences. Even though the county's rates are below state averages, the sharp increases signal a growing crisis that strains emergency services, healthcare systems, and families, and indicates a need for targeted prevention, treatment, and harm-reduction strategies.[35]

[33] Source: https://www.cdc.gov/suicide/facts/index.html
[34] Source: https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health
[35] Source: https://www.cdc.gov/overdose-prevention/about/

Figure ST5: Overdose Deaths



Source: National Center for Health Statistics

Priority: Tobacco and Alcohol Use

According to 2022 data in the Behavioral Risk Factor Surveillance System, the percentage of adults who are current smokers (age-adjusted) is 17%, higher than the NYS average of 12% and a decrease of 19%. The percentage of adults reporting binge or heavy drinking increased 10% to 22%, above the NYS average of 20%. Data on e-cigarette use among adults in the county are not available. Both smoking and excessive alcohol use are major risk factors for chronic diseases, including heart disease, cancer, liver disease, and respiratory illnesses. Higher rates of these behaviors in the community increase the burden on healthcare systems, contribute to preventable morbidity and mortality, and can reduce quality of life. Persistent smoking above the state average and rising binge or heavy drinking indicate that residents may face elevated long-term health risks and that targeted prevention and intervention efforts are needed.[36]

Priority: Adverse Childhood Experiences

Adverse Childhood Experiences are those emotional and physical circumstances one experiences before age 18. They may include neglect, sexual abuse, parental divorce, mental illness and/or substance abuse in the home, and exposure to violence. ACEs impact individuals well into adulthood and may include physical and mental long-term health problems. Data are tracked in the Behavioral Risk Factor Surveillance System and reflect data from 2021. The age-adjusted percentage of adults with two or more adverse childhood experiences decreased 36% to 36.5%, below the NYS average of 40.5%

[36] Source: Kim Y. The effects of smoking, alcohol consumption, obesity, and physical inactivity on healthcare costs: a longitudinal cohort study. BMC Public Health. 2025 Mar 5;25(1):873. doi: 10.1186/s12889-025-22133-4. PMID: 40045251; PMCID: PMC11881326.

ACEs have long-lasting effects on physical, mental, and behavioral health. Experiencing two or more ACEs increases the risk of chronic diseases, mental health disorders, substance use, and social challenges well into adulthood. Even though the county's rate of adults with two or more ACEs has decreased to 38.8% - below the state average - this still represents a substantial portion of the population at higher risk for long-term health problems and increased healthcare and social service needs.[37]

Priority: Healthy Eating

The percentage of adults who eat fruits (44.7% - an increase of 9%) and vegetables (52%, a decrease of 21% from 2016) daily may be tied to the availability of fresh produce and the convenience of a nearby grocery store. The percentage of adults with an annual household income of less than $25,000 who drink one or more sugary drinks every day decreased 42% to 25%, lower than the NYS average of 29.1%. Data comes from 2021 in the Behavioral Risk Factor Surveillance System.

Low consumption of fruits and vegetables and high intake of sugary drinks contribute to poor nutrition, obesity, diabetes, heart disease, and other chronic conditions. When access to healthy foods is limited, especially for lower-income populations, residents are more likely to develop diet-related illnesses, increasing healthcare costs and reducing overall community health and quality of life.[38]

Social and Community Context Domain Summary: Steuben County faces significant mental health and substance use challenges. In 2022, 19% of adults reported 14 or more days of poor mental health per month, above the state average, signaling rising stress, depression, and anxiety. The adult depression rate is 29.5%, markedly higher than the NYS average, and suicide rates, particularly among youth, are also elevated.

Substance misuse is a growing concern, with overdose deaths from opioids, pain relievers, and other drugs sharply increasing since 2014. Tobacco and heavy alcohol use remain above state averages, contributing to chronic disease risk.

Adverse Childhood Experiences affect over a third of adults, creating long-term risks for physical and mental health. Dietary behaviors show low fruit and vegetable intake and high sugary drink consumption, further increasing risks for obesity, diabetes, and heart disease. Collectively, these trends highlight the urgent need for comprehensive mental health, substance use prevention, and nutrition-focused interventions in the county.

Domain: Neighborhood and Built Environment

Regular physical activity provides significant health benefits across the lifespan. It reduces the risk of major chronic diseases—including heart disease, stroke, type 2 diabetes, and several cancers—and promotes stronger bones and muscles, better sleep, improved mental health, and longer life expectancy.

[37] Source: https://www.cdc.gov/aces/about/index.html
[38] Source: https://www.cdc.gov/nutrition/php/about/index.html

However, opportunities for physical activity are not equally accessible to everyone. Structural barriers such as unsafe neighborhoods, limited or inaccessible recreational facilities, and built environments that do not support diverse needs all influence a person's ability to be active. Social factors—including income, education, community support, and cultural norms—also shape activity levels. Physical features of the environment, such as well-maintained parks, safe sidewalks, bike lanes, and walkable neighborhood designs, play a critical role in enabling regular movement.

Active transportation, such as walking or biking for daily travel, can help integrate physical activity into routine behaviors. Yet this depends on having safe, connected routes and destinations that are within a reasonable distance.

Injuries, both intentional and unintentional, remain a major cause of premature death. Motor vehicle crashes, falls, and overdoses contribute significantly to injury-related mortality, with disproportionate impacts on racial and ethnic minority groups, older adults, and individuals employed in high-risk occupations.

Priority: Opportunities for Active Transportation and Physical Activity

In 2024, 52% of the population had adequate access to locations for physical activity, a significant increase of 940%, but still well below the New York State average of 93%. In 2023, 9.9% of households lacked access to a vehicle, up 10%, compared to the state average of 29%. The county's walkability index remained unchanged at 1.83 in 2019 (on a scale of 0–20, with 20 being most walkable). Among adults aged 18 and older, 24% reported no leisure-time physical activity, slightly below the NYS average of 25%, representing a 14% decrease.

Access to safe spaces for physical activity, transportation options, and walkable environments directly affect residents' ability to maintain regular exercise. Low physical activity is linked to higher risks of obesity, heart disease, diabetes, mental health issues, and overall premature mortality. Limited walkability and inadequate access to activity locations or transportation can create barriers to healthy lifestyles, contributing to long-term health disparities in the community.[39]

Priority: Access to Community Services/Civic Participation

"The degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, among others, may affect that community's ability to prevent human suffering and financial loss in the event of a disaster" define its social vulnerability index. In Steuben County, the SVI, as measured in 2022, is 0.5410 (1 is the highest vulnerability), an increase of 18%.

Civic engagement may be measured as voting, volunteering, and participating in community events. The percentage of the population of voting age who voted in the 2020 presidential election is 63.2%.

[39] Source: https://www.who.int/news-room/fact-sheets/detail/physical-activity

Per the 2025 National County Health Rankings, "in Steuben County there were 11.1 membership organizations per 10,000 people. These include civic, political, religious, sports and professional organizations."

Social vulnerability reflects how well a community can withstand and recover from disasters or emergencies. A higher Social Vulnerability Index (SVI) indicates that residents - particularly those in poverty, without transportation, or living in crowded households - may face greater risk of harm and slower recovery. Civic engagement and strong community networks, such as high voter participation and membership in organizations, help build social cohesion, improve disaster preparedness, and support collective action during crises. Steuben County's relatively low SVI and strong civic involvement suggest it has a solid foundation to respond to community challenges, though vulnerabilities still exist for certain populations.[40]

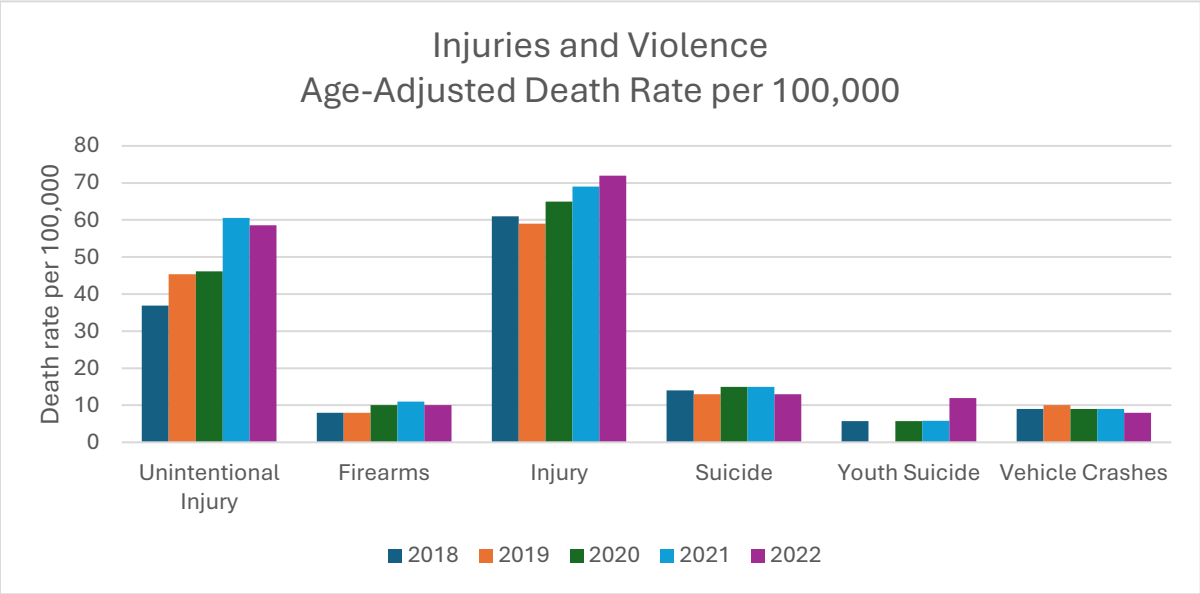
Priority: Injuries and Violence

Unintentional injury deaths continue to be concern. Firearm, injury, motor vehicle crash and suicide deaths are all above state rates and increasing. Overall injury and violence-related deaths are a growing threat to community health and safety. Figure ST6 details age-adjusted injury and violence death rates per 100,000 population. The age-adjusted rate of unintentional injury death in 2022 increased 99% from 2015 to 58.6 (NYS average of 54.1); death due to firearms increased 25% from 2018 to 10 (NYS average of 5); death due to injury increased 18% from 2018 to 72 (NYS average of 60); adult suicide decreased 7% from 2018 to 13 (NYS average of 54.1); youth suicide increased 120% from 2015 to 11.9 (NYS average of 5.6); vehicle crashes decreased 11% from 2018 to 8 (NYS average of 6).

