TUESDAY, MAY 20, 2025
WEXNER MEDICAL CENTER BOARD MEETING

Leslie H. Wexner, chair
Alan A. Stockmeister
Gary R. Heminger
Tomislav B. Mitevski
Juan Jose Perez
George A. Skestos
Joshua H.B. Kerner
Robert H. Schottenstein
Stephen D. Steinour
Cindy Hilsheimer
Amy Chronis
Hiroyuki Fujita
John W. Zeiger (ex officio, voting)
Walter E. Carter Jr. (ex officio, voting)
Ravi V. Bellamkonda (ex officio, voting)
Michael Papadakis (ex officio, voting)
John J. Warner (ex officio, voting)

Location: Sanders Grand Lounge, Longaberger Alumni House
2200 Olentangy River Road, Columbus, Ohio 43210

Time: 1:00-3:30 p.m.

Public Session **1:00-1:30 p.m.**

1. Approval of February 2025 Wexner Medical Center Board Meeting Minutes
2. *CEO Report – Dr. John Warner* 1:00-1:10 p.m.
3. *Wexner Medical Center Financial Report – Mr. Richard Silveria* 1:10-1:15 p.m.
4. Recommend for Approval Wexner Medical Center FY26 Budget – Mr. Richard Silveria 1:15-1:20 p.m.
5. Recommend Approval to Enter Into Professional Services and Enter Into Construction Contracts – Ms. P'Elizabeth Koelker
6. Recommend for Approval the Purchase of Real Property – Ms. P'Elizabeth Koelker
7. Approval of the Community Health Needs Assessment and Implementation Strategy – Dr. Andrew Thomas 1:25-1:30 p.m.

Executive Session **1:30-3:30 p.m.**

THE OHIO STATE UNIVERSITY

Board of Trustees

University Square South
15 East 15th Avenue, 5th Floor
Columbus, OH 43201

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SUMMARY OF ACTIONS TAKEN

February 18, 2025 – Wexner Medical Center Board Meeting

Members Present:

Alan A. Stockmeister	Joshua H.B. Kerner	John W. Zeiger (ex officio)
Gary R. Heminger	Robert H. Schottenstein	Walter E. Carter Jr. (ex officio)
Tomislav B. Mitevski	Cindy Hilsheimer	Ravi V. Bellamkonda (ex officio)
Juan Jose Perez	Amy Chronis	Michael Papadakis (ex officio)
George A. Skestos	Hiroyuki Fujita	John J. Warner (ex officio)

Members Present via Zoom: N/A

Members Absent:

Leslie H. Wexner, Stephen D. Steinour

PUBLIC SESSION

The Wexner Medical Center Board convened for its 53rd meeting on Tuesday, February 18, 2025, in person at Longaberger Alumni House on Ohio State's Columbus campus. Board Secretary Jessica A. Eveland called the meeting to order at 2:08 p.m.

At the beginning of the meeting, Mr. Robert Schottenstein welcomed Executive Vice President and Provost Ravi Bellamkonda to the university and Wexner Medical Center Board, noting how exited he and other Board members are to work with him.

Item for Action:

1. Approval of Minutes: No changes were requested to the November 19, 2024, meeting minutes; therefore, a formal vote was not required, and the minutes were considered approved.

Items for Discussion:

2. Chief Executive Officer's Report: Dr. John Warner, chief executive officer, Wexner Medical Center, first reflected on the great work being done by the heart and vascular team at the medical center. November marked the 20th anniversary of the Richard M. Ross Heart Hospital which, when it opened, was the first academic hospital in the nation dedicated to comprehensive cardiovascular care. Over the past year, the hospital hosted nearly 25,000 new outpatient visits and almost 7,000 new inpatient visits — both figures representing strong increases over the prior year. The past year has also seen new partnerships and services.

   Dr. Warner then shared an update on the Wexner Medical Center's partnership with Helix to help accelerate the integration of genomic data into research and decision-making. In collaboration with other academic institutions, the initiative will provide no-cost genetic screenings to 100,000 individuals to identify risk factors and inform preventative measures for certain conditions. It will eventually make it easier to develop personalized health plans for patients. He illustrated the value of these efforts with the story of the Smith family, who is affected by a rare aortic dissection

condition.

Dr. Warner updated the Board on progress within the SOAR study, noting that Ohio State has exceeded its target number of completed wellness surveys from across the state and is well over halfway to meeting its goal of enrolling brain-health phenotyping participants. He also discussed the early work of a new mobile MRI unit and its contributions to the SOAR study.

Finally, Dr. Warner recognized Dr. Sylvester Black and Dr. Kymberly Gowdy, both recipients of the Presidential Early Career Award for Scientists and Engineers, and highlighted the 20-person living kidney transplant chain completed at Ohio State in December.

(See Attachment X for background information, page XX)

3. James Cancer Hospital Report: Dr. David Cohn, interim chief executive officer and chief medical officer, James Cancer Hospital and Solove Research Institute shared an update on the institution's work to renew its designation by the National Center Institute as a Comprehensive Cancer Center. He also briefed the Board on The James' new outpatient bone marrow transplant program. This is one example of a broader effort to expand access to, and the reach of, Ohio State's exceptional cancer care — from more robust pre-diagnosis options and outpatient treatments to new partnerships and expanded in-patient capacity in the new hospital tower currently under construction. He closed by noting that registration for Pelotonia 2025 begins in March.

(See Attachment X for background information, page XX)

4. Wexner Medical Center Financial Report: Mr. Ryan Goerlitz provided a high-level report out of the medical center's financial performance through the first six months of FY25. He detailed the medical center's robust position and projected similarly strong performance for the second half of the fiscal year.

(See Attachment X for background information, page XX)

Items for Action:

5. Resolution No. 2025-53, Recommend Approval To Enter Into/Increase Professional Services And Enter Into/Increase Construction Contracts:

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES CONTRACTS
BRAIN & SPINE – AHU REPLACEMENT

APPROVAL TO ENTER INTO/INCREASE PROFESSIONAL SERVICES AND CONSTRUCTION CONTRACTS
2001 POLARIS PARKWAY – CELL THERAPY LAB

APPROVAL TO ENTER INTO CONSTRUCTION CONTRACTS
EMERGENCY RESPONSE RADIO SYSTEM
JAMES OUTPATIENT CARE - NUC MED EXPANSION
OHIO STATE EAST HOSPITAL – EMERGENCY GENERATOR

Synopsis: Authorization to enter into/increase professional services and construction contracts, as detailed in the attached materials, is proposed.

WHEREAS in accordance with the attached materials, the University desires to enter into professional services contracts for the following project; and

	Prof. Serv. Approval Requested	Total Requested

Brain & Spine – AHU Replacement	$5.2M	$5.2M	Auxiliary Funds

WHEREAS in accordance with the attached materials, the University desires to enter into/increase professional services contracts and enter into/increase construction contracts for the following project; and

	Prof. Serv. Approval Requested	Construction Approval Requested	Total Requested	
2001 Polaris Pkwy – Cell Therapy Lab	$0.3M	$4.3M	$4.6M	Auxiliary funds

WHEREAS in accordance with the attached materials, the University desires to enter into construction contracts for the following projects; and

	Construction Approval Requested	Total Requested	
Emergency Response Radio System	$3.2M	$3.2M	Auxiliary funds
James Outpatient Care – Nuc Med Expansion	$5.0M	$5.0M	Auxiliary funds
Ohio State East Hospital – Emergency Generator	$4.2M	$4.2M	Auxiliary funds

NOW THEREFORE BE IT RESOLVED that the Wexner Medical Center Board hereby approves and proposes that the professional services and construction contracts for the projects listed above be recommended to the University Board of Trustees for approval.

BE IT FURTHER RESOLVED, that the President and/or Senior Vice President for Business and Finance be authorized to enter into professional services and construction contracts for the projects listed above in accordance with established University and State of Ohio procedures, with all actions to be reported to the Board at the appropriate time.

(See Attachment X for background information, page XX)

6. Resolution No. 2025-54, Ratification of Committee Appointment FY 2025-2026:

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves that the ratification of appointment to the Quality and Professional Affairs Committee for FY 2025-2026 is as follows:

Quality and Professional Affairs Committee

Alan A. Stockmeister, Chair
Juan Jose Perez
George A. Skestos
Joshua H.B. Kerner
Ravi V. Bellamkonda
Michael Papadakis
John J. Warner
Eric Adkins
Doreen Agnese

Jay M. Anderson
Carol R. Bradford
Stacy A. Brethauer
David E. Cohn
Scott A. Holliday
Elizabeth Seely
Deana Sievert
Corrin Steinhauer
Andrew M. Thomas

Action: Upon the motion of Mr. Heminger, seconded by Mr. Stockmeister, the Wexner Medical Center Board recommended agenda items No. 5 – Recommend Approval to Enter Into Professional Services and Construction Contracts, and No. 6 – Ratification of Committee Appointment FY 2025-2026, for approval by roll-call vote with the following members present and voting: Mr. Stockmeister, Mr. Heminger, Mr. Mitevski, Mr. Perez, Mr. Skestos, Mr. Kerner, Mr. Schottenstein, Ms. Hilsheimer, Ms. Chronis, Dr. Fujita, Mr. Zeiger, President Carter, Mr. Papadakis and Dr. Warner. Dr. Bellamkonda abstained.

EXECUTIVE SESSION

It was moved by Mr. Stockmeister and seconded by Mr. Mitevski that the Wexner Medical Center Board recess into executive session to consider business-sensitive trade secrets and quality matters required to be kept confidential by federal and state statutes; to consult with legal counsel regarding pending or imminent litigation; and to discuss personnel matters involving the appointment, employment and compensation of public officials, which are required to be kept confidential under Ohio law.

A roll-call vote was taken, and the Board voted to go into executive session with the following members present and voting: Mr. Stockmeister, Mr. Heminger, Mr. Mitevski, Mr. Perez, Mr. Skestos, Mr. Kerner, Mr. Schottenstein, Ms. Hilsheimer, Ms. Chronis, Dr. Fujita, Mr. Zeiger, President Carter, Dr. Bellamkonda, Mr. Papadakis and Dr. Warner.

The Wexner Medical Center Board entered executive session at 2:40 p.m. and adjourned at 4:55 p.m.

Wexner Medical Center Board
Financial Report
Public Session

May 20, 2025

March Financial Results

The Ohio State University Health System

Consolidated Statement of Operations
For the YTD ended: March 31, 2025
(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	3,725,165	3,511,431	213,734	6.1%	3,291,631	13.2%
Operating Expenses						
Salaries and Benefits	1,478,892	1,461,844	(17,048)	-1.2%	1,390,311	-6.4%
Resident/Purchased Physician Services	191,444	192,340	896	0.5%	165,205	-15.9%
Supplies/Pharmaceuticals/Other	1,520,467	1,376,098	(144,369)	-10.5%	1,264,591	-20.2%
Depreciation	191,702	191,702	-	0.0%	179,426	-6.8%
Interest	38,230	37,794	(436)	-1.2%	31,653	-20.8%
Total Expense	3,420,735	3,259,778	(160,957)	-4.9%	3,031,186	-12.9%
Gain (Loss) from Operations (pre MCI)	304,430	251,653	52,777	21.0%	260,445	16.9%
Medical Center Investments	(194,038)	(178,170)	(15,868)	-8.9%	(187,771)	-3.3%
Income from Investments	51,114	42,024	9,090	21.6%	42,837	19.3%
Other Gains (Losses)	27,630	28,252	(622)	-2.2%	22,046	25.3%
Excess of Revenue over Expense	$ 189,136	$ 143,759	$ 45,377	31.6%	$ 137,557	37.5%
Non-Budgeted One-Time Recognitions	$ -	$ -	$ -	0.0%	$ 3,358	0.0%
Margin with Non-Budgeted One-Time Recognitions	$ 189,136	$ 143,759	$ 45,377	31.6%	$ 140,915	34.2%
Margin Percentage	5.1%	4.1%	1.0%	24.0%	4.3%	0.8%
EBIDA	$ 419,068	$ 373,255	$ 45,813	12.3%	$ 351,994	19.1%
EBIDA Margin Percentage	11.2%	10.6%	0.6%	5.7%	10.7%	0.5%

The Ohio State University Wexner Medical Center

Combined Statement of Operations
For the YTD ended: March 31, 2025
(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	4,993,812	4,734,039	259,772	5.5%	4,440,199	12.5%
Operating Expenses						
Salaries and Benefits	2,638,120	2,608,551	(29,569)	-1.1%	2,446,713	-7.8%
Resident/Purchased Physician Services	191,444	192,340	896	0.5%	165,205	-15.9%
Supplies/Pharmaceuticals/Other	1,831,898	1,643,651	(188,247)	-11.5%	1,551,950	-18.0%
Depreciation	195,334	195,211	(123)	-0.1%	183,022	-6.7%
Interest	38,386	37,794	(592)	-1.6%	31,813	-20.7%
Total Expense	4,895,182	4,677,547	(217,635)	-4.7%	4,378,703	-11.8%
Gain (Loss) from Operations	98,630	56,493	42,137	74.6%	61,496	60.4%
Income from Investments	58,860	49,677	9,183	18.5%	50,572	16.4%
Other Gains (Losses)	25,137	25,009	128	0.5%	19,496	28.9%
Excess of Revenue over Expense	$ 182,627	$ 131,179	$ 51,448	39.2%	$ 131,564	38.8%
Non-Budgeted One-Time Recognitions	$ -	$ -	$ -	0.0%	$ 3,358	0.0%
Margin with Non-Budgeted One-Time Recognitions	$ 182,627	$ 131,179	$ 51,448	39.2%	$ 134,922	35.4%
Margin Percentage	3.7%	2.8%	0.9%	32.0%	3.0%	0.7%
EBIDA	$ 416,347	$ 364,184	$ 52,162	14.3%	$ 349,757	19.0%
EBIDA Margin Percentage	8.3%	7.7%	0.6%	8.4%	7.9%	0.4%

*** Combined Medical Center includes Health System, OSUP, and College of Medicine.**

**** This statement does not conform to Generally Accepted Accounting Principles. Different accounting methods are used in each of these entities and no eliminating entries are included.**

***** Medical Center financial statements exclude market value adjustments for long-term investment funds**

The Ohio State University Wexner Medical Center

Combined Balance Sheet
As of: March 31, 2025
(in thousands)

	Mar 2025	June 2024	Change
Cash	$ 1,542,427	$ 1,476,652	$ 65,775
Net Patient Receivables	821,207	756,178	65,029
Other Current Assets	244,044	218,438	25,606
Assets Limited as to Use	856,817	958,622	(101,806)
Property, Plant & Equipment - Net	3,919,821	3,706,478	213,344
Other Assets	631,478	610,379	21,099
Total Assets	$ 8,015,792	$ 7,726,748	$ 289,044
Current Liabilities	$ 620,841	$ 477,234	$ 143,607
Other Liabilities	433,885	426,301	7,584
Total Debt	1,370,851	1,438,011	(67,160)
Net Position	5,590,215	5,385,201	205,014
Liabilities and Net Position	$ 8,015,792	$ 7,726,748	$ 289,044
Days Cash on Hand	148.4	151.7	(3.3)
Net Days in Accounts Receivable	53.5	54.3	0.8
Debt to Capital	19.7%	21.1%	1.4%

*** Combined Medical Center includes Health System, OSUP, and College of Medicine.**

**** This Balance sheet is not intended to conform to Generally Accepted Accounting Principles. Different accounting methods are used in each of these entities and no eliminating entries are included.**