Unintentional and intentional injury deaths, such as those from firearms, motor vehicle crashes, and suicide, directly contribute to premature mortality and long-term physical, emotional, and economic consequences for families and communities. Rates above state averages and increasing trends indicate rising risk factors, such as unsafe environments, mental health challenges, substance use, and lack of safety interventions. High injury and violence-related death rates also strain healthcare systems, emergency services, and social support networks, highlighting the need for targeted prevention, education, and community safety initiatives.[41]

[40] Source: County Health Rankings.
[41] Source: https://www.cdc.gov/injury/index.html

Figure ST6: Injuries and Violence



Source: NYSDOH - Office of Quality & Patient Safety

Neighborhood and Built Environment Domain Summary: In Steuben County, access to physical activity locations improved to 52% in 2024, though it remains well below the NYS average of 93%, and 24% of adults report no leisure-time physical activity. Limited walkability and transportation access continue to pose barriers to healthy lifestyles, increasing long-term health risks. The county's social vulnerability index rose to 0.541 in 2022, while civic engagement is relatively strong, with 63.2% voter turnout and 11.1 membership organizations per 10,000 people, providing community resilience despite existing vulnerabilities. Injury and violence-related deaths—including from firearms, motor vehicle crashes, and suicide—are above state averages and increasing, signaling rising risks to health and safety and emphasizing the need for targeted prevention and safety initiatives.

Domain: Health Care Access and Quality

Prenatal care - encompassing risk assessment, health promotion, and timely clinical intervention - is most effective when initiated early and continued throughout pregnancy. Consistent prenatal care reduces the likelihood of preterm birth, low birth weight, and both maternal and infant mortality.

Chronic diseases such as heart disease, stroke, cancer, diabetes, and obesity remain leading causes of death in New York State and throughout the Finger Lakes region. These conditions contribute significantly to morbidity, health care costs, and reduced quality of life.

Oral health is a critical component of overall well-being, influencing nutrition, speech, and social development. Vulnerable populations, particularly low-income communities, experience higher

rates of untreated dental disease, reflecting persistent disparities in access to preventive and restorative dental care.

Routine immunizations and developmental screenings are essential for supporting healthy growth in children; however, access and uptake remain uneven. Systemic inequities, transportation challenges, and historical mistrust create barriers that contribute to gaps in vaccination and screening rates. Early Intervention Programs provide crucial support for infants and toddlers with developmental delays, and timely identification and services can prevent or reduce long-term educational and social challenge - yet equity gaps persist across communities.

Priority: Access to and Use of Prenatal Care

Receiving early and adequate prenatal care is important for ensuring a healthy pregnancy. Smoking, alcohol and illegal drug use abstinence are important indicators of appropriate prenatal care. Steuben County improved in all three from 2018. The percentage of birthing persons who abstained from alcohol was 99.5%, an increase of 9% (2024 data from the National Survey on Drug Use and Health), abstinence from smoking was 84.5%, an increase of 14%, and abstinence from illegal drug use was 98%, an increase of 5%.[42]

In addition, prenatal care may be measured using low live birth weights (<2,500 grams or about 5 lbs., 8 oz.) and premature births (live births before 37 weeks). Vital Records data indicate that 7.8% of births (2022 data) were preterm, a decrease of 9% from 2013 and lower than the state average of 9.5%. Live births with low birth weights were 7% (2023 data), unchanged from 2018 and just below the NYS average of 8%.

Breastfeeding infants is important to ensure optimal nutrition. The percentage of infants fed breast milk only or both breast milk and formula at the time of hospital discharge (2024 data) was 84.7%, an increase of 27% from 2015. Those who were fed exclusively breast milk in the hospital was 65.1%, a decrease of 5% from 2013 and higher than the NYS average of 46.7%.[43]

Priority: Prevention of Infant and Maternal Mortality

Prematurity and its related conditions are the leading causes of infant mortality. Reducing rates of premature births may have a direct impact on rates of infant mortality. Data for infant mortality are measured in deaths per 1,000 individuals. Steuben County's infant mortality rate in 2022 was 6 per 1,000 population, a decrease of 14% but higher than the state average of 4 per 1,000.[44]

Maternal mortality is measured per 100,000 population. Steuben County's maternal morality rate in 2022 was 34.5 per 100,000 population, an increase of 11% and higher than the state average of 22 per 100,000 population.

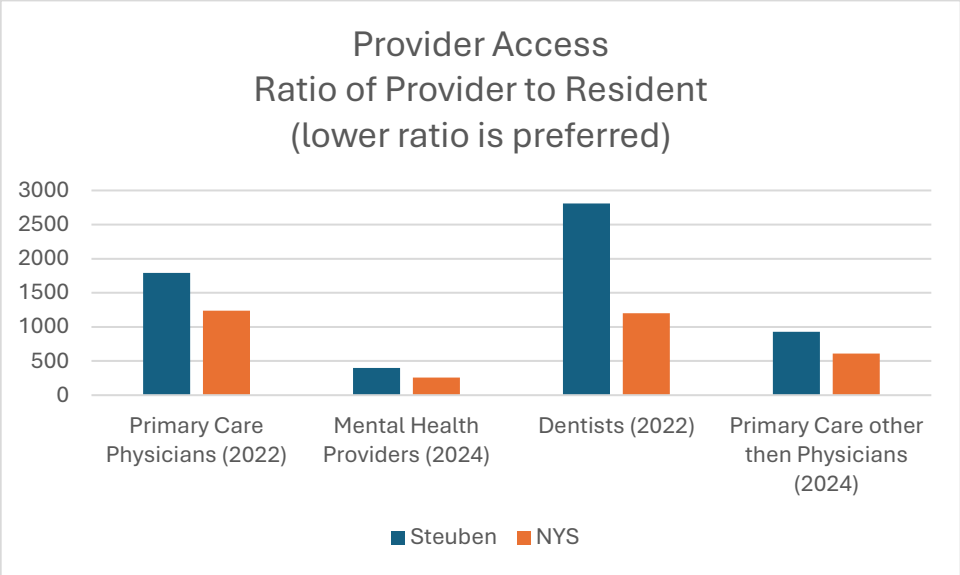
Priority: Preventive Services for Chronic Disease Prevention and Control

[42] Source: U.S. Department of Health and Human Services, Healthy People 2020, *National Center for Health Statistics*
[43] Source: *NYS Prevention Agenda, Vital Records*
[44] Source: *NYS Prevention Agenda, Statewide Perinatal Data System, Vital Records*

Many factors impact access to care for the community. Provider shortages, insurance coverage and economic and geographic challenges all pose barriers to access to care in Steuben County.

There are fewer primary care physicians (1,790:1), mental health providers (400:1), dentists (2,810:1) and primary care providers other than physicians (930:1) compared to state averages. This is specially challenging for rural residents and those with limited transportation. Most residents have health insurance, with rates better than NYS. Low-income households and rural communities face higher barriers to accessing preventive and specialty care. Many residents struggle with transportation, cost, and availability of services. (Figure ST7)

Figure ST7: Provider Access



Source: County Health Rankings, Area Health Resource File/American Medical Association

Health insurance access is holding steady or increasing in 2022. The percentage of the adult population under age 65 without health insurance decreased 17% to 5%, lower than the 7% in NYS. The percentage of the population under 65 without health insurance is unchanged at 5% and below the state average of 6%. The most dramatic change is the children under 19 without health insurance which increased 50% to 3%, even with the NYS average of 3%.[45]

Preventive care shows mixed trends, based on 2022 data. Mammogram rates among women ages 50–74 increased 4% from 2018 to 76.9%, and Medicare enrollees receiving mammograms rose to 50%, above the state average of 44% and an increase of 2% from 2018. Colorectal screening declined 9% from 2018 to 59.9%, and adults aged 45+ tested for high blood sugar or diabetes dropped 11% from 2018 to 59.4%, below the state average of 63.8% (data from 2021). Among lower-income adults (<$25,000), 49.5% in 2018 had blood pressure or diabetes tests in the past three years, down 19% from 2016. The prevalence of high blood pressure in 2021 in adults 18+ increased 4% to 29.8%.[46]

[45] Source: County Health Rankings, Small Area Health Insurance Estimates
[46] Source: CDC, Local Data for Better Health; County Health Rankings: Mapping Medicare Disparities Tool; Behavioral Risk Factor Surveillance System

Oral Health Care

According to County Health Rankings, Steuben County has a dentist-to-population ratio of 2,810 to 1. Adult dental care use has declined. In 2019, 59.5% of adults had a dental visit in the past year - a 14% decrease since 2014 and below the New York State average of 71.3%.