Thank You

Wexnermedical.osu.edu

Wexner Medical Center Board
FY2026 Budget Update
Public Session

May 20, 2025

DRAFT

The Ohio State University Wexner Medical Center

Combined Income Statement
For the Years Ended June 30

	Actual 2024	Forecast 2025	Budget 2026	% Change
OPERATING STATEMENT (in millions)				
Total Revenue	$ 6,006	$ 6,650	$ 7,190	8.1%
Operating Expenses				
Salaries and Benefits	3,278	3,521	3,878	10.1%
Resident / Purchased Physician Services	230	264	304	15.2%
Supplies / Pharmaceuticals / Other	1,945	2,266	2,456	8.4%
Depreciation	252	273	296	8.4%
Interest	52	60	56	-6.4%
Total Expense	5,757	6,383	6,990	9.5%
Gain (Loss) from Operations	$ 249	$ 267	$ 201	-24.8%
Excess of Revenue over Expense	$ 249	$ 267	$ 201	-24.8%
Non-Budgeted One-Time Recognitions	$ 26	$ 21	$ -	0.0%
Margin with Non-Budgeted One-Time Recognitions	$ 275	$ 288	$ 201	-30.2%
EBIDA	$ 579	$ 620	$ 552	-10.9%
Financial Metrics				
Integrated Margin Percentage	4.6%	4.3%	2.8%	-1.5%
EBIDA Margin Percentage	9.6%	9.3%	7.7%	-1.6%

DRAFT

The Ohio State University Wexner Medical Center

Combined Income Statement
For the Years Ended June 30

(in millions)	Actual 2024	Forecast 2025	Budget 2026	% Change
Health System				
Revenues	$ 4,444	$ 4,965	$ 5,391	8.6%
Expenses	4,159	4,667	5,174	10.9%
Net	285	298	216	-27.6%
OSUP				
Revenues	$ 944	$ 1,038	$ 1,149	10.7%
Expenses	945	1,038	1,149	10.7%
Net	(1)	0	-	-100.0%
COM/OHS				
Revenues	$ 618	$ 647	$ 650	0.5%
Expenses	627	658	666	1.2%
Net	(9)	(11)	(15)	42.6%
Total Medical Center				
Revenues	$ 6,006	$ 6,650	$ 7,190	8.1%
Expenses	5,731	6,363	6,990	9.9%
Net	275	288	201	-30.2%

Thank You

Wexnermedical.osu.edu

RECOMMEND APPROVAL TO ENTER INTO PROFESSIONAL SERVICES AND ENTER INTO CONSTRUCTION CONTRACTS

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES CONTRACTS
UH-DOAN HALL SPRINKLER INSTALLATION

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES AND CONSTRUCTION CONTRACTS
DOAN – REPLACE SPECT CTS
OUTPATIENT EAST – EXISTING LOT RENOVATION
OUTPATIENT EAST –NEW WEST PARKING LOT

Synopsis: Authorization to enter into professional services and construction contracts, as detailed in the attached materials, is proposed.

WHEREAS in accordance with the attached materials, the University desires to enter into professional services contracts for the following project; and

	Prof. Serv. Approval Requested	Total Requested	
UH-Doan Hall Sprinkler Installation	$1.2M	$1.2M	Auxiliary Funds

WHEREAS in accordance with the attached materials, the University desires to enter into professional services contracts and enter into construction contracts for the following projects; and

	Prof. Serv. Approval Requested	Construction Approval Requested	Total Requested	
Doan – Replace SPECT CTs	$0.3M	$4.3M	$4.6M	Auxiliary funds
Outpatient East – Existing Lot Renovation	$0.8M	$4.7M	$5.5M	Auxiliary funds
Outpatient East – New West Parking Lot	$1.1M	$6.1M	$7.2M	Auxiliary funds

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves and proposes that the professional services and construction contracts for the projects listed above be recommended to the University Board of Trustees for approval.

BE IT FURTHER RESOLVED, That the President and/or Senior Vice President for Business and Finance be authorized to enter into professional services and construction contracts for the projects listed above in accordance with established University and State of Ohio procedures, with all actions to be reported to the Board at the appropriate time.

Project Data Sheet for Board of Trustees Approval

UH-Doan Hall Sprinkler Installation

OSU-255353 (REQ ID# WMC240003)

Project Location: Doan Hall (0089)

- **Approval Requested and Amount**

Professional services	$1.2M
Total requested	$1.2M

- **Project Budget**

Professional services	$1.2M
Construction w/contingency	TBD
Total project budget	TBD

- **Project Funding**
  Auxiliary funds

- **Project Schedule**

BoT professional services approval	05/25
Design	08/25 – 01/26
BoT construction approval	TBD
Construction	TBD
Facility opening	TBD

- **Project Delivery Method**
  Design Build - Competitive GMP

- **Planning Framework**
  - This project was included in the FY24 Capital Investment Plan.

- **Project Scope**
  - This project will upgrade the existing sprinkler coverage in Doan Hall to meet new code requirements, with compliance required by June 2028.
  - The renovation scope includes removing all medical gas and plumbing fixtures on floors 6-11.
  - Final scope and total project cost will be confirmed during design.

- **Approval Requested**
  - Approval is requested to enter into professional services contracts.

- **project team**
  University project manager: Radabaugh, Alexandra
  AE/design architect: TBD
  CM at Risk or Design Builder: TBD

Doan - Replace SPECT CTs

OSU-240329 (REQ ID# WMC240003)

Project Location: Doan Hall (0089)

- **Approval Requested and Amount**

Professional services	$0.3M
Construction w/contingency	$4.3M
Total requested	$4.6M

- **Project Budget**

Professional services	$0.3M
Construction w/contingency	$4.3M
Total project budget	$4.6M

- **Project Funding**
  Auxiliary funds

- **Project Schedule**

BoT professional services approval	05/25
BoT construction approval	05/25
Design	06/25 – 10/25
Construction	11/25 – 03/26
Facility opening	04/26

- **Project Delivery Method**
  Construction Manager at Risk

- **Planning Framework**
  - This project is included in the FY24 Capital Investment Plan.

- **Project Scope**
  - The project will remove four SPECT-CTs and re-install three new SPECT-CTs in Doan Hall within the Nuclear Medicine suite.
  - The space will be renovated to include infrastructure upgrades that accommodate a larger footprint and meet the criteria outlined by the Facility Guidelines Institute for Design & Construction of Health Facilities.

- **Approval Requested**
  - Approval is requested to enter into professional services and construction contracts.

- **project team**
  University project manager: Cashman, Catie
  AE/design architect: TBD
  CM at Risk or Design Builder: TBD

Project Data Sheet for Board of Trustees Approval

Outpatient East - Existing Lot Renovation

OSU-240249 (REQ ID# EAS240017)

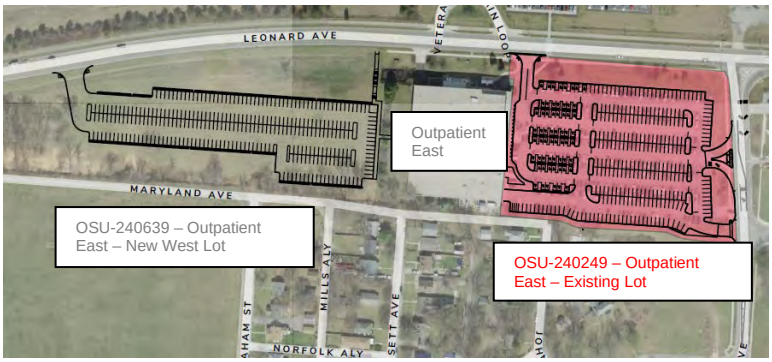
Project Location: Outpatient Care East (0837)

- **Approval Requested and Amount**

Professional services	$0.8M
Construction w/contingency	$4.7M
Total requested	$5.5M

- **Project Budget**

Professional services	$0.8M
Construction w/contingency	$4.7M
Total project budget	$5.5M



- **Project Funding**
  Auxiliary funds

- **Project Schedule**

Design	08/24 – 01/26
BoT professional services approval	05/25
BoT construction approval	05/25
Construction	03/26 – 09/26
Facility opening	09/26

- **Project Delivery Method**
  General Contracting

- **Planning Framework**
  - This project is included in the FY24 Capital Investment Plan.
  - This project was originally below Board of Trustees threshold for approval.

- **Project Scope**
  - During design, the extent of the rehabilitation was expanded which increased the total project cost above the Board of Trustees threshold for approval.
  - The project will reconstruct the existing parking lot on the east side of the Outpatient Care East facility.
  - The new layout will enhance traffic flow and improve patient access by optimizing both pedestrian pathways and vehicular travel lanes.
  - Construction is contingent upon the approval and completion of the New West Parking Lot (OSU-240639), which will provide temporary parking during the east lot's renovation.

- **Approval Requested**
  - Approval is requested to enter into professional services and construction contracts.

- **project team**
  University project manager: Kitchen, Donovan
  AE/design architect: Korda
  CM at Risk or Design Builder: TBD

Project Data Sheet for Board of Trustees Approval

Outpatient East - New West Parking Lot

OSU-240639 (REQ ID# EAS240043)

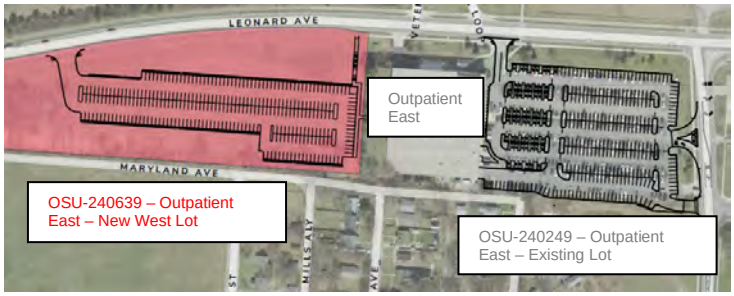
Project Location: Outpatient Care East (0837)

- **Approval Requested and Amount**

Professional services	$1.1M
Construction w/contingency	$6.1M
Total requested	$7.2M

- **Project Budget**

Professional services	$1.1M
Construction w/contingency	$6.1M
Total project budget	$7.2M



- **Project Funding**
  Auxiliary funds

- **Project Schedule**

Design	08/24 – 04/25
BoT professional services approval	05/25
BoT construction approval	05/25
Construction	07/25 – 12/25
Facility opening	12/25

- **Project Delivery Method**
  General Contracting

- **Planning Framework**
  - This project is included in the FY24 Capital Investment Plan.
  - This project was originally below Board of Trustees threshold for approval.

- **Project Scope**
  - Due to contaminated soils on-site, the total project cost increased above the Board of Trustees threshold for approval.
  - A new staff parking lot will be built on the vacant lot west of the Outpatient Care East building to address parking concerns and serve as temporary parking during the renovation of the existing lot reconstruction project (OSU-240249).

- **Approval Requested**
  - Approval is requested to enter into professional services and construction contracts.

- **project team**
  University project manager: Kitchen, Donovan
  AE/design architect: EMH&T
  CM at Risk or Design Builder: TBD

The Ohio State University
Wexner Medical Center Board

May 20, 2025

RECOMMEND FOR APPROVAL THE PURCHASE OF REAL PROPERTY

5.070+/- ACRES AT 1800 ZOLLINGER ROAD,
UPPER ARLINGTON, FRANKLIN COUNTY, OHIO

Synopsis: Authorization to purchase property described as Outpatient Care Upper Arlington from Medstone Realty Company, LLC located at 1800 Zollinger Road, Upper Arlington, Ohio is proposed.

WHEREAS The Ohio State University seeks to acquire 5.070 acres of improved real property located at 1800 Zollinger, Upper Arlington, Ohio, identified as Franklin County parcel number 070-003229; and

WHEREAS the purchase of this property supports the university's plan for strategic investment in outpatient services for neighboring communities:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves and proposes that the purchase of said property be recommended to the University Board of Trustees for approval; and

BE IT RESOLVED, That the Board of Trustees hereby approves that the President and/or Senior Vice President for Business and Finance shall be authorized to take any action required to effect the purchase of the aforementioned property upon the terms and conditions deemed to be in the best interest of the university.

APPROVAL FOR ACQUSITION OF REAL PROPERTY
1800 ZOLLINGER ROAD
UPPER ARLINGTON, FRANKLIN COUNTY, OHIO
BOARD BACKGROUND

Background

In 2015, Medstone Realty Company, LLC (Medstone), a subsidiary of Campus Partners, acquired unimproved property located at 1800 Zollinger Road, Upper Arlington, Ohio for the purpose of constructing a medical office facility that would be leased to The Ohio State University (OSU). In 2016, OSU entered into a long-term lease with Medstone for the building now known as The Ohio State Outpatient Care Upper Arlington and pre-paid rent to Medstone in the amount of $20,867,000. The lease contained a purchase option for OSU to acquire the property from Medstone for one dollar ($1.00). The university would like to exercise its purchase right.

Location and Description

The subject property consists of approximately 5.070 acres of improved real property situated at 1800 Zollinger Road, Upper Arlington, Ohio. The property is Franklin County parcel number 070-003229 and located in the Kingsdale Shopping Center area of Upper Arlington.

Property History

In 2009, the City of Upper Arlington entered into a development agreement with Continental Real Estate Companies (Continental) to bring new investment and business to the Kingsdale shopping center. As part of that agreement, Upper Arlington purchased approximately five acres of the Kingsdale property from Continental to facilitate the development of new professional or medical office space. Continental retained a right to repurchase the office parcel and held the exclusive right to market it for development through November 2014. In order to react in a quickly evolving market, Upper Arlington, Medstone, and the university entered into a Tri-Party Agreement to develop the site. Medstone acquired the property and has held ownership since May 14, 2015.

Purchase of Property

Planning, Architecture and Real Estate recommends that the above referenced property be acquired under terms and conditions that are deemed to be in the best interest of the university.

THE OHIO STATE UNIVERSITY

5.070 Acres
1800 Zollinger Road Acquisition
Upper Arlington, Franklin County, Ohio

Prepared By: The Ohio State University
Office of Planning, Architecture and Real Estate
Issue Date: March 12, 2025
The Ohio State University Board of Trustees

The Ohio State University Wexner Medical Center

HealthMap 2025
Implementation Strategy 2025-2027

The Ohio State University
Wexner Medical Center

HealthMap 2025 Implementation Strategy 2025-2027

As indicated in The Ohio State University Wexner Medical Center's Community Health Needs Assessment, the four health systems in Franklin County, Columbus Public Health and Franklin County Public Health and several community partners jointly completed the Franklin County *HealthMap 2025*. The Franklin County *HealthMap 2025* identifies five health priorities and corresponding indicators. The five health priorities are as follows:

- Social Drivers of Health
- Mental Health
- Adverse Childhood Experiences (ACEs)
- Maternal and Infant Health
- Violence and Injury-Related Deaths

This implementation strategy explains how the Ohio State Wexner Medical Center will address and try to impact the priorities identified in The Ohio State University Wexner Medical Center's Community Health Needs Assessment.

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Priority Health Needs 2025-2027

Social Drivers of Health

- **Specific and interrelated indicators include:**
- **Housing security (decreased homelessness, increased affordability)**
- **Economic stability**
- **Neighborhood safety (reduced crime)**
- **Food security (increased access to nutritious foods)**
- **Education**
- **Transportation**
- **Access to care**

Social drivers of health refer to the conditions in which people are born, grow, live, play, work and age that influence a person's health. Non-medical factors, such as economic stability, education and health care access, transportation and neighborhood safety, are key drivers of good health outcomes. The Ohio State Wexner Medical Center has instituted many programs that address needed community services and supports in an effort to improve health outcomes for our patients.

Healthy Community Center

On the Near East Side, the Ohio State Wexner Medical Center's Healthy Community Center opened in spring 2024, collaboratively designed with neighborhood residents. Utilizing the Columbus Metropolitan Library's original Martin Luther King Jr. branch near East Hospital, this multipurpose facility provides no direct clinical services, but it fills a major gap in the community and demonstrates Ohio State's commitment to its neighbors' well-being.

The Ohio State University Healthy Community Center features:

- a teaching kitchen with demonstrations for families and individuals of all ages
- the Near East Café, providing catering and healthy foods to the community
- a meeting center and café space for a new and/or growing business
- soundproofed multipurpose classrooms and meeting rooms that can be sectioned off as needed
- innovation space that teaches mindfulness, body weight resistance as well as Pilates
- community garden and composting
- senior activities, screening for common health concerns and health education programs.

Since its opening in May 2024, programming at the Healthy Community Center had reached more than 3,000 participants by the end of 2024.

Healthy Community Day

Celebrating its 25th anniversary in 2025, The Ohio State University Wexner Medical Center's Healthy Community Day is a free health fair that brings together health expertise from more than 50 organizations. This annual community event takes place on the first Saturday of June at our Outpatient Care East facility. In 2024, we provided more than 400 health screenings, served more than 600 lunches and distributed more than 2,600 pounds of fresh produce to the Near East Side community.

Food Access

The science is clear that access to food, especially fruits and vegetables, is critical for improved health outcomes, prevention of disease progression and lower overall costs of medical care.

Mid-Ohio Farmacy

In September 2019, the Wexner Medical Center partnered with the nation's seventh-largest food bank, the Mid-Ohio Food Collective, to better connect Ohio State patients with documented food insecurity with enhanced access to fresh produce and other nutrient-rich foods. What resulted was the Mid-Ohio Farmacy, a partnership that allows Ohio State staff and providers to screen and refer patients to receive a fresh-food "prescription" card, with a unique Rx ID. This Rx ID permits patients weekly access to fresh produce at any of the Mid-Ohio Food Collective's 12 participating pantries in central Ohio. Not only does the increased access to fruits and vegetables at food pantries improve health outcomes through nutrition, but patients also don't have to spend as much of their limited budgets on food.

The program was initially offered at two Family and Community Medicine clinics, but it has expanded to additional clinics. Currently providers at these locations are prescribing the Mid-Ohio Farmacy card:

- Family and Community Medicine at Primary Care Northwood-High and Outpatient Care East
- Total Health Care Center at East Hospital
- Maternal Fetal Medicine at McCampbell Outpatient Care and East Hospital
- Diabetes-specific endocrinology clinics
- Primary Care – General Internal Medicine at Martha Morehouse Outpatient Care and Outpatient Care East

As of October 2024, more than 2,480 patients have benefited from the program, leading to more than 23,867 food pantry visits with patients selecting produce during 19% of those visits. The change in A1c levels for enrolled patients decreased by 0.5%. In

addition, among referred patients with A1c greater than 9%, numbers declined from 30.4% to 21.6% after three months.

Additional Mid-Ohio Food Collective Partnerships

Other longstanding partnerships between Ohio State and Mid-Ohio Food Collective include:

- Donation of 40,000 pounds of food each year to the food bank's Second Servings program. Surplus food items are prepared into packaged meals by our hospital kitchens. These meals head directly to Second Servings' soup kitchens and emergency shelters. Uncooked produce, bread and other foods also are donated to the food bank.
- James Mobile Education Kitchen medical center chefs and clinicians distribute food samples and hold cooking and nutrition demonstrations at food pantries and other community locations, such as the Reeb Avenue Community Center.

Bronzeville Food Co-Op

Several grocery stores were once located on the Near East Side. The last grocery store closed in the early 2010s. The Bronzeville Food Co-op is working to establish a community-led grocery store that provides affordable, nutritious food. Due to our prominence in the community, the Ohio State Wexner Medical Center has been involved since the exploratory committee's creation. We currently have membership on the Steering Committee for the endeavor. We also provided funding for a market study and a community survey to help move this project forward. We are committed to helping the community reach its goal of having access to affordable, healthy food.

Access to Care

Timely, culturally appropriate and easy-to-get-to health care is an additional strategy for enhancing health outcomes for all.

To improve access to care, the Wexner Medical Center has pursued multiple initiatives, including:

New Inpatient Hospital Tower

Opening in 2026, Ohio State's new inpatient tower is the largest single facilities project in the history of The Ohio State University. The 1.9 million-square-foot hospital will replace 440 outdated beds at our current University Hospital, nearly doubling that number with 820 beds equipped to provide the highest level of patient care. With a

strategic objective to be the preeminent tertiary/quaternary care hospital serving the residents of central Ohio, the new inpatient hospital will serve as a model for all 21st-century hospitals, where faculty, staff and learners will bring together expertise to advance innovations and solve unrelenting medical and health care challenges. Our culture of innovation and this new tower will help us provide the very best care to our patients, ensuring that their stay is as comfortable as possible.

Ohio State Dental Clinic

On Oct. 1, 2024, the Ohio State Wexner Medical Center and the Ohio State College of Nursing's Federally Qualified Health Center (FQHC), Ohio State Total Health Care Center, opened their much-anticipated Ohio State Dental Clinic at Outpatient Care East. Its opening marked a new approach to community health care.

The Ohio State Dental Clinic was made possible through contributions from state government, championed by the district's Senator Hearcel Craig. The collaboration among state government, the university's FQHC, the College of Nursing, the College of Dentistry and thee Wexner Medical Center led to a significant step in the university's mission to lead the transformation of health care in central Ohio and address barriers to health by expanding access to all Ohioans.

Access to oral health is a critical but often overlooked piece of overall health and well-being. By partnering to establish the clinic on the Near East Side, we are addressing one of the most prevalent barriers to health care – accessibility. The Near East Side once hosted many professional offices, including physicians and dentists. Due to several factors, many of these professionals moved to other areas, leaving dentistry in short supply. With the creation of this clinic, we are helping to restore dentistry to the neighborhood.

Additionally, the Ohio State Dental Clinic is just one part of efforts to centralize health care at Outpatient Care East. We are in the process of co-locating services there, allowing us to address oral health, primary care, behavioral health and eventually vision care. Plans are underway for the addition of an optometry clinic to this space.

Eastland Prosperity Center

Mid-Ohio Food Collective (MOFC) is leading efforts to co-locate services for the Eastland neighborhood. The food collective, partnering with various government stakeholders, is transforming a 67,000 square-foot former grocery store into a center that will offer a free food market, a community health center, city programs and other resources to residents in southeast Columbus.

In fall 2024, Total Health Care Center was approached by MOFC to serve as the on-site community health center. This partnership will allow the federally qualified health center to expand its services to a new location, serving the needs of residents of central Ohio. Construction began earlier this year and is expected to conclude in 2026.

Epic Connect

Ohio State's Epic Connect Program provides and manages the hardware infrastructure to run the Epic electronic medical record (EMR) platform for partnering hospitals, community health centers and independent providers. The Epic EMR suite is at the heart of the Ohio State Wexner Medical Center Connect program and is considered the "best in KLAS," an award that recognizes software and services companies who excel in helping health care professionals improve patient care. Epic improves care coordination by providing an integrated, single source to access and seamlessly share health information with providers, improving clinical efficiency, safety and quality, productivity and satisfaction.

Patients benefit from Epic's intuitive one-stop patient portal for mobile, tablet and desktop applications. This shared ecosystem focuses on interoperability, allowing different health care technologies to exchange and use information effectively. Nationwide Children's Hospital, Mount Carmel Health System and OhioHealth each have their own instances of Epic, but this interoperability is critical for patient care.

Ohio State's Epic Connect is Ohio State's instance of Epic that is shared with 12 other hospitals throughout the state, as well as with Heart of Ohio Family Health, a Federally Qualified Health Center, and Lifecare Alliance, right here in Columbus. In March 2025, Columbus City Council passed legislation allowing Columbus Public Health to enter into a contract with Ohio State Wexner Medical Center so that it too could join the Epic Connect program.

Partnering with the Wexner Medical Center's Connect program reduces capital expenditure costs for an organization while also implementing the best cybersecurity practices to reduce potential security risks. Health organizations are able to leverage our expertise and resources. We assist in the installation, training and utilization of their new EMR. Additionally, the Ohio State Wexner Medical Center provides the organizations with a dedicated support team, including help desk and software specialists who manage workflows and builds, reducing IT workload.

The Ohio State University Mobile Units

Ohio State deploys mobile units throughout central Ohio to improve access to care in underserved areas. In March 2020, the Wexner Medical Center added the Community Care Coach to its mobile fleet. The 38-foot coach is the first mobile primary care and Ob/Gyn unit at Ohio State. The wheelchair-accessible coach includes two exam rooms, a waiting room and a point-of-care testing lab. It provides primary care, such as vaccines, physical exams, blood tests and prenatal and postpartum care for mothers. The care coach partners with Moms2B, making prenatal care available at a number of its in-person educational sessions.

The Community Care Coach joins three other Ohio State mobile units. These include:

- The OSUCCC – James' Mobile Education Kitchen, whose purpose is to educate the public about healthy, cancer-preventive foods and how to prepare these foods at home.
- The James Mobile Mammography Unit meets women where they live to provide an effective, affordable and convenient way to detect breast cancer.
- The College of Dentistry's Dental Health Outreach Mobile Experience Coach is an outreach program that strives to meet the oral health needs of Ohioans in key underserved areas while training sensitive and culturally competent health professionals.

These units are addressing needed community services and supports by providing convenient care close to home, eliminating barriers, such as insurance, transportation and child care.

Expanding Ambulatory Services

The Ohio State University Wexner Medical Center continues to expand its care with large ambulatory facilities in New Albany (opened summer 2021) and Dublin (opened summer 2022). Outpatient Care Powell is currently under construction and is expected to open in summer 2026.

The comprehensive facilities are part of a suburban outpatient care program that supports growth in the region and excellence in academic health care. At approximately 200,000 square feet, the five-story medical office building and two-story ambulatory health center in Powell will include imaging, outpatient rehab/PT, endoscopy and related support space.

In addition, since our last Community Health Needs Assessment, the medical center has opened new primary care locations in Grove City and Pickerington as well as purchased/opened urgent care locations in Gahanna and Hilliard.

Additionally, in July 2023, we opened The James Outpatient Care, a new ambulatory cancer center, with a focus on cancers that affect bone and soft tissue, blood, kidney, bladder and prostate – cancers in which treatment options have advanced to the point that outpatient care is now an option. It includes outpatient operating rooms, interventional radiology rooms, extended recovery unit, pre-anesthesia center, a diagnostic imaging center, retail pharmacy, hematology clinic, genitourinary clinic, infusion and medical office and support spaces. The approximately 385,000 square-foot, cancer-focused facility also includes central Ohio's first proton therapy center, in partnership with Nationwide Children's Hospital, that provides children and adults with the latest radiotherapy available.

Transportation Assistance

The Ohio State Wexner Medical Center continues to work to provide better transportation assistance for our low-income patients to make it easier for them to attend appointments, especially services on our main campus. This assistance includes enhanced parking subsidies and working with more flexible ride programs, such as Lyft.

Education

Our Workforce Development team has taken an innovative approach to increasing the health care workforce. The Wexner Medical Center is central Ohio's largest health care employer with more than 22,000 employees. We are actively building the future by creating more than 2,000 new career positions, including many for the new hospital tower. Following the COVID-19 pandemic, we have thousands of open positions in addition to the 2,000 jobs our growth plans will create. These are some of the large initiatives that we are doing to help educate and recruit new health care workers:

K-12 Partnerships

Until recently, the Ohio State Wexner Medical Center had historically limited opportunities for minor students to participate in on-site learning experiences. On July 1, 2023, a new Unpaid Student Experience Policy was put into effect to encourage partnering with local school districts for on-site visits – including internship opportunities. The new policy creates opportunity but also requires training, time commitments and engagement from Wexner Medical Center staff who are interested in hosting students. To ensure a smooth transition to the new policy, we are working with a limited number of partners who have experience in these programs and have been invited to participate. We originally started with the four largest school districts in the central Ohio region and have recently added our fifth school district. We plan to expand partnerships as our resources and ability allows.

In just one year of establishing a position for an associate director of Workforce Partnerships for our K-12 students, we have been able to impact 16,901 lives, including students, teachers and parents. Additionally, in November 2024, we introduced a new policy to provide paid experiences at our medical center for 17-year-old high school students enrolled in health care-specific pathways. This initiative aims to support their educational journey and career development.

Other partnerships with local school districts include educator tours of our facilities and experiences, a parent academy that informs parents and students about in-demand opportunities for employment and student events with our district partners. We have had 22 students complete internships and another 60 students who have completed one-time shadows in a field of their choosing. We have participated in 63 career exploration events at various schools in the community, and we have hosted 39 events for students and teachers at one of our medical center facilities. We currently have 218 team members internally (up from 26 in March 2024) who serve as ambassadors for our K-12 work.

In the past year, our participation with the Healthcare Career Collaborative of Central Ohio, a partnership between five major health care organizations in the greater Columbus area, created a health care-specific station for middle schoolers at Junior Achievement's Finance Park where hundreds of middle schoolers will have the opportunity to learn about health care careers annually. In partnership with the Healthcare Career Collaborative of Central Ohio, we created six career-specific "day-in-the-life" videos to help share about priority occupations in health care. Five of these can be viewed on the collaborative's website.

Our industry sector partnership also hosted our second Healthcare Career Summit for high school students in central Ohio. This year we added opportunities for more students and opened it to the community. We hosted 1,900 students from 58 schools during the two-day event. The event provides hands-on experiences for students to learn about health care careers in imaging, nursing, surgical technology, medical assisting, laboratory and respiratory therapy. The work was made possible by grant funding from the state of Ohio. The first event was recognized with the annual award for Workforce Innovation by the Ohio Economic Development Association.

Finally, we launched an externally facing web page to help connect us to the community, for career exploration experiences. To date, we have received 161 requests from the community.

Columbus Promise

The Ohio State Wexner Medical Center was one of the initial funders for the Columbus Promise, a pilot program created by the city of Columbus, I Know I Can and Columbus State Community College, to boost college-going, student success and growth of the job market in Columbus. The Columbus Promise Scholarship covers tuition and fees to Columbus State Community College after the Pell grant (if eligible) and any tuition-restricted scholarship(s). An additional $500 per semester for educational expenses, up to six semesters, is also included. Columbus Promise Scholars receive exclusive advising and support to develop skills, behaviors and habits that contribute to success in and beyond college.

Besides being an initial funder, the Ohio State Wexner Medical Staff have participated in numerous recruiting and employment events with Columbus State for Columbus Promise participants.

Health Sciences Academies

The Health Sciences Academies are a partnership between PACT, an Ohio State Wexner Medical Center subsidiary, Columbus City Schools and the Wexner Medical Center. All six East Side public schools are designated as a Health Sciences Academy, with

a monthly focus on diseases that may impact students' lives. Every student reads a health science-related book each year. In all their classes, students create a project that culminates in a cross-curricular fair. The Science Café is attended up to three times a year by a select group of students who visit a community partner for a hands-on experience centered on a career in the health sciences. East High School students participate in the Health Science Career Connections club every week to learn from professional in health sciences-related fields, engage in mentoring opportunities from Ohio State medical students, complete community service projects and learn professional skills.

Surgical Technial Program

Facing 85 openings in the surgical technical field at the Wexner Medical Center, our workforce development team reached out to Columbus State Community College to triple the number of yearly graduates. Columbus State had limited facility space and teaching staff for the program and had turned away applicants in the past. On Feb. 28, 2024, both institutions announced a collaboration that would allow Columbus State to provide the curriculum and accreditation and Ohio State to provide the instructional support and clinical training space. The program launched in August 2024.