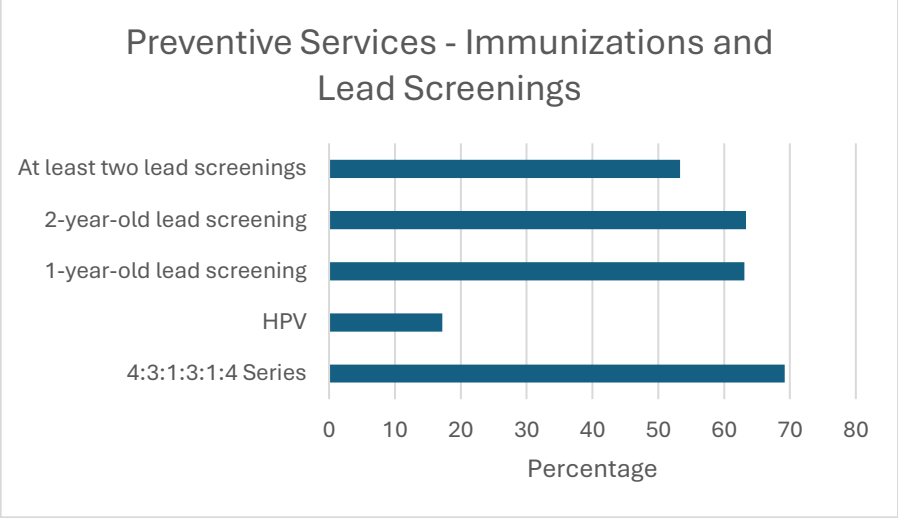
Access is even more limited for Medicaid enrollees. In 2023, 41.1% of Medicaid-insured children and youth (ages 2–20) had at least one dental visit in the past year, a 24% increase since 2014 and below the state average of 48.6%. Preventive visits were also lower, with 38.5% receiving at least one – a 25% increase but below the state average of 45.2%.

For Medicaid-enrolled adults, only 23.9% had a dental visit in the past year (an increase of 3% since 2014), and just 20.2% had a preventive visit (unchanged). Both rates remain lower than the statewide averages of 30.1% and 26.0%, respectively.[47]

Preventive Services – Immunizations and Lead

Data from 2025 indicate that the percentage of children who have received the 4:3:1:3:1:4 (four doses of DTaP (Diphtheria, Tetanus, and Pertussis), three doses of polio (IPV), one dose of MMR ((Measles, Mumps, and Rubella)), three doses of Hib ((Haemophilus influenzae type b)), three doses of Hepatitis B, one dose of Varicella, and four doses of pneumococcal vaccine (PCV)) immunization increased 30% from 2016 to 69.2%, higher than the state average of 63.6%. The number of children who received the HPV vaccine increased 5% to 17.2%.

Figure ST8: Preventive Services – Immunizations and Lead Screenings



Source: NYSIIS Performance Report, IAP Baseline Report

Lead screening 2024 data indicate that the percentage of children aged one year who received one lead screening is 63.1%, an increase of 45% from 2015. The percentage of children aged two years who received at least one lead screening was 63.3%, an increase of 21%. Those who received at least two lead screenings by two years of age was 53.3%, an increase of 45%. (Figure ST8)

Health Care Access and Quality Domain Summary: In Steuben County, prenatal care improved from 2018, with high rates of abstinence from alcohol (99.5%), smoking (84.5%), and illegal drug use (98%). Preterm births decreased to 7.8%, while low birth weight remained stable at 7%, slightly below the state average. Breastfeeding rates at hospital discharge increased to 84.7%, with 65.1%

[47] Source: *Behavioral Risk Factor Surveillance System, NYS Medicaid Program, NYS Prevention Agenda*

exclusively breastfed. Infant mortality decreased to 6 per 1,000 births, though still above the state average, and maternal mortality rose to 34.5 per 100,000.

Access to preventive care shows mixed trends: most residents have insurance, but provider shortages pose barriers, particularly for rural and low-income populations. Mammogram rates improved, while colorectal cancer and diabetes screenings declined. Adult dental care decreased overall, with particularly low preventive care use among Medicaid enrollees.

Child preventive services improved, with 69.2% receiving recommended immunizations (above NYS averages) and modest HPV vaccination coverage. Lead screening rates for children increased substantially, though gaps remain. Overall, the county shows progress in maternal and child health, but access to preventive services and chronic disease management remains a concern.

Domain: Education Access and Quality

Chronic absenteeism, defined by the U.S. Department of Education as missing at least 10% of the school year for any reason, rose sharply in New York State after the COVID-19 pandemic. In 2022–23, 26.4% of all students and 34.1% of high schoolers were chronically absent, far above the pre-pandemic rate of 15.5%. Chronic absenteeism is associated with lower academic achievement, social disengagement, higher dropout risk, and poorer long-term health and economic outcomes.

Education strongly influences health. Individuals with more schooling live longer, have fewer chronic diseases, and experience greater economic stability. Several factors contributing to absenteeism such as physical and mental health challenges, substance use, unsafe school environments, and low fitness levels.

Post-secondary education also brings substantial benefits. Adults with a bachelor's degree earn significantly more, are less likely to be unemployed, and have better health and safer working and living conditions than those with only a high school diploma. However, affordability and unequal access remain challenges.

Priority: Health and Wellness Promoting Schools

County-specific absenteeism data were not available. State level data may be found in the regional section of this CHA.

Additional indicators to explain Steuben County's health and wellness promoting schools may include 2025 data from the County Health Rankings. The percentage of teens and young adults who were neither working nor in school (disconnected youth) is 9%, lower than the state average of 7%, the number of school age students who are eligible for free or reduced lunch (50% vs 57% for the NYS) and the number of child care centers per 100,000 children under age 5 (8 vs 6 for NYS).[48]

Priority: Opportunities for Continued Education

The percentage of adults ages 25 and over with a high school diploma or equivalent increased 2% to 92% in 2023, higher than the NYS average of 88%. The percentage of adults in 2023 aged 25-44 with some post-secondary education increased 3% to 64%, lower than the NYS average of 71%. The

[48] Source: County Health Rankings

percentage of ninth grade cohort that graduates in 4 years is 91% in 2023, higher than the NYS average of 87% and an increase of 5%. The average gap in dollars between actual and required spending per pupil among public school districts in 2022 is $12,721 compared with $12,745 on average in NYS; an increase of 19%. The percentage of economically disadvantaged graduation rate in 2023 is 85% vs. 82% for NYS; an increase of 6%.

Education Access and Quality Domain Summary: While county-level absenteeism data for Steuben County are unavailable, related indicators from the 2025 County Health Rankings provide context for school-based health and wellness. Steuben has a slightly higher rate of disconnected youth than the state (9% vs. 7%), but fewer students qualify for free or reduced lunch and the county has more child care centers per young children than the state average. Educational outcomes show strong high school completion and four-year graduation rates that exceed state averages, alongside a rising share of adults with a high school diploma. However, post-secondary attainment among adults ages 25–44 remains below the New York State average.

Chronic Disease

Chronic disease prevention is key in helping communities maintain and improve health outcomes and well-being. Many chronic diseases impact the community. The prevalence of adults over age 20 with diagnosed diabetes in 2022 is 9%, a decrease of 36% and slightly lower than the NYS average of 10%. The percentage of adults presenting as obese in 2021 decreased 3% to 30.8%, lower than the NYS average of 31.6. The percentage of children and adolescents with obesity increased 29% to 24.6% in 2018 (the most recent data available), higher than the NYS average of 20.6%. The percentage of children ages 2-4 with obesity who participate in SNAP and WIC decreased 2% to 15.1% in 2017 (the most recent data available), higher than the NYS average of 15.2%.

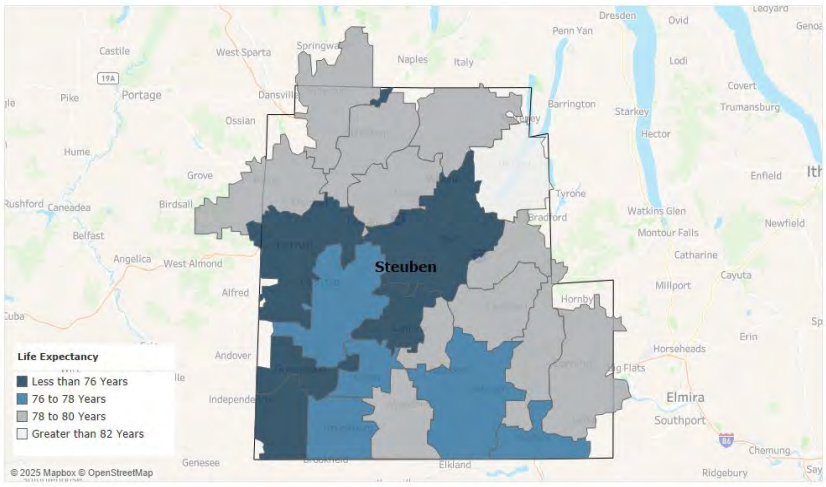
Source: Steuben County.gov

Leading Cause of death and Life Expectancy

The average number of years a person in Steuben County may expect to live based on 2022 data is 76.3. This number decreased 3% from 2018. Life expectancy varies throughout the county as may be seen in Map ST3. Those areas of the county with lower life expectancy mirror those areas with increased rates of poverty.