Offering English as a Second Language Classes for Employees

The Ohio State Wexner Medical Center offers an English as a Second Language program to its current employees. It reduces barriers to employees in the workspace and in the community. The program is delivered free of charge in partnership with Columbus State Community College. It provides 16 weeks intensive language training by a certified instructor from Columbus State. Many employees who complete the course continue their education at Columbus State. In May 2025, we will have more than 100 graduates over the program's two-year history. Graduates have been from a wide range of backgrounds – from entry-level proficiencies to an MD from Ukraine.

COTA

The Central Ohio Transit Authority (COTA) recently passed a ballot initiative to increase the sales tax for the creation of LinkUs, a transformative mobility plan designed to foster growth, affordability and opportunity. LinkUs will address key priorities for central Ohio families, including sidewalk improvements and additions to protect pedestrian safety. The initiative will modernize central Ohio's transit system, making buses faster and more reliable (45% more service hours), while adding more than 500 miles of new sidewalks, multi-use paths and bikeways. LinkUs aims to enhance connectivity across more than 40 communities. It will build the infrastructure we need to grow our economy while creating walkable communities with more access to work, home and health care. The Ohio State Wexner Medical Center supported the ballot initiative. Our patients and employees will also benefit from the new LinkUs routes, including the one that will run right past our new inpatient tower.

Additionally, our partnership with COTA is improving access to care through proposed new bus stops at our outpatient care facilities in Dublin and New Albany and the creation of a new bus line. The new line will start at our Dublin Outpatient Care facility and end at The Ohio State University's campus, running through Hilliard and Upper Arlington along the way. It will be a boon for our patients and staff as another way for them to access our world-class health care.

Housing

The Wexner Medical Center Housing Program was created for patients and their support members who need temporary housing assistance while receiving care at the Wexner Medical Center. We offer accommodations through a hotel partnership designed to relieve the burden of lodging expenses that would be a barrier to successful completion of their care plan. This has been especially critical to support patients and their caregivers in our cancer and transplant service lines who are experiencing either housing insecurity or who live a significant distance from Columbus but who do not have the financial resources to afford local hotel accommodations.

PACT (Partners Achieving Community Transformation)

In 2010, PACT began with a $10 million investment from the Wexner Medical Center. PACT was founded as a partnership among the Ohio State Wexner Medical Center, the city of Columbus, the Columbus Metropolitan Housing Authority and community neighbors, and has worked to develop a revitalization plan called the Blueprint for Community Investment. The plan seeks to make the Near East Side neighborhood a healthy, sustainable community offering residents access to safe, affordable homes, quality health care and education and local employment opportunities.

The original $30 million investment by the three original partners was leveraged into an additional $30 million federal Housing and Urban Development grant in 2014. Then, based on this sound foundation of commitment to the Near East Side, Fifth Third Bank announced a $20 million investment in the Near East Side in fall 2021 as part of the financial institution's $180 million national Neighborhood Investment Program in collaboration with Enterprise Community Partners. The program supports revitalization in communities throughout the country that have experienced a sustained period of disinvestment. Columbus is one of nine cities to receive the award.

PACT and its partners are leveraging the neighborhood's rich cultural legacy and creating an economic impact corridor. Late last year, PACT presented Requests for Expressions of Interest (REI) for nine sites, totaling six acres, along Taylor Avenue. Taylor Avenue is a prominent corridor in the PACT geography and is often described as a gateway to Columbus' Near East Side. With the REI, PACT is specifically seeking proposals that promote quality, sustainable housing for a range of income levels and vibrant and safe neighborhoods. Decisions are being made about these nine sites that could transform the corridor.

What We Will Do

- Open the new inpatient tower in 2026.
- Open an optometry clinic at Outpatient Care East.
- Expand Dental Clinic hours at Outpatient Care East.
- Open the new Total Health Care Center's site at the Eastland Prosperity Center.
- Finalize our contract with the city of Columbus on Epic Connect and begin to provide Columbus Public Health with IT support for EPIC.
- Continue to address access to care through taking care to our patients and providing them with better transit access.
- Continue to create and enhance partnerships around workforce development and education.
- PACT will select developers for the nine parcels presented in its 2024 REI and planning and construction will begin.

Mental Health

Specific indicators include:

- **Depression prevalence**
- **Loneliness prevalence**
- **Suicide death rate**

Mental and social health are increasingly recognized as both direct and indirect contributions to overall health. Experiencing violence or being exposed to violence in the home has long-term physical and mental health impacts. In addition to the direct impact on an individual's mortality, suicide also has rippling negative effects among other community members, from family members to peers to first responders.

Behavioral Health Urgent Care

To close gaps in the continuum of care for people requiring behavioral health services, the Ohio State Wexner Medical Center has initiated a Behavioral Health Urgent Care Clinic. The clinic seeks to assist two groups of patients in particular need of continuous access to care.

The first group are people discharged from an inpatient hospitalization and waiting to see a provider. This group may have to wait months before seeing a clinician at a time when they are most likely to decompensate or be at risk for suicide. Their diagnoses cover a whole range of severe mental illnesses.

Staff members schedule to see the patient within seven days of discharge from an acute inpatient hospital and then initiate routine appointments or phone calls to check in with patients. They're available to monitor symptoms, including medication side effects, ensure compliance with safety planning and provide counseling as needed. They also provide case management services, such as coordination of non-psychiatric medical issues and facilitation of community outpatient follow-up.

Important goals are to make sure an individual takes prescribed medicine as directed and shows up for the first outpatient visit. Services are provided for up to eight weeks after hospital discharge.

The second group of people are those who are in crisis but do not require an emergency room visit. Many of these patients may be active in outpatient behavioral health treatment, but patients can often go three or six months between visits with their provider. People in crisis who do not meet the criteria for hospitalization benefit from a bridging service to provide care when they need it. The Urgent Care Clinic provides that bridge to the next appointment with counseling, video visits and medication adjustments or refills.

Same-day appointments are available, and patients can seek care once or several times until they are able to be seen by their provider or be linked in the community. Both virtual visits and walk-in appointments are available.

The Urgent Care Clinic team includes psychiatrists, nurse practitioners, social workers, case managers and a nurse. They provide care five days a week. From January through November 2024, BHUC served 2,063 unique patients through more than 4,368 visits, slashing unnecessary psychiatric ED visits by 33% compared to the same period in 2023 (N=1,740 (2024) vs. N=1,172 (2023). The staff are tracking data to confirm that services provided are meaningful to patients and achieving desired outcomes.

The Early Psychosis Intervention Center

Although many people suffering with confusing and distressing mental health concerns feel alone, psychosis, which is most likely to occur in young adults, is quite common. In fact, nearly three of every 100 young people will experience a psychotic episode. Psychotic symptoms occur in people from all backgrounds.

The key to recovery is early intervention. As with physical illness, treatment early in the course of a mental illness can lead to better outcomes. The longer the illness is left untreated, the greater the potential disruption to the person's ability to transition into adulthood, fulfill the demands of school or work, meet new people or become fully independent.

The Early Psychosis Intervention Center (EPICENTER) at Ohio State was established to deliver comprehensive behavioral health services to youth and young adults who are showing the early warning signs of a burgeoning psychotic disorder or who have experienced a first onset of psychotic symptoms within the last five years. This includes treatment for illnesses such as:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (with psychotic features)
- Unspecified psychosis
- Major depressive disorder (with psychotic features)

It's encouraging to know that for many people, recovery is possible. Ongoing support can help individuals enjoy significant improvement and more effective illness management so that they may lead more productive, fulfilling lives.

At EPICENTER, people have the opportunity to discuss their concerns, get practical support and participate in research studies. Based on each individual's needs, a team of experts from different fields, such as psychology, psychiatry, nursing and social work, creates a specialized, phase-specific treatment plan to help minimize symptoms, reduce stress and improve function and independence.

The ultimate goal is to help each person return to daily life feeling more secure and positive about the future, knowing their illness does not need to define their future or their goals.

Stress, Trauma And Resilience

The Stress, Trauma And Resilience (STAR) Program in The Ohio State University Department of Psychiatry and Behavioral Health focuses on three areas: support for health care professionals and first responders, support for trauma survivors and leading-edge research on the impact of stress and trauma.

The STAR Trauma Recovery Center (STAR TRC) — one of the first of its kind in the Midwest — focuses on providing holistic longitudinal support for survivors of crime-related violence free of charge. The Wexner Medical Center Emergency Department and other medical center physicians refer patients directly to the STAR TRC. In addition, local community-based organizations, police/fire/EMS, local prosecutors' offices, other hospitals — and even other trauma centers in Columbus or the nearby region — frequently refer individuals because of STAR TRC's extensive programming and level of psychiatric care. Patients receive standardized assessments based on research, and our evidence-based treatment is given with compassion and respect for each person.

TRC services are available free of charge, and survivors of traumatic events receive not only counseling, but also case management and medication management. In addition to community outreach to build awareness in underserved populations who are frequently unable to access care, TRC team members are also committed to victim advocacy.

Because each trauma experience is unique, treatment is tailored to the individual. Care teams may include physicians, licensed social workers, clinical counselors, case managers, psychiatrists, nurses and other professionals who coordinate internal and community resources to navigate each recovery process.

In support of healthcare professionals and hospital systems, the STAR Program has developed the B.E.S.T. (Brief Emotional Support Team) Program, which introduces evidence-based techniques that equip professionals to respond effectively in a crisis while also engaging in skills that build resilience to cope with chronic exposure to stress. This peer-support model creates a culture of compassion and helps colleagues learn how to care for each other in the demanding, difficult, harrowing and crucial work that they do each day. Monthly "Refresh & Support" sessions create the opportunity for B.E.S.T.-trained individuals to continue to develop their skillset in addition to forming an ongoing sense of community where they can receive their own support as needed as well.

The STAR program also serves as the facilitator for Schwartz Center Rounds. Held monthly, this social-emotional grand rounds panel discussion creates the opportunity for employees and learners across the organization to discuss and normalize emotional responses to challenging cases. By reducing stigma, these discussions serve as an important mechanism for helping healthcare professionals reduce feelings of isolation and process the inherently emotional nature of their work.

Free and confidential post-incident peer support is also available through the STAR program. Proactive outreach occurs following known adverse incidents, and individuals can also self-refer.

For other first responders, the STAR program has developed the F.I.R.S.T. (First Incident Response Support Technology) Support app for first responders. Backed by research completed at The Ohio State University, the F.I.R.S.T. Support app uses proven methods to help reduce stress and increase resilience. At its core, the strength of fire and police departments are based on the strength of working relationships. The F.I.R.S T. program provides a common language for first responders to process difficult runs and challenges faced in the intensity of the work environment. Department trainings are available that take what first responders do and see each day and provide a method to process these events. The F.I.R.S.T. program has demonstrated statistically significant decreases in issues related to depersonalization, burnout and avoidance. There are times when more than an interactive application is needed, so individual and group support sessions are available through STAR.

Franklin County Bedboard

Through the Central Ohio Hospital Council (COHC), central Ohio psychiatric providers are working together to ensure timely access for patients in need of inpatient psychiatric services. Franklin County's three adult hospital systems are partnering with other inpatient psychiatric providers to communicate psychiatric bed availability and match open beds with patients in need of inpatient placement. The "Bedboard Group" has developed a web-based, secure bedboard listing all psychiatric patients needing admission in the county as well as all open beds. This collaborative effort has reduced the wait time for patients in local emergency departments by 70% since 2018, and it has led to a better working relationship with psychiatric care providers in the community.

Mental Health and Addiction Crisis Center

Beginning even before the COVID-19 vaccine was available to the general public, the Born from discussions within the Bedboard Group came a broader community discussion on ways to improve the crisis system, specifically on ways to decrease the number of patients presenting in emergency departments in psychiatric crisis. In partnership with the Alcohol, Drug Addiction and Mental Health (ADAMH) Board of Franklin County, the three adult hospital systems worked with several community stakeholders to develop a plan for the construction of a new Crisis Center for Franklin County residents. A steering committee, co-chaired by ADAMH and COHC, oversaw the development of the plan, with strategic work groups building out specific portions of the plan.

Including support from the three adult hospital systems, more than $60 million was raised for the construction of the crisis center. The crisis services focus on recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments for consumers and staff and a collaboration with law enforcement and first responders. The center will open this summer, and the Ohio State Wexner Medical Center has entered into contract with RI International, the operator of the center, to serve as its medical partner.

Care for Our Own

We have several programs that provide health and well-being resources for our own faculty and staff.

- Our Gabbe Well-Being Office has created a centralized website to house and socialize a wide variety of resources to support the well-being of employees and learners across the organization.
- Our team of specialized providers in the STAR Program has provided support for all medical center employees since 2009 through a wide range of peer support, respite and self-care programs developed to address health care workforce-related stress.
- The Behavioral Emergency Response Team (BERT), trained to de-escalate situations involving upset patients or family members, shields our frontline workers from an increasing number of intense and potentially volatile situations. In 2025, the team expanded to offer consultation and support at East Hospital as well.
- Our Workplace Safety Steering Committee works diligently to identify and address opportunities to enhance workplace safety and streamline post-incident support services for impacted employees and learners across the organization.

What We Will Do

- Participate in the Franklin County Crisis Care Center upon its opening.
- Expand access to care by utilizing telehealth and growing outpatient options.
- Examine the possibility of expanding Behavioral Health Urgent Care services to East Hospital/Talbot Hall.
- Expand use of patient-reported outcomes in clinical decision making throughout a variety of programs and across the continuum of behavioral health care.

Adverse Childhood Experiences

Specific indicators include:

- **Adverse childhood indicators prevalence**
- **Depression prevalence**

Adverse childhood experiences (ACEs) are traumatic events that occur during childhood and impact mental health. Examples of ACEs include violence, abuse or neglect, as well as contextual factors that might negatively affect a child's sense of safety or ability, such as growing up in a household with people who have substance use problems, mental health problems or parents who were separated or in jail.

Research shows that ACEs can have lasting effects on health and well-being in childhood, as well as impact one's education and job potential into adulthood. While the bOhio State Wexner Medical Center does not provide a full spectrum of mental health treatment to minors, EPICENTER does provide services to youth and young adults. We also treat adults who experienced traumatic events while they were children.

The Early Psychosis Intervention Center (EPICENTER)

Although many people suffering with confusing and distressing mental health concerns feel alone, psychosis, which is most likely to occur in young adults, is quite common. In fact, nearly three of every 100 young people will experience a psychotic episode. Psychotic symptoms occur in people from every background.

The key to recovery is early intervention. As with physical illness, treatment early in the course of a mental illness can lead to better outcomes. The EPICENTER at Ohio State was established to deliver comprehensive behavioral health services to youth and young adults who are showing the early warning signs of a burgeoning psychotic disorder or who have experienced a first onset of psychotic symptoms within the last five years. To learn more about EPICENTER, please visit page 16 in the Mental Health Section.

Stress, Trauma And Resilience

The Stress, Trauma And Resilience (STAR) Program in The Ohio State University Department of Psychiatry and Behavioral Health focuses on three areas: support for health care professionals and first responders, support for trauma survivors and leading-edge research on the impact of stress and trauma.

The STAR Trauma Recovery Center (STAR TRC) — one of the first of its kind in the Midwest — provides comprehensive psychiatric care that is specially equipped to assist with particularly traumatic incidents. To learn more about STAR, please visit page 17 in the Mental Health Section.

Behavioral Health Urgent Care

To close gaps in the continuum of care for people requiring behavioral health services, the Ohio State Wexner Medical Center has initiated a Behavioral Health Urgent Care Clinic (BHUC). Same-day appointments are available, and patients can seek care once or several times until they are able to be seen by their provider or be linked in the community. Both virtual visits and walk-in appointments are available. To learn more about BHUC, please visit page 15 in the Mental Health Section.

What We Will Do

- Expand EPICENTER staffing to allow the clinic to increase its active patient census.
- Explore moving EPICENTER to a youth-friendly, stigma-free environment.

Maternal and Infant Health

Specific indicators include:

- **Maternal health**
- **Infant mortality rate**

According to the Centers for Disease Control and Prevention, each year, more than 50,000 pregnant people are affected by severe maternal morbidity. Each year 800 women die due to pregnancy-related complications and more than 20,000 infants die. And per CelebrateOne, a public/private impact collaborative addressing and reducing infant mortality, 126 babies died in Franklin County before their first birthday, including 23 due to sleep-related conditions in 2023.

Ohio State is tackling this problem from multiple angles, using research, treatment programs and community outreach to create a better future for all pregnancies and babies. We are also partnering with CelebrateOne, Ohio Better Birth Outcomes and a host of community organizations to improve maternal outcomes and reduce infant mortality.

Moms2B Remains National Model for Improving Prenatal Care

It began in a church basement in 2010, with two pregnant moms looking for guidance and two women who dreamed of a way to keep babies alive in Columbus neighborhoods where so many were dying before their first birthdays. Moms2B has since helped more than 3,400 parents, about half of whom learned of the weekly program through previous participants. Moms2B is a one-of-a-kind Ohio State program to reduce infant mortality rates, eliminate disparities in maternal and infant health and address the needed community services and supports that affect pregnancy and babyhood.

In Ohio, Moms2B's success has made it the blueprint for reaching those goals. The program celebrated its 10th anniversary by publishing new research that shows quantitatively how Moms2B leads to a reduction in adverse pregnancy outcomes in communities disproportionately affected by public health issues.

Currently, Moms2B offers three in-person sessions (at a church hall in Northland, at Ohio State East Hospital and at Mount Carmel Health System's Center for Healthy Living in Franklinton) and five virtual sessions available to the whole community. The health care workers follow mothers from pregnancy through their babies' first year. Moms2B provides the families with access to portable play yards, healthy meals and other necessities, as well as consistent education about prenatal care, safe sleep, nutrition, smoking cessation, breastfeeding and reproductive health. Postpartum moms receive a home visit from a Mount Carmel Welcome Home nurse and are connected with patient-centered care teams and parenting groups. From July 1, 2024, through Nov. 30, 2024, Moms2B served 472 unique families within Franklin County.

Outpatient Care East Maternal Fetal Medicine

The Division of Maternal Fetal Medicine at The Ohio State University has exceptional clinicians, researchers and educators. Services include providing care for people with complicated or high-risk pregnancies, with outpatient and inpatient management as well as consultation for patients referred by other obstetrical providers for ongoing prenatal care or pre-conception counseling, prenatal imaging and diagnostic testing.

Maternal Fetal Medicine expanded to Outpatient Care East in the early 2020s. Access to high-quality obstetric care is an important first step in improving maternal and neonatal outcomes. Early care in the first trimester allows the identification and management of pre-existing maternal medical problems and pregnancy specific complications to reduce the risk of adverse pregnancy outcomes including preterm birth.

In 2014, the Kirwan Institute identified hot spots within the county that had the highest infant mortality rates per square mile. The Near East Side, which surrounds East Hospital, had the second highest infant mortality rate within the county – 18.4 deaths per 1,000 live births. This rate is three times higher than the national average. In addition, 18% of pregnant women delivered preterm, which is more than 50% higher than the national average. Among the women living on the Near East Side who delivered during the time of the study, 53.4% lived in poverty, 66.9% received Medicaid and 47.3% reported that no one within the household had a vehicle.

We developed a multidisciplinary obstetric clinic at Outpatient Care East to increase access to high-quality, comprehensive care to pregnant patients living in a community with limited resources. Our goals include increasing access to early obstetric care, improving rates of postpartum follow-up and reducing rates of preterm birth. To achieve this, we have developed an obstetric clinic that provides high-risk maternal-fetal medicine (MFM) obstetric services and prenatal diagnostic imaging. Additionally, we created an urgent clinic for individuals with urgent/nonemergent obstetric or gynecologic concerns to reduce reliance on care within the Emergency Department.

We have been fortunate to continue to experience growth at the Outpatient Care East obstetric office. Currently, we provide obstetric imaging services four days a week. We have also added an advanced practice nurse with expertise in diabetes management in pregnancy to our team who provides obstetric care an additional half day per week. These changes have resulted in a 5.9% increase in clinical visit volume, and a 9.2% increase in ultrasound volume in FY2024.

McCampbell Outpatient Care Ob/Gyn Clinic

The Wexner Medical Center's McCampbell Outpatient Care Ob/Gyn clinic offers care to some of our highest risk populations, including those who attend Substance Treatment, Education and Prevention Program (STEPP) and participate in our McCampbell Fourth Trimester Group. It is a teaching clinic that averages 2,000 patients per month.

Our home visiting program, in collaboration with Nationwide Children's Hospital, also operates out of McCampbell. Nurses and social workers discuss the option of home visits during new obstetric visits and at the 24-week visit. Our home visitors include four nurses who have been trained by Nurse Family Partnership.

Clinic initiatives include:

- Increasing community referrals to
  - o Home Visiting
  - o Moms2B
  - o Baby and Me Tobacco Free at Columbus Public Health

- Improving breastfeeding rates (McCampbell Fourth Trimester Group)
- Improving blood pressure monitoring through blood pressure cuff dispensing
- Increasing maternal understanding of marijuana
- Completing Pregnancy Risk Assessment Forms and initiate progesterone treatment in patients at risk for spontaneous preterm birth

The Fourth Trimester Group Clinic

The Fourth Trimester Group Clinic (FTGC) at McCampbell Outpatient Care is a family-centered approach to increasing breastfeeding rates among high-risk mothers in our Medicaid population, investing in the short- and long-term health of this vulnerable population during a critical window of time.

The benefits of breastfeeding and risks of not breastfeeding for both women and their infants are well established. Our goal is to remove as many of the logistical and social barriers preventing these mothers and infants from succeeding by increasing breastfeeding rates and postpartum visit attendance and allowing easy access to social work resources to optimize maternal and infant care. In addition to these resources, the mothers are provided with a breakfast and a free parking pass to alleviate any financial concerns and emphasize maternal health.

The FTGC visit addresses several key needs of the recently discharged high-risk mother and child. First, a pediatrician provides a group welcome and informational message, and then each mother and her infant are seen individually for private visits. Infants are examined and weighed. Testing for jaundice is available on site and provided as needed. This infant component of the FTGC visit serves in lieu of the first pediatrician visit, and the results from the visit are sent to the selected pediatrician for appropriate infant follow-up. For the maternal component of the FTGC visit, mothers are screened for postpartum depression and have wound incision checks as indicated. Physicians are available to perform breast exams as needed. Social work support is available as needed to ensure the dyad is returning to a safe environment with basic housing and food needs met. Finally, lactation support is offered within a group setting and with individual instruction as needed. Mothers and infants who require ongoing International Board of Lactation Consultant Examiners' evaluation and support are referred to specialists.

Substance Abuse Treatment, Education and Prevention Program

For expectant parents, substance use disorders can further complicate pregnancies that may already be at risk based on other factors. To have pregnancies that produce healthy, full-term babies, these patients need specialized care to overcome addiction. Through an innovative clinic called Substance Abuse Treatment, Education and Prevention Program (STEPP), Ohio State maternal fetal medicine specialists are increasing the odds for those babies to live beyond their first birthday.

The clinic's expert team includes a dedicated nurse, a social worker and a team of physicians. They hold more than a decade of experience leading weekly sessions that provide personalized, high-risk obstetric care, treatment and counseling. STEPP's first graduate from its one-year postpartum program is a mother who began with the clinic at 39 weeks pregnant, while actively using illicit substances and having recently been incarcerated. She delivered two days later, continued with STEPP's postpartum group and now has custody of her child. She's since completed peer support training and is enrolled at Columbus State Community College, working toward becoming a substance abuse counselor and expunging her felony.

In 2021, the STEPP Clinic expanded its program to be able to care for patients up to one year postpartum with an aim to integrate support persons and families in the medications for opioid use disorder (MOUD) treatment and prenatal care already provided for pregnant and postpartum patients with opioid use disorder (OUD).

Data suggests that within the first-year, postpartum maternal substance use contributes to an increased rate of pregnancy-associated maternal deaths and infant mortality. Among the major causes of infant mortality in drug-exposed infants is low birth weight, prematurity, birth defects, sudden infant death syndrome, sleep-related deaths and child abuse.

Death from opioid overdose represents 11-20% of maternal mortality. The most critical time for pregnancy-associated opioid overdose is the postpartum period, specifically 6-12 months after delivery. By expanding the review of pregnancy-associated deaths in the state of Illinois to include violent deaths, homicide, and suicide, substance-use related deaths were found to comprise more than 25% of maternal deaths within the first year postpartum. These combined causes were responsible for more deaths than any single obstetric cause, and the majority of deaths occurred in the late postpartum period.

The postpartum period is a particularly vulnerable time for women with OUD and their children due to the increased stress which leads to recidivism and increased risk for maternal death due to overdose. Increased stress from maintaining treatment for OUD compounded by the physical and behavioral response of the drug-exposed infant can have a destabilizing effect on mother-infant bonding and the family unit.

In expanding the program, STEPP provides an additional evening session to allow for increased participation from patients' partners and families. A boxed meal and valet parking eliminate additional barriers to participation. This session provides education and support for the entire family unit.

Another expansion occurred in 2024 through a grant from the Local Opioid Settlement Fund Grant program, administered by the Franklin County Board of Commissioners. The nearly $200,000 grant allowed STEPP staff to implement contingency management within STEPP to:

- Increase treatment engagement through increased attendance to prenatal, postpartum, individual counseling, group therapy and other medical appointments
- Increase abstinence through decreased percent of urine drug screens positive for illicit substances and increase percentage of urine drug screens for prescribed Medication for Opioid Use Disorder
- Increase lifestyle improvements with increased percent of persons established with primary care provider, increased health maintenance vaccine uptake, phone access, employment and housing

Multimodal Maternal Infant Perinatal Outpatient Delivery System (MOMI PODS)

MOMI PODS delivers dyadic mom/baby primary care to women, including those with severe maternal morbidity risk factors, and their infants for the first 1,000 days of life, encompassing pregnancy through the child's third birthday. MOMI PODS is an interdisciplinary, systemwide program utilizing the Chronic Care Model to integrate primary care, obstetrics, maternal fetal medicine, neonatology, pharmacy and community partners to engage patients across the pregnancy continuum to ensure seamless care transitions and access.

Strategies for success include connecting mom with primary care in the prenatal phase, ensuring warm hand-offs across disciplines (Ob/MFM to primary care) and care settings (inpatient/NICU to outpatient) and engaging with community partners. MOMI PODS is open to pregnant and postpartum women without an established PCP and includes those with pregnancy risk factors. We place a special focus on enrollment of Medicaid-

insured patients, and have a workflow in place to connect patients who do not qualify for insurance with financial assistance that allows access to care. MOMI PODS operates in nine primary care clinics in central Ohio.

Quality health care in the first 1,000 days dramatically improves lifelong health and social outcomes. Medicaid, covering pregnancies and babies, provides critical access to postpartum and early childhood health care. Yet, many high-risk, low-income families face major barriers that impede access. MOMI PODS creatively tailors care to overcome barriers, increase access and improve long-term outcomes.

Primary care supported by MOMI PODS can help increase access to those who most need, yet are least likely to engage, preventive care. MOMI PODS' focused care for vulnerable patients in the first 1,000 days improves outcomes like postpartum visit completion, immunization, developmental screening, obesity prevention and other preventive or chronic disease management.

Promoting Doulas

Beginning in October 2024, any pregnant or postpartum person with Medicaid coverage is now eligible to receive doula services from a Board of Nursing-certified, Medicaid-enrolled doula. Over half of all births in Ohio are covered by Ohio Medicaid, so this rule change has the potential to dramatically increase access to birth support.

Ohio State has been informally working with doulas for years. With the potential increase of doulas in the labor and delivery room, the Ohio State Wexner Medical Center is developing a policy to promote and provide better access to doulas for our patients. We have pulled together leaders from our Department of Obstetrics and Gynecology to develop this policy and to look for additional ways to promote and provide doula services to our patients.

Women's Behavioral Health Partners with Ob/Gyn Providers

Women's Behavioral Health (WBH) at the Wexner Medical Center is a multidisciplinary academic center of excellence providing care to women experiencing stress or stress-related illness during life events that are unique to women. We provide women with state-of-the-art care for mood and anxiety disorders, sexual health, substance use disorders and stress, with a special emphasis on pregnancy, the postpartum period, gynecologic and breast cancers, menopause and the menstrual cycle.

WBH has established a partnership with the STEPP Clinic to increase patients' access to psychiatric and behavioral healthcare services. This collocated provision of treatment includes individual and group psychotherapy as well as access to psychiatric assessments and medication management for pregnant and postpartum women receiving treatment for substance use disorder.

WBH also has partnered with Moms2B, with support from Aetna Medicaid, to deliver mental and behavioral health care services to Moms2B mothers. The enhanced model of care includes three components:

- Implementation of a postpartum depression and anxiety prevention program
- Postpartum triage of mothers with mild-to-moderate mood and anxiety disorders to virtual psychotherapy with a dedicated provider
- Triage and referral for mothers with serious psychiatric comorbidities for individual treatment within WBH or the community

Combining clinical care with clinical and basic science research provides WBH patients with access to the latest information about the safest and most effective treatments available during these periods of greatest vulnerability.

ACHIEVE: Successfully Achieving Glycemic Control During Pregnancy

Type 2 diabetes (T2D) in pregnancy increases the risk of adverse outcomes for both mother and infant. More than one in three infants born to individuals with T2D will experience an adverse outcome, including large-for-gestational-age at birth, preterm birth, birth trauma, neonatal hypoglycemia and stillbirth. Strict maternal glycemic control throughout pregnancy is key to optimizing perinatal outcomes. Glycemic control can be difficult to achieve and requires a multimodal approach, including insulin, vigilant glucose monitoring, lifestyle modifications (diet and exercise) and team-based prenatal care.

Medicaid-enrolled pregnant individuals with T2D are a high-risk, vulnerable population who experience non-medical social needs that limit their ability to achieve glycemic control. These barriers include lack of reliable transportation to attend prenatal visits, access to resources to engage in diet and exercise changes and convenient methods to log self-monitored glucose values and adjust insulin dosing. A multifaceted provider-patient-based approach with proven strategies to improve glycemic control is needed.

ACHIEVE is a multicomponent theory- and evidence-based intervention that includes a mobile health app, provider dashboard, continuous glucose monitoring and care team coaching for medical and social needs. ACHIEVE empowers Medicaid-enrolled pregnant individuals with T2D and their providers to achieve and maintain glycemic control and access to timely diabetes care, patient education and support.

The ACHIEVE mobile app is available for iOS and Android operating systems. The ACHIEVE app provides personalized information for pregnant individuals living with T2D, including support with diabetes management and meeting unmet social needs (e.g., transportation, food, housing, financial needs). It collects real-time patient reported data through surveys and blood glucose data via continuous glucose monitoring. This data are summarized and shared with the patient and the care team. The data are also used to promote discussions between the patient and the care team about diabetes management goals and preferences during the patient's pregnancy.

Community Partnerships

In 2014, the Greater Columbus Infant Mortality (GCIM) Task Force, comprising community and business leaders, released a set of strategies to reduce Franklin County's high infant mortality rate. The strategies were assigned to lead entities, which were charged with successfully implementing the strategies and ensuring progress is made. Strategies to be implemented by the hospital systems were assigned to the COHC, including:

Safe Sleep Education

Since September 2016, all Franklin County birthing hospitals are showing a video to women and families before discharge highlighting the importance of safe sleep practices (ABC – Alone, on the Back, in a Crib). The video also educates parents on breastfeeding, tobacco use in the home and on things parents can do to calm crying babies to reduce shaken baby syndrome. Franklin County hospitals conduct quarterly internal audits to monitor the number of families who see the video before discharge. In addition, the Wexner Medical Center distributes sleep sacks to infants before discharge. Sleep-related deaths tend to increase during the cold months due to blankets and other warm items being placed in cribs.