The leading causes of death and causes of premature death (before Age 75) are generally higher than the NYS average. (Table ST2)

Map ST3: Life Expectancy



Source: NYS Vital Statistics; US Census Bureau County Population Estimates and Claritas ZIP Level Estimates; Years 2018-2022 Analysis and Calculations by Common Ground Health (YPLL/Death Rate per 100k population and Life Expectancy)

Table ST2: Causes of Death

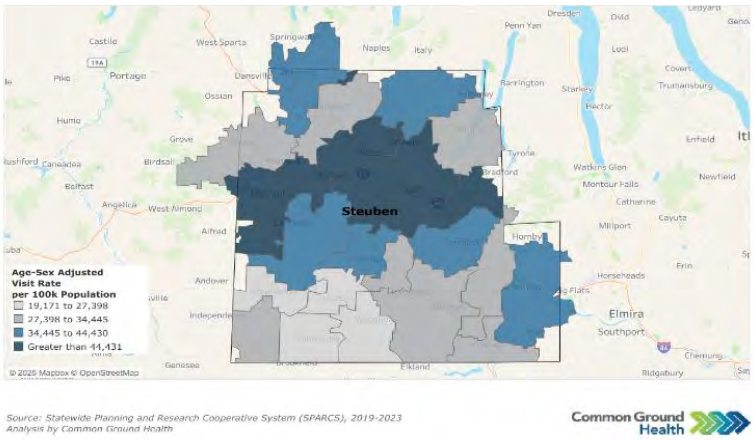
Leading Causes of Death (All Ages – 2022)	Leading Causes of Premature Death (Before Age 75 -2022)
Heart Disease (204.7/100,000 vs NYS 166.4) *Cancer* (187.8/100,000 vs NYS 137) Top Cancers: Female Breast, Prostate, Lung *Alzheimer's* (71.5/100,000 vs NYS 61.65) *Death Rate:* (944.8/100,000 vs 744.2)	*Cancer* (97.1/100,000 vs NYS 73.1) *Heart Disease* (62.6/100,000 vs 55.2) *Unintentional Injury* (48.9/100,000 vs NYS 46.9) *Premature Death Rate*: (423.5/100,000 vs NYS 326.8)

Source: NYS Vital Statistics

Emergency Department Visits and Potentially Preventable Hospitalizations

Overuse of the Emergency Department may signal gaps in outpatient care and in access to outpatient, primary or preventive care. It may also indicate poor chronic disease management which could be a result of gaps in access to care and in education regarding chronic diseases. An increase in the number of Substance Use Disorder ED visits is indicative of a rising substance use crisis. It may also point to mental health emergencies and suicide risk. Maps ST4 and ST5 detail the ED Visits and Preventable Hospitalizations by zip code in Steuben County. Table ST3 highlights ED visits in Steuben County compared with NYS, noting the difference.

Map ST4: ED Visit Rates by Zip Code



Map ST5: Preventable Hospitalizations by Zip Code

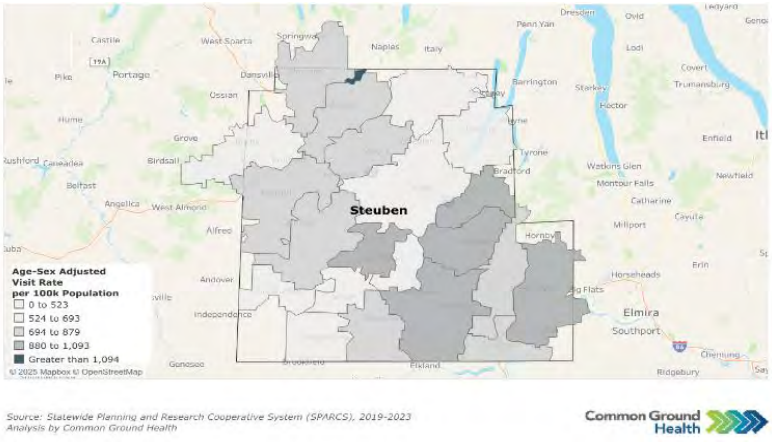


Table ST3: Emergency Department Visits

Issue	Steuben County Rate Per 100,000 (2023)	NYS Rate Per 100,000 (2023)	% Change (from 2017)
All ED Visits	44,043	29,809	+5%
Substance Use Disorder ED Visits	1,850	1,646	+9%
Intentional Self Harm ED Visits	835	343	+12%
Preventable Hospitalizations (Overall)	720	808	-24%
Diabetes Preventable Hospitalizations	166	181	+20%

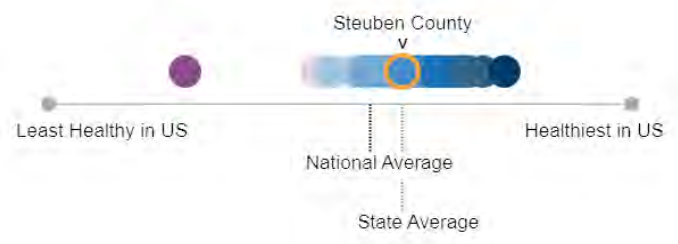
Source: SPARCS

County Health Rankings

Steuben County is performing comparably to New York State and above the national average in overall health and well-being, reflecting both residents' perceived quality of life and their ability to participate in and contribute to their community (Figure ST9). The county also ranks similarly to the state and above the national average for key community conditions and social determinants of health, including economic stability, education, access to healthcare, neighborhood and built environment, and social and community context (Figure ST10). These indicators suggest that, while the county faces some local challenges, Steuben residents generally experience strong community

Figure ST9: Health and Well-Being

Figure ST10: Community Conditions/SDOH



support, access to resources, and opportunities for engagement, positioning the county favorably in promoting population health.

Health Challenges and Associated Risk Factors

Steuben County residents are showing poorer health outcomes due to the shortage of providers in rural areas and service gaps for residents with low-socioeconomic status.

Community members, especially youth and low-income residents, repeatedly cited homelessness and substandard housing Rising homelessness creates unstable, unhealthy environments for individuals and families, impacting Housing and homelessness were specifically mentioned as concerns in community discussions.

Community members report that people often do not prioritize their health. Concerns over injuries are linked to mental health. Transportation is a particular problem for those over 65 years of age.

Youth face unique stressors such as academic pressure, social media, and peer influences, which contribute to mental health struggles and risky behaviors like vaping and substance use. Focus groups cite youth risks like “date rape” and “public drug use” as problems.

Mental health concerns include drug use, suicide rate, and depression.Bullying and peer pressure in schools are significant concerns impacting youth mental health and behavior. There is limited awareness among youth about the long-term health risks of substance use.

Food insecurity is a major concern, especially for low-income residents. Rising living costs, stagnant wages, and high grocery prices make healthy choices difficult. Fast food convenience and limited resources for home gardening or local produce drive unhealthy eating. Access to healthy foods is challenged by affordability, education, and availability (including in schools). Work/life balance and lack of resources make it hard for people to eat better, even when they want to. Community members report not prioritizing health, with injuries often linked to mental health concerns.

Transportation challenges, especially for those over 65, increase injury risk. Environmental and social issues such as poor housing, homelessness, and public drug use raise vulnerability to violence and unintentional injuries.

A proliferation of telehealth and telemedicine services nationwide may seem to be a boon, but access to and use/adoption of broadband services in Steuben County is limited. The percentage of households who have used/adopted broadband service increased 10% to 86% compared with the 90% NYS average. There is still 10% of the population with no access to broadband service in their area, compared with just 1.3% in NYS as whole. Those without a community to turn to may struggle with higher depression, suicide and overdose rates and have little to no access to support and advocacy groups and other support networks.

Priority Areas

Steuben County identified three priority areas for this CHA. They are:

- Housing Stability and Affordability
- Poverty
- Primary Prevention, Substance Misuse and Overdose Prevention

Housing Stability and Affordability

> *"My biggest concern is the lack of adequate housing…particularly in the mobile homes is terribly substandard housing, dangerous housing, housing that you wouldn't want anybody you know to live in. And I think it's a terrific problem."*

Although housing cost burden is lower than the state average, community partners and focus groups consistently identify housing quality and safety as urgent concerns. Poor housing conditions are linked to health risks and are a priority for residents seeking safe, affordable housing.

Focus groups in Steuben County highlighted serious concerns about the state of local housing. Participants described a widespread shortage of safe and adequate housing, noting that many homes are in poor or unsafe condition. Common issues included substandard or dangerous living environments, and housing costs that are too high for many residents.

A lower housing cost burden (11%, an increase of 10%, vs. 19% NYS) and high homeownership (74%, an increase of 1%) may mitigate urgency regarding housing stability and affordability, the high Area Deprivation Index (9.4, an increase of 1%, where 1 is most advantaged and 10 is least) reflects concentrated disadvantage, which poverty interventions can indirectly address.

Poor housing conditions are linked to health risks, and community voices emphasize the need for safe and affordable housing.

Poverty

Poverty is a central driver of health inequities in Steuben County, with a 13.7% poverty rate (even with the state average of 13.7% and higher than the PA target of 12.5%) and child poverty at 19% (matching the state average of 19%) and unchanged from 2018. The percentage of the population over 65 years-of-age living in poverty is 11.1% (lower than the NYS average of 12.7% and about equal to the PA target of 11%) and an increase of 63% from 2018.

This theme intersects with food insecurity, housing instability, substance misuse, and chronic disease risk, making it a root cause of many health issues. Addressing poverty is seen as a lever for improving multiple health outcomes and breaking cycles of disadvantage.

"Eating on the run and busy schedules make it difficult to make a healthy choice and plan meals. It's just easier to stop and get fast food."

Childhood poverty correlates with developmental delays, toxic stress, and chronic illness, perpetuating cycles of disadvantage. Poverty reduction strategies - including family planning, education, and job training, to name a few - improve intergenerational mobility and health outcomes.

Primary Prevention, Substance Misuse, and Overdose Prevention

"Social pressures and academic pressures contribute heavily to behavior choices. There is limited awareness of long-term risks due to vaping and drug use among youth."

Overdose deaths exceed state averages and several continue to trend upward at alarming rates.

The rate of overdose deaths involving drugs, per 100,000 is 31.3, higher than the PA target of 22.6.

Focus groups cited illegal drug use (and alcohol) as big challenges in the community. They did not, however, that strong community networks exist in the county to help foster belonging. Examples of networks included local church communities, neighbors, walking groups, and local volunteers. However, among the youth, one focus group noted how students feel over-committed with little free time for healthy activities and that the youth seem to lack a sense of community as they underuse parks and public spaces, and often stay confined to their immediate neighborhoods.

Community Assets and Resources

Steuben County has a long-standing reputation of collaboration and coordination among its many and varied partners. The county also has relationships with two agencies that promote and facilitate collaboration: Pivital Public Health Partnership and Common Ground Health. Pivital is a partnership of eight rural health departments in the Finger Lakes Region. The network's focus is on improving the health and well-being of Finger Lakes residents. Common Ground Health covers the same geographic footprint, with the addition of Monroe County, and focuses on bringing together leaders from all sectors to collaborate on strategies for improving health in the region. Both agencies provide support, collaboration and resources to improve the health of Steuben County residents.

Additionally, Steuben County has expertise in policy, and advocacy empowers organizations to influence decision-making and drive systemic change. Strong media connections and proactive

communications strategies amplify public health messaging and counteract misinformation. A dedicated staff maintain consistent community engagement, facilitate inclusive meetings, and support effective participation in MAPP (Mobilizing for Action through Planning and Partnerships) activities. Robust organizational infrastructure provides both physical and virtual spaces for engagement, ensuring participation is accessible and adaptable for diverse community members. Partners are actively engaged in group meetings, focus groups, and data analysis, demonstrating a strong willingness and capacity for collaboration. A shared commitment to inclusivity is reflected in the ongoing desire to expand membership and increase participation, broadening community representation. All agencies and organizations—through direct and indirect services—play a vital role in addressing mental health, chronic disease, and overall community well-being.

Behavioral Risk Factors and Health Disparities

Steuben County faces a range of health challenges that affect the well-being of its residents, shaped by social, behavioral, and environmental factors. Mental health concerns are prominent, with 19% of adults reporting 14 or more days of poor mental health per month, exceeding the New York State average. Elevated rates of depressive disorders and rising suicide rates, particularly among youth, point to increasing stress, anxiety, and unmet behavioral health needs within the community. Substance use further exacerbates these challenges, as overdose deaths, including those involving opioids and pain relievers, have risen sharply, while adult smoking and binge or heavy alcohol consumption remain above state averages, increasing the risk of chronic diseases such as heart disease, cancer, and liver disease.

Nutrition and physical activity present additional concerns. Daily consumption of fruits and vegetables is below optimal levels, and sugary drink intake among lower-income adults continues to contribute to poor dietary outcomes. Only about half of residents have adequate access to locations for physical activity, and the county's low walkability limits opportunities for exercise, with 24% of adults reporting no leisure-time physical activity. These factors contribute to elevated rates of obesity among both adults and children and increase the risk of diabetes, cardiovascular disease, and other chronic conditions. Preventive care utilization is inconsistent, with lower-than-average screening rates for conditions such as diabetes and colorectal cancer, particularly among low-income populations, while oral health access remains limited, especially for Medicaid enrollees.

Maternal and infant health outcomes show mixed progress. While prenatal care indicators have improved, including reductions in alcohol, tobacco, and drug use during pregnancy, rates of preterm births and low birth weight remain concerns. Infant mortality, though decreasing, remains above the state average, and maternal mortality has increased, underscoring ongoing risks in perinatal care. Social determinants of health, including housing instability and poverty, further influence health outcomes. Eleven percent of households experience major housing problems, and a similar percentage spend more than half of their income on housing, contributing to financial stress and limiting access to healthcare and nutritious food. The county's moderate social vulnerability index suggests that certain populations may face greater risk during emergencies or economic disruptions.

Injuries and violence also present significant public health concerns. Rates of intentional and unintentional injuries, including deaths from firearms, motor vehicle crashes, and suicide, exceed state averages and highlight the need for preventive measures and community safety initiatives. Collectively, these health challenges reflect the complex interplay of behavioral, social, and environmental risk factors in Steuben County. Addressing these issues through comprehensive mental health services, substance use prevention, chronic disease management, improved access to preventive care, and targeted interventions to enhance nutrition, physical activity, and social supports is essential for promoting long-term community health and well-being.

Through implementation of the Community Health Improvement Plan, Steuben County and its community partners will work to leverage these relationships. The Steuben County CHIP document has a full description of interventions and partner roles. Table ST4 highlights the specific county partners associated with each priority area and how they may support Steuben County in achieving its goals.

Table ST4: County Resources to Accomplish CHA/CHIP Goals

Priority Area	Potential Assets and Community Resources	Collaboration Potential

Poverty	• Steuben County DSS
	  ○ SC Mental Health Services
	  ○ SC Community Services
	• Foodbank of the Southern Tier
	• Common Ground Health (regional data)
	• Pivital Public Health Partnership
		• Opportunities for shared data collection and analysis to better understand local needs.
		• Ability to coordinate referrals between service providers to reduce service gaps.
		• Potential for joint community outreach and education, particularly around financial stability, food access, and supportive services.
		• Opportunities to leverage existing community programs to expand access to resources for low-income households.

Housing Stability and Affordability	• Steuben County DSS • Community organizations (churches, libraries, community centers, food pantries) • Housing development agencies (e.g Arbor Housing)	• Potential for cross-sector partnerships to identify residents at risk of housing instability and link them with services. • Ability to co-host community engagement efforts, including

		workshops, resource fairs, and educational events. • Opportunities to share local housing data to inform policy recommendations and community planning. • Possibility of co-developing housing support initiatives, such as resource navigation, affordability education, or referral pathways.
Primary Prevention, Substance Misuse, and Overdose Prevention	• Steuben County Public Health • Steuben Prevention Services • Steuben County Opioid Committee • Steuben County Sherriff's Office • Pharmacies • Hospitals and health systems	• Opportunities for coordinated prevention efforts across sectors, including schools, healthcare, and community organizations. • Ability to share real-time community trends to guide intervention planning and improve early identification of high-risk populations. • Potential for joint training, education, and awareness campaigns focused on risk reduction and harm prevention. • Opportunity to align strategies across partners to support consistent messaging, streamline services, and strengthen community-wide prevention networks.

Dissemination of Findings and Improvement Plan

The final 2025–2030 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) were developed collaboratively by Steuben County Public Health, St. James Hospital, and Arnot Health | Ira Davenport Memorial Hospital. An executive summary and full CHA document will be disseminated to the public and partners using multiple communication channels to ensure broad access and awareness. Dissemination strategies include:

- Public posting of the CHA and executive summary on the Steuben County Public Health website and social media platforms
- Public posting of the CHA and executive summary on St. James Hospital and Ira Davenport Memorial Hospital websites and social media platforms
- Sharing through partner organization websites, newsletters, and listservs, including community-based organizations and service providers
- Presentation and sharing with community coalitions, stakeholder groups, and partner meetings
- Submission and sharing with governing entities as required

Operation Green Light for Veterans. Source: The Hornell Sun

A Message from the Public Health Director

To our community members and partners,

We are pleased to present the 2025–2030 Steuben County Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). Together, these documents provide a shared understanding of the health needs of Steuben County residents and a framework for coordinated, multisector efforts to improve community health.

Health outcomes in Steuben County are shaped by social, economic, behavioral, and environmental factors across the places where we live, learn, work, and play. As public health practice continues to evolve, collaboration and shared goals, particularly those focused on social determinants of health and health equity, remain critical.

The CHA examines key factors influencing health risks and outcomes in Steuben County and identifies priority areas including substance use, mental health, and community safety. While challenges exist, the county is supported by strong community-based organizations, engaged partners, and dedicated healthcare systems. In alignment with the New York State Prevention Agenda, the CHIP outlines priority areas and strategies that Steuben County Public Health, local hospitals, and community partners will implement together to improve population health.

The CHA and CHIP were developed through a collaborative process led by Steuben County Public Health, in partnership with [hospital partners], and informed by extensive community input. We thank all who contributed their time, expertise, and perspectives to this important effort and look forward to continued partnership in building a healthier Steuben County.

Sincerely,

Matthew Marmor

Interim Public Health Director

Steuben County Public Health

DECEMBER 2025

STEUBEN COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN

2025 - 2030

In collaboration with

Public Health
Prevent. Promote. Protect.
Steuben County NY

ArnotHealth
A Member of Centralus Health

UR MEDICINE | ST. JAMES HOSPITAL

SMART STEUBEN
YOUR HEALTH YOUR LIFE

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COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) OVERVIEW

The 2025–2030 Steuben County Community Health Improvement Plan (CHIP) was developed using data and community input gathered through the Community Health Assessment (CHA). Throughout 2024–2025, Steuben County Public Health and partners engaged residents and stakeholders through surveys, focus groups, and data review to identify the most pressing health needs in the county.

Based on this assessment, three priority areas were selected for the 2025 - 2030 CHIP: **Housing Stability and Affordability**, **Poverty**, and **Primary Prevention, Substance Misuse, and Overdose Prevention**. These priorities reflect the issues identified by the community and supported by local data trends, particularly those affecting Steuben County's rural population. They also align with the New York State Prevention Agenda[1]. The development of CHIP interventions was guided by several criteria:

- Strength of evidence supporting the intervention
- Ability to reach populations most affected by identified issues
- Organizational capacity and community readiness
- Alignment with ongoing work and available resources
- Potential for meaningful, sustainable impact

The CHIP highlights new or enhanced initiatives that participating organizations have committed to implementing. Interventions were chosen based on evidence-informed practices, feasibility within current capacity, and potential for measurable, countywide impact. Many strategies intentionally focus on reducing health disparities identified in the CHA, including:

- Individuals with low socioeconomic status
- Rural residents with limited access to services
- Older adults
- Individuals experiencing housing instability or homelessness
- Individuals with disabilities
- Individuals with mental health or substance use disorders

Implementation of the CHIP is a shared effort among Steuben County Public Health, healthcare providers, and community organizations. Each entity contributes through leadership, program delivery, staff time, data support, or aligned activities. Several initiatives are supported through state and federal grants, while others are integrated into routine operations.

The 2025–2030 CHIP represents a coordinated roadmap for improving health outcomes in Steuben County. Through collaboration, evidence-based action, and a commitment to equity, the county and its partners aim to make measurable progress in addressing the structural and social determinants of health that most significantly affect the well-being of residents.

[1] Prevention Agenda 2025-2030: New York State's Health Improvement Plan. Ny.gov. Published 2025. https://www.health.ny.gov/prevention/prevention_agenda/2025-2030/

SMART STEUBEN CHIP WORKGROUP

SMART Steuben is a group made of Public Health, local hospital systems, and other health-related organizations in Steuben County working to improve health. The group meets quarterly to improve the health of Steuben residents and will oversee the CHIP progress and implementation. Attendees at these meetings regularly review progress and relevant data on each measure. Group members identify and address any mid-course corrections in interventions and processes that need to take place during these meetings.