Medical Legal Partnership (MLP)

Since 2017, pregnant women who receive care in hospital prenatal clinics are screened to assess if they have a legal issue that needs addressed. If a legal need is identified, the woman is referred to the Legal Aid of Southeast and Central Ohio (Legal Aid), which helps to resolve the legal issues. This program is overseen by Ohio Better Birth

Outcomes, which is a collaborative of health care providers, including the Ohio State Wexner Medical Center, who are dedicated to reducing the infant mortality rate in key Ohio communities. The goal of the initiative is to improve the health of pregnant women by addressing social conditions, such as housing, benefits, and job-related issues that could result in a negative pregnancy outcome.

This partnership started with five clinics and has expanded to 14 clinics throughout central Ohio. Through the MLP clinics, Legal Aid attorneys reach vulnerable Columbus mothers where they are, addressing health-harming legal issues like housing instability, domestic violence and public benefits – ensuring they receive the support needed for safer births and a stronger start for their families.

When people have access to Legal Aid, they report less stress and improved mental health:

- MLP clients report 16-30% reduction in stress levels
- 83% of those surveyed who were referred to Legal Aid while pregnant delivered full term

In 2024, Ohio State referred 49 patients to Legal Aid.

Tobacco Cessation

Franklin County birthing hospitals and prenatal clinics are identifying women who currently smoke tobacco and referring them to Columbus Public Health for cessation counseling. Under the program, staff ask patients about their smoking status, advise them on the impact of tobacco on the mother and infant and assess the patient's willingness to make a quit attempt. Women and in-home partners who are likely to make a quit attempt are referred to Columbus Public Health for assistance.

Very Low Birth Weight Infants

Since 2017, the three adult hospital systems have implemented policies to ensure that mothers at risk of delivering a very low birth weight (VLBW) infant deliver at a facility with higher volumes of VLBW deliveries. Ohio State's University Hospital is such a facility. This work comes from a recommendation of the GCIM Task Force, which considered national studies showing that infants delivered at less than 1500 grams are more likely to survive if they are born in hospitals with higher volumes of VLBW infants.

Maternal Levels of Care

In 2019, Ohio instituted a system of assigning maternal levels of care to complement the neonatal levels of care already in operation. Maternal licensure at the Ohio Department of Health has awarded the Wexner Medical Center's University Hospital a maternal Level IV and neonatal Level III. These are the highest levels possible outside of a dedicated children's hospital for the neonatal level.

WHAT WE WILL DO

- Create a doula policy that promotes and provides for doula services for our patients.
- Increase outreach to the Near East community and improve data collection on obstetric care of the Near East Side residents.
- Enhance referrals to primary care postpartum.
- Improve care coordination related to the same day/urgent Ob/Gyn clinic.
- Develop a virtual library specific to pregnant patients with OUD for community providers.
- Increase the proportion of patients with new OB visits in our MFM offices within 14 days of contact to 75%.

Violence and Injury-Related Deaths

Specific indicators include:

- **Drug overdose death rate**
- **Alcohol-attributable death rate**
- **Traumatic injury prevalence**
- **Violence crime**

Injury and violence affect everyone, regardless of age, race or economic status. According to the CDC, Americans aged 1 to 44 die from injuries and violence – such as motor vehicle crashes, suicide, overdoses or homicides – more than any other cause. Both drug overdose deaths and deaths from alcohol-attributable causes have increased since the last HealthMap. In 2022 in Franklin County, 115.1 per 100,000 residents died of an overdose. In the latest HealthMap, 135.3 per 100,000 residents died of an overdose.

In addition to having a Level 1 trauma center, the Ohio State Wexner Medical Center has committed resources to combatting addiction and depression and is establishing a partnership with Columbus Public Health to address violent crime.

Stress, Trauma And Resilience

The Stress, Trauma And Resilience (STAR) Program in The Ohio State University Department of Psychiatry and Behavioral Health focuses on three areas: support for health care professionals and first responders, support for trauma survivors and leading-edge research on the impact of stress and trauma.

The STAR Trauma Recovery Center (STAR TRC) — one of the first of its kind in the Midwest — focuses on providing holistic longitudinal support for survivors of crime-related violence free of charge. To learn more about STAR, please visit page 17 in the Mental Health Section.

Mental Health and Addiction Crisis Center

In partnership with the ADAMH Board of Franklin County, the three adult hospital systems worked with several community stakeholders to develop a plan for the construction of a new crisis center for Franklin County residents. The crisis services focus on recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments for consumers and staff and a collaboration with law enforcement and first responders. The center will open this summer, and the Ohio State Wexner Medical Center has entered into contract with RI International, the operator of the center, to serve as its medical partner. To learn more about the crisis center, please visit page 15 in the Mental Health Section.

Suicide Prevention and Depression Recovery Program

More than half of patients do not recover with standard, first-line treatments for depression. The majority, more than 90% of this group, go on to develop a chronic "difficult-to-treat" form of the illness characterized by prolonged symptoms and functional impairment. Approximately 30% are predicted to attempt suicide. Likewise, standard interventions for immediate suicide risk do not effectively reduce medium- or longer-term risk. Medicaid is the most common provider for patients with difficult to treat depression or increased risk of suicide presenting to the Ohio State Emergency Department.

The Suicide Prevention and Depression Recovery Program is the first comprehensive program to exist at the Ohio State Wexner Medical Center to identify patients with these conditions and provide them with specialized treatments. This program identifies, assesses and provides specialized, recovery focused treatments for patients with

difficult-to-treat depression and for those at elevated suicide risk. Unlike standard first-line treatments, these interventions were designed specifically for these populations and operate through different mechanisms.

In this program, we employ several different psychotherapies, including:

- brief cognitive behavioral therapy for suicidal patients
- psychotherapy for functional recovery
- mindfulness-based cognitive therapy for relapse prevention

We also provide transcranial magnetic stimulation therapy and esketamine services as part of our psychiatry services.

Talbot Hall Residential Treatment Program Expansion

In March 2024, the Ohio State Wexner Medical Center opened a new treatment option for adults with substance use disorders. The new Residential Treatment Program can house up to 15 men and women at Talbot Hall, located on the Near East Side of Columbus.

Talbot Hall has been providing substance use services since 1974. It provides inpatient withdrawal management, partial hospitalization, intensive outpatient, individual and group counseling and medication management including MOUD.

The Talbot residential program provides a new level of care that was not available at Ohio State and was much needed for our patients and community. It is an American Society of Addiction Medicine 3.5 level of care, which enables patients to stay up to 30 days for residential drug and alcohol treatment. This unit directly impacts the initiation of drug and alcohol treatment within 14 days, as well as helps reduce the rate of ED utilization due to patients having the appropriate level of care. The residential unit treatment team includes physicians, nurses, counselors, recreational therapists, certified peer supporters and patient care associates.

The demand for behavioral health and addiction care in Ohio is rising, with projections indicating a 15% increase in substance use treatments. Each year, more than 1,200 patients are treated at Talbot Hall for inpatient detoxification, along with more than 5,000 patients in various outpatient settings. The program uses Hazelden's Living in Balance model, which is an evidence-based program that has a strong emphasis on relapse prevention.

Naloxone Training and Distribution

Among the most immediate and accessible services Ohio State provides in this effort is free naloxone and training for using it. The nasal-spray drug can temporarily reverse the effects of an opioid overdose, blocking opioids' effects on the brain and restoring breathing. When given in time, naloxone can save a life. As the powerful opioid fentanyl becomes more prevalent and mixed into other substances, it is critical that we maintain and enhance access to this medication.

Since 2015, Ohio State Emergency Departments have distributed naloxone to those at risk of overdose and their family and friends. Beginning in 2018, the Ohio State College of Public Health collaborated with the Wexner Medical Center, Equitas Health and other university groups to hold free training sessions that distributed naloxone kits to the public. In July 2019, Ohio's Project DAWN (Deaths Avoided With Naloxone) granted funds to the Wexner Medical Center, giving Ohio State the ability to significantly widen its naloxone distribution beyond the Emergency Department setting to include all inpatient beds, Talbot Hall and all outpatient pharmacies. The Ohio State Wexner Medical Center was the first hospital system in Ohio to offer naloxone across the entire hospital setting.

Today, free naloxone kits are available at each of Ohio State's Emergency Departments, seven hospitals, including through Talbot Hall Addiction Medicine, and select high-risk outpatient clinics. Kits are also available to anyone — no prescription necessary — at all Wexner Medical Center outpatient pharmacies and the university's Wilce Student Health Services Pharmacy. In the past two years, we have also worked to make naloxone more readily available in non-clinical settings on campus via a naloxone vending machine, with plans to add another machine on campus later this year.

At the onset of the pandemic, Ohio State's Project DAWN pivoted to outreach to distribute naloxone directly to community members in their neighborhoods. This community outreach strategy grew, and we now go into the community several times per month at places such as Star House, food banks, homeless outreach programs and more. Distribution has expanded to include fentanyl test strips, drug disposal bags and information on treatment resources and other harm reduction practices.

In 2023, Ohio State partnered with Franklin County ADAMH by placing NaloxBoxes on the Columbus campus and Wexner Medical Center to expand access to emergency response tools. NaloxBoxes contain two doses of naloxone nasal spray and instructions for use. Similar to automated external defibrillators, the boxes allow bystanders to help save lives.

As our various strategies to increase access to naloxone have expanded, we now reach approximately 6,500 individuals each year with naloxone and other harm-reduction services.

Systemwide Addiction Services

Addiction is a disease that knows no bounds. Because so many people are impacted across our community, the Ohio State Wexner Medical Center found a need to develop a coordinated approach to engaging patients with substance use concerns across all corners of our health system. Systemwide Addiction Services was created as a partnership of multiple departments across our medical center, so we can meet patients where they are and walk with them toward recovery.

By tying together all the services that treat addiction, treatment becomes more accessible to everyone who needs it. This allows for high-quality, evidence-based SUD care no matter where someone enters our health care system — not just if they show up at Talbot Hall Addiction Medicine for specific addiction services, but also if they arrive at a primary care office or the Emergency Department and are admitted with an infection that is a consequence of their addiction.

Medication Treatment for Opioid Use Disorder (MOUD) in the ED

In 2017, the Wexner Medical Center received a grant from the Ohio Department of Health in partnership with Franklin County Public Health to begin offering MOUD in the Emergency Department (ED). Through the grant, we hired ED-based peer supporters who connected patients to treatment as well as to ADAMH Franklin County's established Southeast RREACT program (Rapid Response Emergency Addiction and Crisis Team) to transfer patients presenting in the Emergency Department to treatment facilities including Maryhaven Addiction Stabilization Center, Talbot Hall and other local treatment agencies.

We have continued to supplement treatment of addiction with balanced harm-reduction practices, including naloxone distribution, STI screening and treatment, hepatitis A and COVID-19 vaccination and fentanyl test strip distribution given the unfortunate occurrence of contaminated drug supply and increasing unintentional overdose deaths. This program has been a model of care across Franklin County and Ohio through the National Institutes of Health's HEALing Initiatives Study that was based at Ohio State. In recent years, we have implemented an ED-based addiction consult service that provides on-site engagement, assessment and linkage to treatment from a specialized team.

The Mohamed A. Kandeh Addiction Consult Service

Ohio State hospitalists have been prescribing MOUD for patients hospitalized with acute illnesses often related to intravenous drug use since 2018, and a similar service was created at East Hospital with support from our addiction medicine fellowship program. Since the beginning of 2020, the inpatient addiction medicine consult services have completed thousands of consults, initiating patients on MOUD and linking them to

addiction and recovery services at discharge. This team also works closely with area skilled nursing facilities to ensure those complex patients continue to receive their addiction care after leaving the hospital. This program is now named in memory of the first social worker on this service, Mohamed A. Kandeh, LISW-S, LICDC-CS (1/30/1962-9/3/2024), who was a steadfast advocate for patients and a compassionate educator for all his colleagues.

East Hospital Addiction Consult Service

Our hospital-based services at East Hospital began with a social worker tasked with linking patients with addiction treatment. In collaboration with our addiction medicine fellowship (l https://medicine.osu.edu/departments/psychiatry-and-behavioral-health/education/fellowships/addiction-medicine), the service expanded to include physicians, advanced practice providers and peer recovery supporters. This multidisciplinary team approach helps ensure patients receive medical, psychosocial and recovery support while in the hospital and a plan for recovery after discharge.

Patient-Centered Advocacy and Medicine

Patient-Centered Advocacy and Medicine was created within primary care to serve adult patients with substance use concerns, designed to be accessible and integrated with ongoing medical care. We help patients find individualized strategies to live healthier lives by addressing their substance use and other health issues that a primary care office would handle. This approach helps us to meet patients where they are – in primary care offices – with an integrated specialized team, including physicians, pharmacists, therapists and nurses.

Reducing Opioids for Surgery

An Enhanced Recovery After Surgery (ERAS) protocol that began at Ohio State in 2016 has helped patients manage postsurgical pain without relying on narcotics. Beginning with microvascular breast reconstruction surgeries, ERAS swaps opioids for non-narcotic pain medicine before surgery and avoids long-acting narcotics in the operating room. After surgery, patients take acetaminophen or ibuprofen, with the option of a low-dose opioid for pain spikes.

Buoyed by high patient satisfaction rates, the practice has steadily expanded to other inpatient surgery areas, such as colorectal, bariatric and abdominal wall reconstruction. In 2020, the Division of General and Gastrointestinal Surgery shifted focus to outpatient surgeries, embarking on a three-year study to observe participating patients who undergo select outpatient procedures in general and gastrointestinal surgery, surgical oncology, trauma and vascular surgery.

Researchers aim to determine whether a new postoperative pain management idea — one that does not send patients home with opioid prescriptions — could adequately help patients control their pain, reducing risk of opioid abuse. The Toward Opioid-Free Ambulatory Surgery study has found that in patients undergoing hernia surgery and discharged the day of the procedure, more than half of opioid prescriptions are not used. Reducing the use of opioids postsurgery eliminates the availability of unnecessary opiates and reduces the potential for opioid addiction, whether within a patient's household or the community.

Palliative Harm-Reduction Clinic

This clinic, in operation since September 2020, is the first of its kind in the nation. It combines principles of addiction management, harm reduction and palliative medicine to provide symptom management to patients with both severe cancer pain and substance use disorders. This population needs specialized care, and many have previously been disqualified from cancer pain management services because of their substance use.

Addiction Medicine Collaborates with Infectious Diseases

The divisions of Infectious Diseases and Addiction Medicine have begun enhancing their collaboration with more coordinated care, as infections are a common, severe, co-occurring disease for many patients with addiction. The STEPP Clinic and Talbot Hall, for example, now offer hepatitis C care and are exploring the use of HIV preventive medication (PrEP/PEP).

Addiction Medicine Education

The Ohio State Addiction Medicine teams provide educational experiences for a variety and trainees, including students from the College of Medicine, College of Nursing and College of Social Work; residents from Internal Medicine, Family Medicine, Emergency Medicine, Psychiatry and Podiatry; and fellows from Palliative Medicine and Pain Medicine. In 2017, the Ohio State Wexner Medical Center addiction medicine fellowship was founded and became one of the first fellowships in the country to be approved by the Accreditation Council of Graduate Medical Education in 2018. In 2020, Ohio State was awarded an HRSA grant that allowed the addiction medicine fellowship to expand to four spots per year. Additionally, in 2019, we were awarded the PCSS-Universities Opioid Education Grant, which facilitated DATA-2000 X-waiver training for all graduating medical students as well as residents from primary care disciplines.