Members
Arnot Health - Ira Davenport Memorial Hospital
Common Ground Health
Cornell Cooperative Extention - SNAP-Ed
Corning Hospital
Fingerlakes Community Health
Food Bank of the Southern Tier
Steuben Rural Health Network at The Institute for Human Services, Inc
NAMI Steuben
Oak Orchard Health Center
Pivital Public Health Partnership

Members (cont.)
ProAction of Steuben & Yates
Steuben County Alcoholism and Substance Abuse Services (SCASAS)
Southern Tier Tobacco Awareness Coalition (STTAC)
St. James Hospital
Steuben County Community Services
Steuben County Mental Health Services
Steuben County Opioid Comittee
Steuben County Public Health

SMART STEUBEN
YOUR HEALTH YOUR LIFE

Economic Stability

Domain	Priority	Objective	Intervention	Disparities Being Addressed	Family of Measures	Timeframe		Implementation	Partner Role(s) and Resources
						Start Date (mm/dd/yyyy)	Completion Date (mm/dd/yyyy)		
Economic Stability	Poverty	1.0 Reduce the percentage of people living in poverty from 13.6% to 12.5%.	**1.0.1 Provide routine screening for social needs and provide proactive, assisted referrals to appropriate community resources to support financial and housing stability.**	Low SES	% of patients screened for social determinants of health, including food insecurity, housing, language and literacy % of patients who screen positive for one or more SDoH needs % of patients with identified needs who receive a completed referral to an appropriate resource	01/01/2026	12/31/2030	Hospital	**Lead Partners: Arnot Health/Ira Davenport and St. James Hospital** Social Work; Outpatient outreach teams, community partners Arnot Health - Ira Davenport Memorial Hospital, a member of Centralus Health, and St. James Hospital both administer standardized SDOH screening through their Electronic Medical Records system, EPIC. The system can provide reports on patient demogrpahics, number of patients screened, and successful referrals completed for different services.
Economic Stability	Poverty	1.0 Reduce the percentage of people living in poverty from 13.6% to 12.5%.	**1.0.2 Strengthen food security and nutrition through school-based CATCH curriculum, produce incentives (FVRx), and coordinated food donation/safety-net campaigns.**	Rural populations, Low SES	# of schools implementing nutrition education % of students reporting increased likelihood of engaging in healthy nutrition behaviors Total dollar amount of FVRx vouchers distributed % of vouchers redeemed Total monetary value of food and campaign donations collected	01/01/2026	12/31/2030	Community-based organizations	**Lead Partners: CCE/SNAP-Ed, Corning Wegmans**; Steuben County schools, BOCES, Keuka Family Practice, United Way CCE/SNAP-Ed will continue to promote and provide nutrition education in schools through implementation of Coordinated Approach to Child Health (CATCH) program Corning Wegmans will promote food support - related campaigns to store patrons in partnership with the Foodbank and the United Way
Economic Stability	Poverty	1.0 Reduce the percentage of people living in poverty from 13.6% to 12.5%.	**1.0.3 Provide coordinated navigation and referral support to connect individuals and families to employment services, food assistance, income supports, and other social services.**	Low SES	# contacts referred to social support services in Steuben County	01/01/2026	12/31/2030	Community-based organizations	**Lead Partner: Institue for Human Services (IHS)** IHS will provide referrals for employment services, food assistance, income supports, and related social services to help individuals and families improve economic stability.

Economic Stability

Domain	Priority	Objective	Intervention	Disparities Being Addressed	Family of Measures	Timeframe		Implementation Partner	Partner Role(s) and Resources
Economic Stability	Poverty	1.0 Reduce the percentage of people living in poverty from 13.6% to 12.5%.	**1.0.4 Provide transportation assistance, such as gas cards and transit tokens, and transportation education to reduce transportation-related barriers to accessing healthcare, social services, employment, and benefits-related appointments.**	Low SES	# of tokens distributed # of gas cards distributed	01/01/2026	12/31/2030	Community-based organizations	**Lead Partner: Institue for Human Services (IHS);** DSS, VA IHS will distribute gas cards and transportation tokens to support travel to medical appointments, human services appointments, Veterans Affairs, and DSS services**.** IHS will provide travel training to educate residents on how to effectively use Steuben County's public transportation system.
Economic Stability	Poverty	1.1 Reduce the percentage of people aged 65 years and older living in poverty from 12.2% to 11%.	**1.1.1 Implement a coordinated older adult support initiative that improves access to essential community resources and affordable, nutritious food for adults aged 65 and older.**	Older adults, aging population, low SES	# resource guides distributed Total dollar value of Veggie Van vouchers distributed % of Veggie Van vouchers redeemed % of participants reporting improved access to healthy foods (post-survey) % of FMNP (Farmers Market Nutrition Program) checks redeemed % of SNAP benefits utilized at Veggie Van sites	01/01/2026	12/31/2030	Local health department	**Lead Parters: Steuben County Public Health, CCE/SNAP-Ed;** LHD personnel, OFA, Senior Living Facilities, Community Partners, local farms SCPH will develop and disseminate a comprehensive resource guide for adults aged 65+ that highlights available community services—including financial assistance, food support, transportation, healthcare access, and housing resources. CCE/SNAP-Ed will implement the Veggie Van Voucher program to increase access to affordable produce for older adults. CCE/SNAP-Ed will expand Veggie Van sites serving older adult populations.

Economic Stability

Domain	Priority	Objective	Intervention	Disparities Being Addressed	Family of Measures	Timeframe		Implementation Partner	Partner Role(s) and Resources
Economic Stability	Poverty	1.1 Reduce the percentage of people aged 65 years and older living in poverty from 12.2% to 11%.	**1.1.2 Implement a structured outpatient care management support process to identify older adults with socioeconomic needs and coordinate timely referrals to appropriate community-based services.**	Low SES	# of patients referred through the outpatient care management liaison process. % of referrals completed within the established timeframe. # of outreach opportunities initiated or supported by the liaison. % of patients who engage with recommended socioeconomic support services.	01/01/2026	12/31/2030	Hospital	**Lead Partner: St. James Hospital;** Community partners, St. James personnel St. James Hospital will establish an outpatient care management liaison process to ensure timely internal referrals and coordinated support services for patients with identified socioeconomic needs.
Economic Stability		4.0 Increase the number of people living in HUD-subsidized housing from 987,957 to 1,092,000.	**4.0.1 Develop and implement a structured tracking system to identify individuals experiencing homelessness or housing instability during hospital encounters and monitor housing-related referrals and outcomes.**	Low SES, Unhoused	# of patients presenting as unhoused during hospital admission. % of unhoused patients referred to housing support services. % of referred patients who successfully obtain temporary or permanent housing. % of housing referrals that are unsuccessful, with documented reasons for barriers.	01/01/2026	12/31/2030	Hospital	**Lead Partner: St. James Hospital;** St. James personnel, DSS St. James Hospital will develop a structured tracking system to monitor housing support efforts, follow patient progress, and coordinate placement attempts for individuals experiencing homelessness who are admitted to the hospital.

Economic Stability

Domain	Priority	Objective	Intervention	Disparities Being Addressed	Family of Measures	Timeframe		Implementation Partner	Partner Role(s) and Resources
	Housing Stability and Affordability	4.0 Increase the number of people living in HUD-subsidized housing from 987,957 to 1,092,000.	**4.0.2 Advance a local policy initiative that promotes or requires environmental health and safety standards in rental housing, including testing for environmental contaminants prior to occupancy.**	Low SES	# of landlords participating in the incentive program. # of contaminant tests completed before leasing.	01/01/2026	12/31/2030	Community-based organizations	**Lead Partner: STTAC** STTAC will implement a local policy initiative that encourages or requires landlords to conduct environmental contaminant testing for current tenants and prior to new tenant occupancy.
Economic Stability	Housing Stability and Affordability	4.1 Increase the percentage of adults, with an annual income of less than $25,000, who were able to pay their mortgage, rent, or utility bills in the past 12 months from 85.1% to 89.4%.	**4.1.1 Develop and implement targeted public awareness efforts to promote housing, utility, and emergency assistance programs.**	Low SES	# of social media posts published # of link clicks to program information or applications # of events held % of patients with documented SDoH needs who received notification or outreach about the event(s)	01/01/2026	12/31/2030	Local health department	**Lead Partner: Steuben County Public Health and Arnot Hea;th - Ira Davenport Memorial Hospital;** LHD personnel, local media contacts, community partners SCPH wil develop and implement targeted social media campaigns to promote assistance programs such as HEAP, Emergency HEAP, Weatherization Assistance, Section 8, rental assistance programs, faith-based supports, and utility hardship programs. Arnot Health - Ira Davenport Memorial Hospital, a member of Centralus Health, will host community events that connect residents with resources addressing social needs such as housing assistance, financial counseling, food security, utility support, and other stabilization services.

Economic Stability

Domain	Priority	Objective	Intervention	Disparities Being Addressed	Family of Measures	Timeframe		Implementation Partner	Partner Role(s) and Resources
Economic Stability	Housing Stability and Affordability	4.1 Increase the percentage of adults, with an annual income of less than $25,000, who were able to pay their mortgage, rent, or utility bills in the past 12 months from 85.1% to 89.4%.	**4.1.2 Provide referral and navigation support to connect individuals and households to utility assistance programs and disaster relief services.**	Low SES	# of contacts referred to utility support services # of contacts referred to disaster relief services	01/01/2026	12/31/2030	Community-based organizations	**Lead Partner: Institue for Human Services (IHS)** IHS will provide referrals to utility assistance programs and disaster relief services to support housing stability and prevent service shutoffs or displacement.

Social & Community Context

Domain	Priority	Objective	Intervention	Disparities Being Addressed	Family of Measures	Timeframe		Implementation Partner	Partner Role(s) and Resources
						Start Date (mm/dd/yyyy)	Completion Date (mm/dd/yyyy)		
Social & Community Context	Primary Prevention, Substance Misuse, and Overdose Prevention	11.0 Increase the crude rate of patients per 100,000 population who received at least one buprenorphine prescription for opioid use disorder from 446.0 to 490.6.	**11.0.1 Increase access to Medication-Assisted Treatment for opioid use disorder by enrolling eligible individuals in buprenorphine or other FDA-approved medications, with an emphasis on timely initiation, continuity of care, and sustained treatment retention across clinical and community settings.**	Low SES Individuals with opioid use disorder	# of people enrolled on MAT during treatment % of MAT participants retained in treatment for 30, 60, or 90 days	01/01/2026	12/31/2030	Community-based organizations	**Lead Partner: SCASAS;** Mental Health staff SCASAS will expand access to Medication-Assisted Treatment (MAT) by enrolling eligible individuals in buprenorphine or other approved medications for opioid use disorder.
Social & Community Context	Primary Prevention, Substance Misuse, and Overdose Prevention	12.0 Reduce the crude rate of overdose deaths involving drugs, per 100,000 population, from 32.3 to 22.6.	**12.0.1 Maintain a publicly accessible, regularly updated data dashboard that presents timely opioid- and overdose-related indicators to improve transparency, inform community response efforts, and support data-driven planning and decision-making.**	Rural populations with limited access to real-time health data Individuals with low digital health literacy	# of updates to the dashboard (reviewed quarterly)	01/01/2026	12/31/2030	Local health department	**Lead Partner: Steuben County Public Health;** SC Opioid Committee, SC Sherrif's Office, OD Map, SCPH Personnel SCPH will update and maintain a publicly accessible data dashboard displaying timely opioid-related indicators to increase transparency, inform community response efforts, and support data-driven decision-making.
Social & Community Context	Primary Prevention, Substance Misuse, and Overdose Prevention	12.0 Reduce the crude rate of overdose deaths involving drugs, per 100,000 population, from 32.3 to 22.6.	**12.0.2 Implement comprehensive clinical strategies to reduce overdose risk by routinely screening patients for suicide and substance-use risk, strengthening provider education on evidence-based prescribing and opioid stewardship, and distributing clear, evidence-based patient education on safe pain management and opioid risk reduction.**	Individuals with Mental health disorder(s),Substance Use Disorders	# of patients that received the C-SSRS Assesment % of screened patients with a positive CSSRA result % of patients with a positive C-SSRS result who received follow-up plan # of educational matierals distributed # of providers trained (first time) % of trained providers reporting increased knowledge of safe prescribing practices	01/01/2026	12/31/2030	Hospital	**Lead Partner: Arnot Health- Ira Davenport Memorial Hospital, St. James Hospital;** Arnot Health - Ira Davenport Memorial Hospital, a member of Centralus Health, will screen all patients using the Columbia-Suicide Severity Rating Scale (C-SSRS) to identify individuals at elevated risk and ensure that all patients with positive or high-risk results receive timely, supported referrals to appropriate behavioral health or crisis intervention services. St. James Hospital will distribute evidence-based educational materials to healthcare providers and patients focused on safe post-operative pain management and opioid-use risk reduction. St. James Hospital will provide MyChart-based education and training for healthcare providers on evidence-based prescribing practices, opioid stewardship, and patient communication regarding medication risks.

Social & Community Context

Domain	Priority	Objective	Intervention	Disparities Being Addressed	Family of Measures	Timeframe		Implementation Partner	Partner Role(s) and Resources
Social & Community Context	Primary Prevention, Substance Misuse, and Overdose Prevention	12.0 Reduce the crude rate of overdose deaths involving drugs, per 100,000 population, from 32.3 to 22.6.	**12.0.3 Reduce access to unused or expired prescription medications by maintaining permanent medication disposal sites and coordinating regular drug take-back events to promote safe disposal and prevent diversion and misuse.**	Indivudals experencing SUD impacts	# pounds of medication disposed of yearly	01/01/2026	12/31/2030	Hospital	**Lead Partners: Arnot Health-Ira Davemport Memorial Hospital** Arnot Health - Ira Davenport Memorial Hospital, a member of Centralus Health will maintain permanent safe disposal sites for prescription drugs and organized take-back days.
Social & Community Context	Primary Prevention, Substance Misuse, and Overdose Prevention	12.0 Reduce the crude rate of overdose deaths involving drugs, per 100,000 population, from 32.3 to 22.6.	**12.0.4 Strengthen community-based mental health and substance-use supports by integrating family education programs, youth-focused mental health literacy initiatives, community education sessions, and streamlined referral pathways to local and regional support services, informed by ongoing data collection and reporting requirements.**	Individuals experiencing mental health and SUD impacts	# of education/training sessions conducted # of participants (Family-to-Family, tMHFA, education sessions) % reporting increased knowledge, confidence, and skills post-training # of contacts referred to mental health/substance-use services # of Helpline calls requesting support related to substance use and overdose # of trainers certified	01/01/2026	12/31/2030	Community-based organizations	**Lead Partner: Institute for Human Services, NAMI Steuben, Helpline;** GetHelpNY, 2-1-1 Teen Helpline, Helpline, Opioid Committee resources, CPR/AED/First Aid resources IHS will implement Teen Mental Health First Aid (tMHFA) to equip youth with skills to recognize signs of mental health challenges and substance misuse risk in themselves and peers.; implement the Living Healthy chronic disease and pain self-management curriculum to support individuals with chronic pain who may be at increased risk for opioid misuse by improving their coping strategies, communication skills, and confidence in managing their condition. IHS will strengthen referral pathways for individuals using opioids or at risk of overdose by promoting and enhancing access to 2-1-1 and GetHelpNYY NAMI Steuben will promote and facilitate "Family to Family" signature program to engage residents in support services; Partner with Helpline to collect and report data for OMH requirements; Provide educational sessions and materials related to preventative factors such as mental wellness, drug use, and access to care/support services.
Social & Community Context	Primary Prevention, Substance Misuse, and Overdose Prevention	12.0 Reduce the crude rate of overdose deaths involving drugs, per 100,000 population, from 32.3 to 22.6.	**12.0.5 Increase the availability of and access to overdose-reversal (Naloxone) trainings for prescribers, pharmacists, and community members to expand the network of individuals prepared to respond to overdoses**		# of trainings administered # of participants % of participants reporting confidence in administering Narcan (score of 4-5)	01/01/2026	12/31/2030	Community-based organizations	**Lead Partners: SCASAS, Steuben County Public Health, Opioid Committee;** OASAS, SCASAS staff, SCPH staff, Opioid Committee members Lead partners will provide Narcan (naloxone) training oppurtuities to commity members and othe rprofessionals in Steuben County.

Social & Community Context

Domain	Priority	Objective	Intervention	Disparities Being Addressed	Family of Measures	Timeframe		Implementation Partner	Partner Role(s) and Resources
Social & Community Context	Primary Prevention, Substance Misuse, and Overdose Prevention	12.0 Reduce the crude rate of overdose deaths involving drugs, per 100,000 population, from 32.3 to 22.6.	**12.0.6 Provide evidence-based intervention (EBI) substance-use prevention education across school districts; expand youth substance-use prevention efforts via STTAC Reality Check**	Youth, rural populations	# students educated about substance use, misuse & prevention % students indicated an increase in knowledge about substance use, life skills and/or prevention factors # students counseled who are at risk for substance abuse % students showing an increase in protective factors after counseling	01/01/2026	12/31/2030	Community-based organizations	**Lead Partner: Steuben Prevention Coalition, STTAC;** Schools, Coalition members STTAC will expand STTAC and Reality Check efforts to promote and execute substance use prevention efforts for youth, decreasing the likelihood of later drug experimentation and misuse. Steuben Prevention Coalition will provide substance misuse and abuse prevention education across Steuben County school districts, incorporating EBIs.
Social & Community Context	Primary Prevention, Substance Misuse, and Overdose Prevention	12.0 Reduce the crude rate of overdose deaths involving drugs, per 100,000 population, from 32.3 to 22.6.	**12.0.7 Reduce access to tobacco and e-cigarette sales through policy work, supporting the reduction of early nicotine use and risk factors for later substance misuse, particularly among adolescents.**	Low SES, LGBTQ+	# of policies presented % of policies adopted	01/01/2026	12/31/2030	Community-based organizations	**Lead Partner: STTAC;** Roswell Park, Quitline, community partners STTAC will advocate for policy changes surrounding tobacco, nicotine, and e-cigarretes, specifically addressing concerns of substance use in adolecent populations
Social & Community Context	Primary Prevention, Substance Misuse, and Overdose Prevention	12.1 Reduce the crude rate of overdose deaths for Black, non-Hispanic residents, per 100,000 population, from 59.2 to 35.5.	**12.1.1 Implement Narcan training programs for incarcerated individuals in Steuben County, ensuring access to overdose-prevention knowledge and skills prior to release.**	Incarecrated indivduals Black, non-Hispanic residents disproportionately affected by overdose Individuals with substance use disorders Individuals re-entering the community following incarceration	# of incarcerated individuals enrolled in Narcan training # of certified trainers delivering the program # of trainings administered % of participants reporting high confidence in administering Narcan (score 4–5) % of incarcerated individuals with a drug-related offense	01/01/2026	12/31/2030	Local health department	**Lead Partner: Steuben County Public Health;** LHD personel, SC Sherrif, Opioid Committee, Steuben Prevention Coalition SCPH will collaborate with the Sherrif's Office and other community organizations to implement Narcan training programs for incarcerated individuals in Steuben County, ensuring access to overdose-prevention knowledge and skills prior to release, with special focus on disparity populations and re-entry support.