Substance Abuse Treatment, Education and Prevention Program

For expectant parents, substance abuse disorders can further complicate pregnancies that may already be at risk based on other social determinants. To have pregnancies that produce healthy, full-term babies, these patients need specialized care to overcome addiction. Through an innovative clinic called Substance Abuse Treatment, Education and Prevention Program (STEPP), Ohio State maternal fetal medicine specialists are increasing the odds for those babies to live beyond their first birthday. This past year has seen an expansion of services for women and their infants through the first year postpartum. See page X in Maternal and Infant Health for more information.

Columbus and Franklin County Addiction Plan

The Franklin County hospital systems are working together to implement a set of strategies assigned to them under the Columbus and Franklin County Addiction Plan. This plan was developed by ADAMH Franklin County and is supported by the Columbus mayor, city council and the county commissioners as the community plan to address and combat the addiction crisis. Central Ohio Hospital Council is working to implement the activities assigned to the hospital systems under the action plan and has begun a process of further defining hospital standards for addiction treatment for the four systems. Representatives from all four hospital systems also present opioid overdose education and prevention information at events held throughout the community.

VOICE Partnership

VOICE (Violence Outreach, Intervention, Community Engagement) assists victims of violent crime who have been referred by a hospital Emergency Department to Columbus Public Health and the Columbus Recreation and Parks APPS (Applications for Purpose, Pride, and Success) program. The VOICE social worker/intervention team provides wrap-around services and connects participants to needed medical, clinical and community social services programs. VOICE supports and advocates for clients, connecting them to resources that help prevent re-injury and jail time and assist with recovery. Participants can receive stipends for positive steps, progressing through their individual phases and following their life plan. To determine if a client is progressing in the program, they are placed in one of four phases:

- Crisis Intervention
- Stabilization

- Action
- Self-Sufficiency

The goal of this program is to break the cycle of violence and reduce recidivism and retaliation. The city of Columbus and the Ohio State Wexner Medical Center are working on incorporating VOICE into East Hospital's Emergency Department with hopes that it will eventually be incorporated into University Hospital's Emergency Department.

WHAT WE WILL DO

- Begin our partnership with RI International and Franklin County ADAMH on the crisis center.
- Explore and enter a partnership with the city of Columbus on their VOICE expansion.
- Increase staffing across our Suicide Prevention and Depression Recovery Program.
- Explore expansion of BHUC to East Hospital/Talbot.

The Ohio State University Wexner Medical Center
University Hospital

Community Health Needs Assessment 2025

The Ohio State University
Wexner Medical Center

As one of America's top-ranked academic medical centers, our mission is to improve health in Ohio and across the world through innovation in research, education and patient care.

John J. Warner, MD
Chief Executive Officer of The Ohio State University Wexner Medical Center
Executive Vice President at Ohio State

410 W. 10th Ave.
Columbus, OH 43210

Board approval of CHNA Report:

Initial Web posting of CHNA Report:

Tax identification number:

TABLE OF CONTENTS

INTRODUCTION

Accreditation

- Ranked the No. 1 adult hospital in Columbus and No. 2 in Ohio in 2024 by *U.S. News & World Report.*
- Eight nationally ranked and four high-performing specialties.
- Ranked College of Medicine, seven hospitals, a network of primary and specialty care practices and more than 45 research centers and institutes.
- More "Top Doctors" than any other central Ohio hospital.
- The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute has been designated as an NCI Comprehensive Cancer Center since 1976.

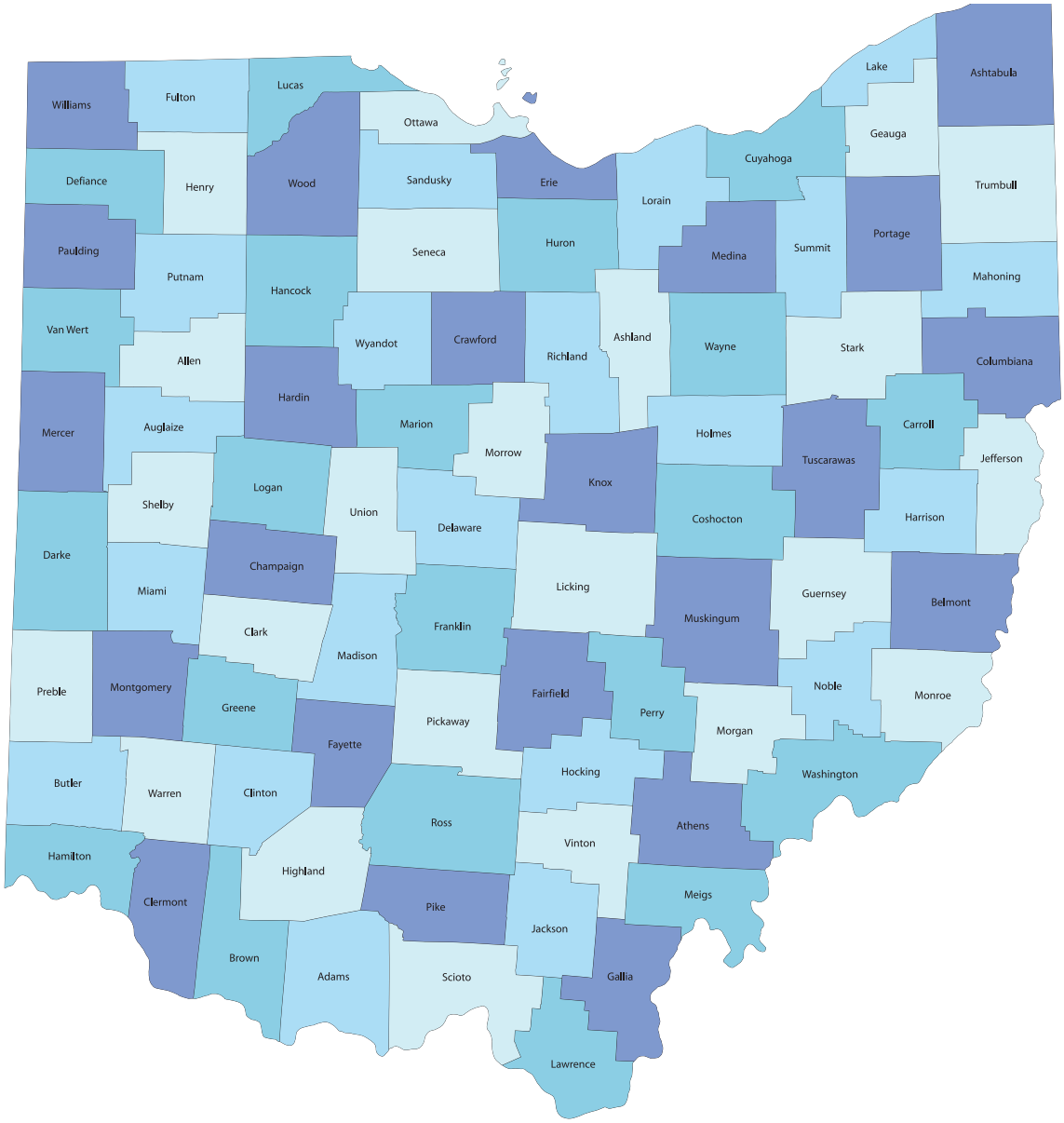
The Ohio State University Wexner Medical Center comprises:

- Brain and Spine Hospital
- Dodd Rehabilitation Hospital
- East Hospital
- Harding Hospital
- Richard M. Ross Heart Hospital
- University Hospital

Adjacent to the medical center is The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, a dedicated cancer hospital and research center with its own governance structure coordinated with the medical center.

For information about The Ohio State University Wexner Medical Center's Community Health Needs Assessment (CHNA) processes and for a copy of the reports, please visit https://wexnermedical.osu.edu/healthy-community/community-health-needs-assessment, or email Annie.Marsico@osumc.edu, to obtain hard copies of the CHNA reports at no charge. Written comments regarding this CHNA report and related implementation strategy may be submitted to Annie Marsico at Annie.Marsico@osumc.edu.

COMMUNITIES SERVED BY THE OHIO STATE WEXNER MEDICAL CENTER



UNIVERSITY HOSPITAL

Time Frame	CY24 Discharges				
Patient State	**Patient County**	**Main**	**East**	**Total**	**% of Total**
OH	Franklin	19,248	6,961	26,209	53%
	Delaware	1,527	161	1,688	3%
	Licking	1,201	245	1,446	3%
	Fairfield	1,207	145	1,352	3%
	Ross	947	88	1,035	2%
	Pickaway	849	49	898	2%
	Union	738	67	805	2%
	Madison	698	67	765	2%
	Logan	661	97	758	2%
	Muskingum	625	87	712	1%
	Knox	585	87	672	1%
	Richland	573	63	636	1%
	Scioto	569	65	634	1%
	Clark	525	48	573	1%
	Montgomery	496	32	528	1%
	Allen	488	23	511	1%
	Crawford	439	66	505	1%
	Marion	406	32	438	1%
	Jackson	318	62	380	1%
	Pike	333	33	366	1%
	Hocking	289	72	361	1%
	Fayette	307	42	349	1%
	Perry	283	44	327	1%
	Highland	285	29	314	1%
	Champaign	273	22	295	1%
	Gallia	242	52	294	1%

UNIVERSITY HOSPITAL

Patient State	Patient County	Main	East	Total	% of Total
OH	Belmont	268	25	293	1%
	Coshocton	256	30	286	1%
	Athens	241	37	278	1%
	Washington	227	20	247	1%
	Greene	223	19	242	0%
	Guernsey	184	26	210	0%
	Wyandot	184	26	210	0%
	Auglaize	184	12	196	0%
	Hancock	177	13	190	0%
	Mercer	138	30	168	0%
	Morrow	137	24	161	0%
	Warren	153	6	159	0%
	Meigs	127	30	157	0%
	Shelby	140	11	151	0%
	Seneca	141	8	149	0%
	Miami	128	19	147	0%
	Vinton	120	19	139	0%
	Hardin	125	12	137	0%
	Lorain	130	1	131	0%
	Lawrence	117	12	129	0%
	Wayne	108	7	115	0%
	Morgan	103	9	112	0%
	Noble	101	8	109	0%
	Ashland	76	9	85	0%
	Lucas	78	5	83	0%
	Putnam	75	7	82	0%
	Clinton	62	10	72	0%
	Hamilton	65	4	69	0%
	Monroe	52	17	69	0%

UNIVERSITY HOSPITAL

Patient State	Patient County	Main	East	Total	% of Total
OH	Jefferson	57	9	66	0%
	Tuscarawas	61	3	64	0%
	Darke	55	7	62	0%
	Butler	51	6	57	0%
	Cuyahoga	44	10	54	0%
	Adams	49	3	52	0%
	Van Wert	46	3	49	0%
	Wood	39	5	44	0%
	Huron	33	7	40	0%
	Stark	37	2	39	0%
	Holmes	33	1	34	0%
	Clermont	31	1	32	0%
	Trumbull	25	6	31	0%
	Summit	25	3	28	0%
	Preble	21	5	26	0%
	Mahoning	19	1	20	0%
	Erie	16	3	19	0%
	Defiance	15	1	16	0%
	Fulton	16		16	0%
	Paulding	15	1	16	0%
	Sandusky	12		12	0%
	Brown	8	2	10	0%
	Carroll	10		10	0%
	Harrison	8	2	10	0%
	Portage	9		9	0%
	Columbiana	8		8	0%
	Medina	8		8	0%
	Henry	5	2	7	0%
	Lake	7		7	0%

UNIVERSITY HOSPITAL

Patient State	Patient County	Main	East	Total	% of Total
OH	Williams	7		7	0%
	Ottawa	4	1	5	0%
	Geauga	4		4	0%
	Ashtabula	2		2	0%
Non-Ohio	790	102	892	2%	0%
Grand Total		**39,802**	**9,381**	**49,183**	**100%**

OSUCCC – JAMES

Time Frame	CY24 Discharges		
Patient State	**Patient County**	**Discharges**	**% of Total**
OH	Franklin	5,176	35%
	Delaware	687	5%
	Licking	637	4%
	Fairfield	486	3%
	Montgomery	367	2%
	Clark	337	2%
	Ross	305	2%
	Scioto	291	2%
	Richland	290	2%
	Muskingum	250	2%
	Madison	238	2%
	Allen	237	2%
	Pickaway	236	2%
	Knox	224	2%
	Logan	224	2%
	Athens	163	1%

OSUCCC – JAMES

Patient State	Patient County	Discharges	% of Total
OH	Perry	163	1%
	Marion	161	1%
	Union	158	1%
	Auglaize	143	1%
	Greene	135	1%
	Miami	126	1%
	Champaign	122	1%
	Mercer	122	1%
	Fayette	120	1%
	Crawford	119	1%
	Jackson	117	1%
	Belmont	115	1%
	Hancock	115	1%
	Guernsey	110	1%
	Gallia	105	1%
	Hocking	104	1%
	Coshocton	103	1%
	Highland	100	1%
	Hamilton	98	1%
	Pike	98	1%
	Morrow	88	1%
	Warren	87	1%
	Washington	80	1%
	Clinton	78	1%
	Seneca	78	1%
	Shelby	77	1%
	Meigs	75	1%
	Wyandot	74	0%
	Hardin	72	0%