Social & Community Context

Domain	Priority	Objective	Intervention	Disparities Being Addressed	Family of Measures	Timeframe		Implementation Partner	Partner Role(s) and Resources
Social & Community Context	Primary Prevention, Substance Misuse, and Overdose Prevention	13.0 Increase the number of naloxone kits distributed from 397,620 to 596,430.	**13.0.1 Distribute naloxone and naloxone kits to the community via community access points such as wall box units, trainings, and community venues**	Rural communities with limited access to harm-reduction services Low-income individuals Individuals with substance use disorders	# of kits distributed # of wall box units in Steuben County	01/01/2026	12/31/2030	Local health department	**Lead Partners: Steuben County Public Health, SCASAS, Steuben Prevention Coalition, Opioid Committee, The Institue for Human Services;** Steuben County IT, SC Opioid Committee, Prevention Services SCPH will provide naloxone kits through in=person and online trainging, and through the publicly available Harm Reduction Vending Machine. SCASAS will partner with the Opioid Committee to ensure wall-mounted naloxone boxes remain stocked at key community sites for clients, visitors, and the public. Steuben Prevntion Coalition and Opioid Committee will continue to provide naloxone through trainings for the community. IHS will deliver American Heart Association (AHA) CPR and emergency response trainings that integrate updated Narcan administration guidelines.

Steuben County Community Health Improvement Plan (CHIP)
2025-2030 Progress Reporting and Revision Plan

In order to continually evaluate the relevance and effectiveness of the CHIP throughout the cycle, the following progress reporting and revision plan will be followed by Steuben County Public Health and the SMART Steuben group. Doing so will ensure that interventions outlined in the CHIP will continue to meet the evolving needs of the Steuben County community.

Timeframe	Activities	Responsible Agencies
April 2026	Submit tracking metrics for Q1 2026 to SCPH	Reporting Partners
Quarter 2 2026 (June)	Attend SMART Steuben meeting and discuss the following: • Progress towards interventions • Successes and barriers in Q1 2026 • Review of recently available data • Changes in resources	All SMART Steuben members
August 2026	Submit tracking metrics for Q2 2026 to SCPH	Reporting Partners
Quarter 3 2026 (September)	Attend SMART Steuben meeting and discuss the following: • Progress towards interventions • Successes and barriers in Q2 2026 • Review of recently available data • Changes in resources	All SMART Steuben members
November 2026	Submit tracking metrics for Q3 2026 to SCPH	Reporting Partners
Quarter 4 2026 (December)	Attend SMART Steuben meeting and discuss the following: • Progress towards interventions • Successes and barriers in Q2 2026 • Review of recently available data • Changes in resources	All SMART Steuben Members

Timeframe	Activities	Responsible Agencies
December 2026	Submit Y1 CHIP/CSP progress report by December 2026.	Steuben County Public Health Arnot Health St. James Hospital
January 2027	Submit tracking metrics for Q4 2026 to SCPH Complete the Annual Review Form and submit to SCPH	Reporting Partners Appropriate SMART Steuben members
Quarter 1 2027 (March)	Attend SMART Steuben meeting and discuss the following: • Progress towards interventions • Successes and barriers in Q4 2026 • Review of recently available data • Changes in resources	All SMART Steuben Members
April 2027	Submit tracking metrics for Q1 2027 to SCPH	Reporting Partners
Quarter 2 2027 (June)	Attend SMART Steuben meeting and discuss the following: • Progress towards interventions • Successes and barriers in Q1 2027 • Review of recently available data • Changes in resources	All SMART Steuben Members
August 2027	Submit tracking metrics for Q2 2027 to SCPH	Reporting Partners
Quarter 3 2027 (Septmeber)	Attend SMART Steuben meeting and discuss the following: • Progress towards interventions • Successes and barriers in Q2 2027 • Review of recently available data • Changes in resources	All SMART Steuben Members

Timeframe	Activities	Responsible Agencies
November 2027	Submit tracking metrics for Q3 2027 to SCPH	Reporting Partners
Quarter 4 2027 (December)	Attend SMART Steuben meeting and discuss the following: • Progress towards interventions • Successes and barriers in Q3 2027 • Review of recently available data • Changes in resources	All SMART Steuben Members
December 2027	Submit Y3 CHIP/CSP progress report by December 2027.	Steuben County Public Health Arnot Health St. James Hospital
January 2028	Submit tracking metrics for Q4 2027 to SCPH Complete the Annual Review Form and submit to SCPH	Reporting Partners Appropriate SMART Steuben members
Quarter 1 2028 (March)	Attend SMART Steuben meeting and discuss the following: • Progress towards interventions • Successes and barriers in Q4 2027 • Review of recently available data • Changes in resources	All SMART Steuben Members
April 2028	Submit tracking metrics for Q1 2028 to SCPH	Reporting Partners
Quarter 2 2028 (June)	Attend SMART Steuben meeting and discuss the following: • Progress towards interventions • Successes and barriers in Q1 2028 • Review of recently available data • Changes in resources	All SMART Steuben Members
August 2028	Submit tracking metrics for Q2 2028 to SCPH	Reporting Partners

Timeframe	Activities	Responsible Agencies
Quarter 3 2028 (Septmeber)	Attend SMART Steuben meeting and discuss the following: • Progress towards interventions • Successes and barriers in Q2 2028 • Review of recently available data • Changes in resources	All SMART Steuben Members
November 2028	Submit tracking metrics for Q3 2028 to SCPH	Reporting Partners
Quarter 4 2028 (December)	Attend SMART Steuben meeting and discuss the following: • Progress towards interventions • Successes and barriers in Q3 2028 • Review of recently available data • Changes in resources	All SMART Steuben Members
December 2028	Submit the mid-cycle CHA update to assist hospitals with their IRS-required CSP, if applicable Submit Y4 CHIP/CSP progress report by December 2028. Submit the 2028-2030 CHA/CSP by December 2028 (Hospitals)	Steuben County Public Health Arnot Health St. James Hospital
January 2029	Submit tracking metrics for Q4 2028 to SCPH Complete the Annual Review Form and submit to SCPH	Reporting Partners Appropriate SMART Steuben members
Quarter 1 2029 (March)	Attend SMART Steuben meeting and discuss the following: • Progress towards interventions • Successes and barriers in Q4 2028 • Review of recently available data • Changes in resources	All SMART Steuben Members

Timeframe	Activities	Responsible Agencies
April 2029	Submit tracking metrics for Q1 2029 to SCPH	Reporting Partners
Quarter 2 2029 (June)	Attend SMART Steuben meeting and discuss the following: • Progress towards interventions • Successes and barriers in Q1 2029 • Review of recently available data • Changes in resources	All SMART Steuben Members
August 2029	Submit tracking metrics for Q2 2029 to SCPH	Reporting Partners
Quarter 3 2029 (Septmeber)	Attend SMART Steuben meeting and discuss the following: • Progress towards interventions • Successes and barriers in Q2 2029 • Review of recently available data • Changes in resources	All SMART Steuben Members
November 2029	Submit tracking metrics for Q3 2029 to SCPH	Reporting Partners
Quarter 4 2029 (December)	Attend SMART Steuben meeting and discuss the following: • Progress towards interventions • Successes and barriers in Q3 2029 • Review of recently available data • Changes in resources	All SMART Steuben Members
December 2029	Submit Y5 CHIP/CSP progress report by December 2029.	Steuben County Public Health Arnot Health St. James Hospital

Timeframe	Activities	Responsible Agencies
January 2030	Submit tracking metrics for Q4 2029 to SCPH Complete the Annual Review Form and submit to SCPH	Reporting Partners Appropriate SMART Steuben members
Quarter 1 2030 (March)	Attend SMART Steuben meeting and discuss the following: • Progress towards interventions • Successes and barriers in Q4 2029 • Review of recently available data • Changes in resources	All SMART Steuben Members
April 2030	Submit tracking metrics for Q1 2030 to SCPH	Reporting Partners
Quarter 2 2030 (June)	Attend SMART Steuben meeting and discuss the following: • Progress towards interventions • Successes and barriers in Q1 2030 • Review of recently available data • Changes in resources	All SMART Steuben Members
August 2030	Submit tracking metrics for Q2 2030 to SCPH	Reporting Partners
Quarter 3 2030 (Septmeber)	Attend SMART Steuben meeting and discuss the following: • Progress towards interventions • Successes and barriers in Q2 2030 • Review of recently available data • Changes in resources	All SMART Steuben Members
November 2030	Submit tracking metrics for Q3 2030 to SCPH	Reporting Partners

Timeframe	Activities	Responsible Agencies
Quarter 4 2030 (December)	Attend SMART Steuben meeting and discuss the following: • Progress towards interventions • Successes and barriers in Q3 2030 • Review of recently available data • Changes in resources	All SMART Steuben Members
December 2030	Submit End of Cycle CHIP/CSP progress report by December 2030.	Steuben County Public Health Arnot Health St. James Hospital
Ongoing	Comply with all CHA/CHIP reporting requirements as outlined by the NYSDOH	All SMART Steuben Members

In addition to the timelines laid out above, Steuben County Public health will schedule and host meetings as appropriate whenever there is a need to discuss challenges, successes, and/or possible revisions to the CHIP.

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
- 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

Appendix 1: Steuben County 2025 - 2030 Community Health Improvement Plan , Annual Review Form

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

Completion date: _____
Completed by: _____
Reporting agency: _____

1. Please provide any relevant updates related to activities and strategies included in your agency's CHIP that were not already reported in the NYSDOH CHIP Workplan.

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 Housing Stability and Affordability, Poverty, and Primary Prevention, Substance Misuse, and Overdose Prevention.

4. Are you aware of any newly available data sources or updated indicators within the priority areas of Housing Stability and Affordability, Poverty, and Primary Prevention, Substance Misuse, and Overdose Prevention? 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!

Public Health
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Steuben County NY

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Appendix 2: 2025 - 2030 CHIP Intervention Amendment Form

If you would like to change existing interventions and/or measures, or you would like to add an intervention to report, please use the template below to indicate the approriate information for each area.

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

Priority Area: _____ **Objective: _____**

Intervention	Performance Measures	Disparities Addressed	Partner Agencies and Resources

Public Health
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Steuben County NY

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

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