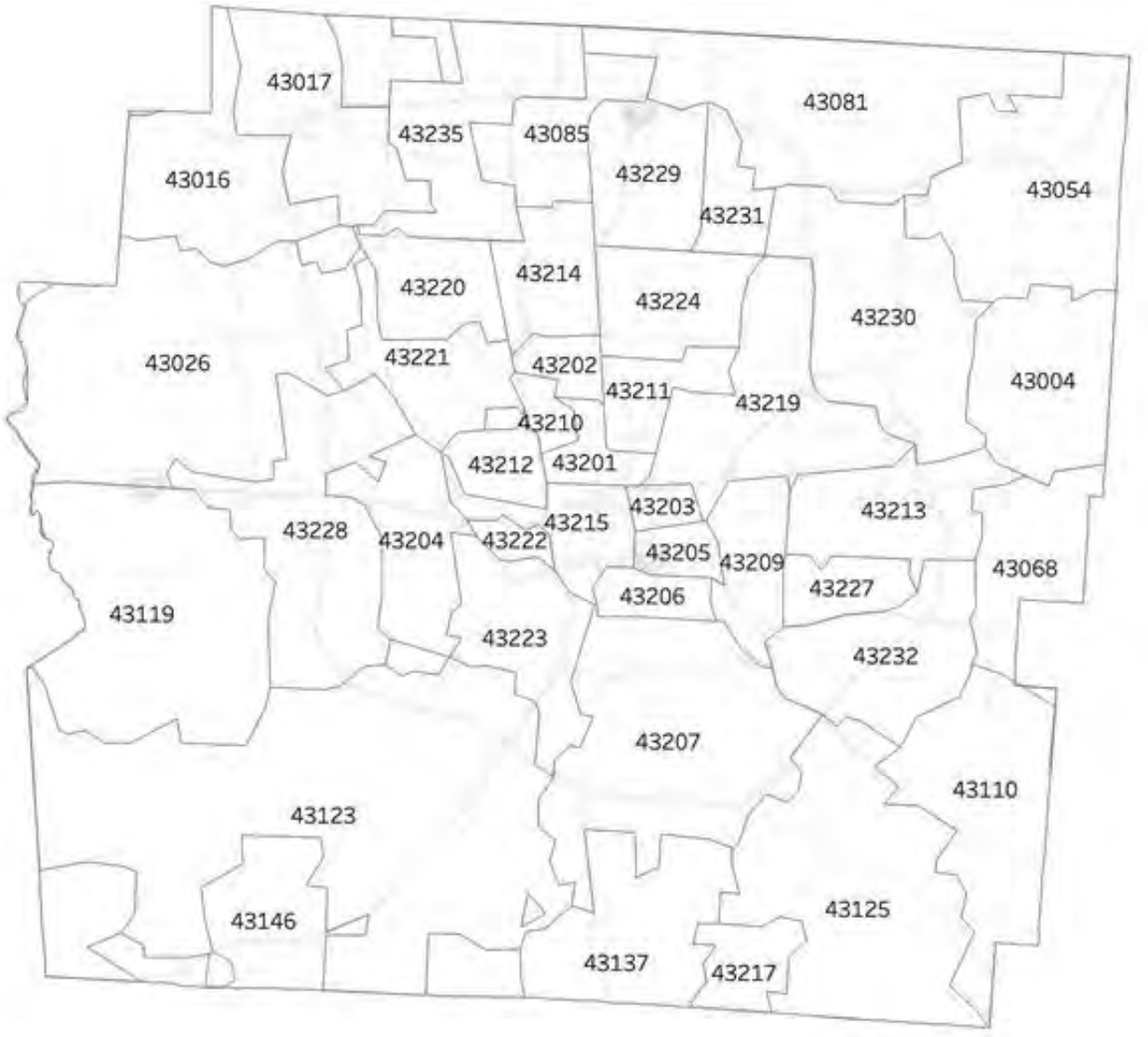
OSUCCC – JAMES

Patient State	Patient County	Discharges	% of Total
OH	Putnam	72	0%
	Butler	71	0%
	Lawrence	71	0%
	Darke	63	0%
	Wayne	56	0%
	Wood	50	0%
	Clermont	43	0%
	Morgan	40	0%
	Preble	39	0%
	Ashland	38	0%
	Lucas	37	0%
	Vinton	36	0%
	Jefferson	34	0%
	Monroe	32	0%
	Van Wert	31	0%
	Stark	30	0%
	Tuscarawas	30	0%
	Adams	26	0%
	Huron	25	0%
	Noble	20	0%
	Lorain	19	0%
	Holmes	18	0%
	Defiance	13	0%
	Cuyahoga	12	0%
	Harrison	10	0%
	Mahoning	10	0%
	Henry	9	0%
	Medina	9	0%
	Portage	9	0%

OSUCCC – JAMES

Patient State	Patient County	Discharges	% of Total
OH	Summit	9	0%
	Brown	8	0%
	Fulton	8	0%
	Sandusky	7	0%
	Trumbull	7	0%
	Lake	6	0%
	Paulding	6	0%
	Erie	4	0%
	Ottawa	4	0%
	Columbiana	3	0%
	Williams	3	0%
	Carroll	1	0%
Non-Ohio		574	4%
Grand Total		**14,884**	**100%**

FRANKLIN COUNTY SERVED BY THE OHIO STATE WEXNER MEDICAL CENTER



UNIVERSITY HOSPITAL

Time Frame	CY24 Discharges			
County	Franklin, OH			
ZIP Code	Main	East	Total	%
43219	700	806	1,506	6%
43207	893	489	1,382	5%
43211	903	445	1,348	5%
43232	745	397	1,142	4%
43213	540	454	994	4%
43230	722	234	956	4%
43224	728	219	947	4%
43227	468	453	921	4%
43209	450	406	856	3%
43204	703	116	819	3%
43229	675	140	815	3%
43201	693	115	808	3%
43228	718	89	807	3%
43223	688	108	796	3%
43123	686	106	792	3%
43206	484	300	784	3%
43081	643	108	751	3%
43026	671	54	725	3%
43203	242	440	682	3%
43068	521	137	658	3%
43205	310	327	637	2%
43235	479	51	530	2%
43110	427	91	518	2%
43221	458	35	493	2%
43212	429	49	478	2%
43215	337	139	476	2%
43214	398	48	446	2%

UNIVERSITY HOSPITAL

ZIP Code	Main	East	Total	%
43220	357	32	389	1%
43210	278	111	389	1%
43004	302	82	384	1%
43085	326	47	373	1%
43202	331	35	366	1%
43016	333	23	356	1%
43017	322	24	346	1%
43119	310	27	337	1%
43054	283	43	326	1%
43231	219	46	265	1%
43125	201	58	259	1%
43222	163	55	218	1%
43217	45	5	50	0%
43137	35	3	38	0%
43216	8	5	13	0%
43126	7		7	0%
43226	2	2	4	0%
43218	3	1	4	0%
43086	3	1	4	0%
43260	2	1	3	0%
43236	1	2	3	0%
43234	2	1	3	0%
43109	2	1	3	0%
43195	1		1	0%
43002	1		1	0%
Grand Total	**19,248**	**6,961**	**26,209**	**100%**

OSUCCC – JAMES

Time Frame	CY24 Discharges	
County	Franklin, OH	
ZIP Code	Discharges	%
43230	250	5%
43081	249	5%
43123	242	5%
43207	221	4%
43068	211	4%
43026	208	4%
43223	186	4%
43219	181	3%
43235	179	3%
43232	178	3%
43224	169	3%
43228	168	3%
43229	160	3%
43204	150	3%
43016	148	3%
43211	147	3%
43017	147	3%
43213	142	3%
43110	137	3%
43054	131	3%
43221	123	2%
43085	120	2%
43206	119	2%
43209	118	2%
43227	117	2%
43220	105	2%

OSUCCC – JAMES

Time Frame	CY24 Discharges	
County	Franklin, OH	
ZIP Code	Discharges	%
43214	105	2%
43201	98	2%
43004	88	2%
43212	79	2%
43231	74	1%
43119	69	1%
43215	68	1%
43205	65	1%
43125	55	1%
43203	50	1%
43202	49	1%
43222	30	1%
43137	17	0%
43210	11	0%
43217	7	0%
43236	3	0%
43126	1	0%
43086	1	0%
Grand Total	5,176	100%

Source: Ohio Hospital Association

Review of the Ohio State Wexner Medical Center internal data has shown that for Fiscal Year 2021, 54% of all patients who were admitted to the Wexner Medical Center resided in Franklin County at the time of discharge. Accordingly, Franklin County, Ohio, has been determined to be the community served by the Wexner Medical Center.

Review of OSUCCC – James internal data has shown that for Fiscal Year 2021, 32% of all patients who were admitted to The James resided in Franklin County at the time of discharge. Because no other county reached above 5% for patient discharges, Franklin County, Ohio, has been determined to be the community served by The James.

DEMOGRAPHICS OF COMMUNITIES WE SERVE

This section provides demographic information about Franklin County's residents and households. These graphs were taken from HealthMap2025. For purposes of the graphs, HealthMap has been abbreviated as HM with the corresponding year.

Franklin County Residents[1-3]

		Franklin County		
		HM2019	HM2022	HM2025
Total population	Population of Franklin County	1,264,518	1,316,756	1,321,820
Sex	Male	48.8%	48.8%	49.2%
	Female	51.2%	51.2%	50.8%
Age	Under 5 years	7.3%	7.0%	6.5%
	5-19 years	19.0%	19.1%	19.2%
	20-64 years	62.3%	61.4%	61%
	65 years and over	11.3%	12.4%	13.3%
Race (any ethnicity)	White	68.1%	66.5%	65.1%
	Black	23.1%	23.9%	24.9%
	Asian-American/Pacific Islander	5.4%	6.0%	6.0%
	American Indian/Alaskan Native	0.1%	0.3%	0.4%
	Two or more races	3.2%	3.4%	3.7%
Ethnicity	Hispanic or Latino (of any race)	5.4%	5.8%	7.3% ▲
Foreign-born	Foreign-born	-	11.4%	12.6% ▲
	(Among foreign-born) Naturalized	-	*48.2%*	*45.4%*
	(Among foreign-born) Not a U.S. citizen		*51.8%*	*54.6%*
English proficiency	Percent of people age 5+ who speak English less than "very well"	-	5.3%	6.4% ▲
Most common languages spoken by people who speak a non-English language at home	Spanish	-	49,949	56,793▲
	Amharic, Somali, or other Afro-Asiatic languages	-	25,051	27,074
	Arabic	-	8,437	15,285▲
	Yoruba, Twi, Igbo, or other languages of Western Africa	-	10,904	12,435▲
	Nepali, Marathi, or other Indic languages	-	9,668	11,076▲
	Chinese (incl. Mandarin, Cantonese)	-	13,072	8,188 ▼
	French (incl. Cajun)	-	5,789	7,579 ▲
	Swahili or other languages of Central, Eastern, and Southern Africa	-	3,608	6,634▲

* An upward-facing triangle (▲) indicates the HealthMap2022 (HM2022) statistic is greater than the one reported in HealthMap2019 (HM2019) by 10% or more. A downward-facing triangle (▼) indicates the HM2022 statistic is less than the one reported in HM2019 by 10% or more. Use caution when interpreting indicators with small values, which only need relatively small changes to produce a 10% difference.

		Franklin County		
		HM2019	HM2022	HM2025
Educational Attainment	No/Some high school, no degree	9.7%	8.8%	8.7%
	High school graduate	25%	24.6%	24.5%
	Some college (no degree)	20.2%	19.6%	18%
	Associate's degree	6.8%	6.9%	6.5%
	Bachelor's degree	24.4%	25.3%	25.8%
	Graduate/Professional degree	14%	14.8%	16.5% ▲

Although the number of households in Franklin County has increased over time, other household characteristics remained relatively stable over time (e.g., household size, household type).

Franklin County Households[1]

		Franklin County		
		HM2019	HM2022	HM2025
Total households	Number of households	502,932	522,383	550,153
Household size	Average household size	2.5	2.5	2.4
	Average family size	3.2	3.2	3.1
Household type	Family households	58.0%	58.5%	55.8%
	Nonfamily households	42.0%	41.5%	44.2%
	Single parent households	-	18.4%	18.3%

* Household size includes all people occupying a housing unit, while family size includes the family householder and all other people in the housing unit related to the householder by birth, marriage or adoption.

References

[1]U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019 (HM2022), 2016 (HM2019), 2013 (HM2016)

Impact of Actions to Address Priority Needs in 2022 Community Health Needs Assessment

HealthMap 2022 Priorities

The Franklin County Community Health Needs Assessment Steering Committee identified three priority areas: basic needs, behavioral health and maternal and infant health.

1. Basic Needs:

- **At the time of *HealthMap 2022*, the total persons under 65 with health insurance in Franklin County was 91.1%, which did not meet the national goal of 92.2%.**
- **Franklin County has 201,099 people below the 100% federal poverty level.**
- **According to *HealthMap 2022*, 12.8% of residents and 17.5% of children experienced food insecurity.**

Key Indicators

- **Housing security (decreasing homelessness, increased affordability)**
- **Financial stability**
- **Neighborhood safety (reduced crime)**
- **Food security**
- **Increased access to nutritious foods**
- **Access to care**

Efforts by the Ohio State Wexner Medical Center to address these indicators include:

- Opening the Healthy Community Center on the Near East Side in May 2024. Designed in collaboration with neighborhood residents, the facility fills a major gap in the community and demonstrates Ohio State's commitment to its neighbors' well-being.

- Expanding access to the Mid-Ohio Farmacy program, a partnership with Mid-Ohio Food Collective, to better connect Ohio State patients with documented food insecurity with enhanced access to fresh produce and other nutrient-rich foods.
- Opening the new Outpatient Care Dublin, opening new primary care locations in Grove City and Pickerington as well as purchasing/opening urgent care locations in Gahanna and Hilliard to expand access to care for the residents of central Ohio.
- Providing fresh food through a partnership with Mid-Ohio Food Collective and housing assistance for Moms2B participants.
- Supporting Partners Achieving Community Transformation's (PACT) work on needed community services and supports through a place-based program and project investments. PACT signature programs include:
    - The Ohio State University Employee Homeownership Incentive Program
    - Exterior home repair grants
    - Connected Communities (closing the digital divide)
    - Neighborhood Leadership Academy
    - Health Science Academies and Parent University
    - Community Safety Advisory Group
    - Growing and Growth Collective (the collaboration of community gardens in partnership with The James Mobile Education Kitchen and OSU Extension)
    - Maroon Arts Group annual film series
    - Venture Suite
- Supporting The James Mobile Education Kitchen, which focuses on nutrition-related issues and cancer-risk reduction through education on healthy foods and preparation.

2. Behavioral Health:

- **At the time of *HealthMap 2022*, 23.1% of Franklin County residents reported being told that they had a form of depression, up 1.3% from *HealthMap 2019*.**
- **Attempting suicide leading to hospitalization rates were also up nearly 2 percentage points from *HealthMap 2019*, at a rate of 6.8.**
- **Likewise, psychiatric admissions rates rose as compared with *HealthMap 2019*, to a rate of 36.1.**
- **Narcan administration in *HealthMap 2022* increased by 733 usages, but deaths attributed to opioids also rose.**
- **Unintentional drug/medication mortality rates nearly doubled.**

Key Indicators

- **Access to mental health care resources**
- **Screening for mental health issues**
- **Decreased unintentional drug and alcohol deaths**
- **Youth mental health supports (clinical, social)**

Efforts by the Ohio State Wexner Medical Center to address these indicators include:

- Supporting Alcohol, Drug and Mental Health (ADAMH) Board of Franklin County's Mental Health and Addiction Crisis Center with an early investment to help with the construction of the new center. The Ohio State Wexner Medical Center will also serve as the medical partner for the new facility.
- Partnering with Franklin County ADAMH by placing NaloxBoxes on The Ohio State University's campus around the Wexner Medical Center to expand access to emergency response tools.
- Partnering with the other health systems, public health, Federally Qualified Health Centers (FQHCs) and community organizations to address addiction through the work of the Columbus and Franklin County Addiction Plan.
- Providing Ohio State STAR (Stress, Trauma And Resilience) services for first responders through its collaboration with ADAMH to provide peer support group sessions and create an app for first responders that will assess mental health and provide tools.
- Increased naloxone education and distribution by integrating naloxone distribution models further within emergency departments and hospitals, addiction services and other treatment settings.

- Partnering with Columbus Division of Fire's RREACT (Rapid Response Emergency Addiction Crisis Team) program to increase the number of on-campus and community sites that can distribute naloxone, fentanyl test strips, drug disposal bags and education on harm reduction and treatment resources.
- Enhanced Medication for Opioid Use Disorder (MOUD) access by providing technical assistance and support to providers (both internally and externally throughout the community).
- Supporting the Substance Abuse Treatment, Education and Prevention Program (STEPP) Clinic as it provides addiction and mental health services and weekly education sessions to promote a healthy pregnancy and postpartum period for its moms with the goal of having healthy, full-term babies.
- Partnering with Southeast Healthcare's RREACT team to transfer patients presenting in the emergency department to treatment facilities including Maryhaven Addiction Stabilization Center and Talbot Hall.
- Growing outpatient operations from one clinic at Harding Hospital to four clinics, ensuring a behavioral health presence wherever ambulatory is expanding.
- Closing gaps in the continuum of care for people requiring behavioral health services by opening a Behavioral Health Urgent Care Clinic.

3. Maternal and Infant Health:

- **Overall health of pregnant women before delivery.**
- **Prevention of preterm births.**
- **The infant mortality rate for Franklin County reduced to 6.9 in *HealthMap 2022*.**

Key Indicators

- **Infant mortality**
- **Maternal pre-pregnancy health**

Efforts by the Ohio State Wexner Medical Center to address these indicators include:

- Supporting the work of Moms2B, a prevention program for expectant moms at high risk for infant mortality, through virtual and in-person education sessions, baby and mom well-checks and support for wrap-around services from patient navigators.

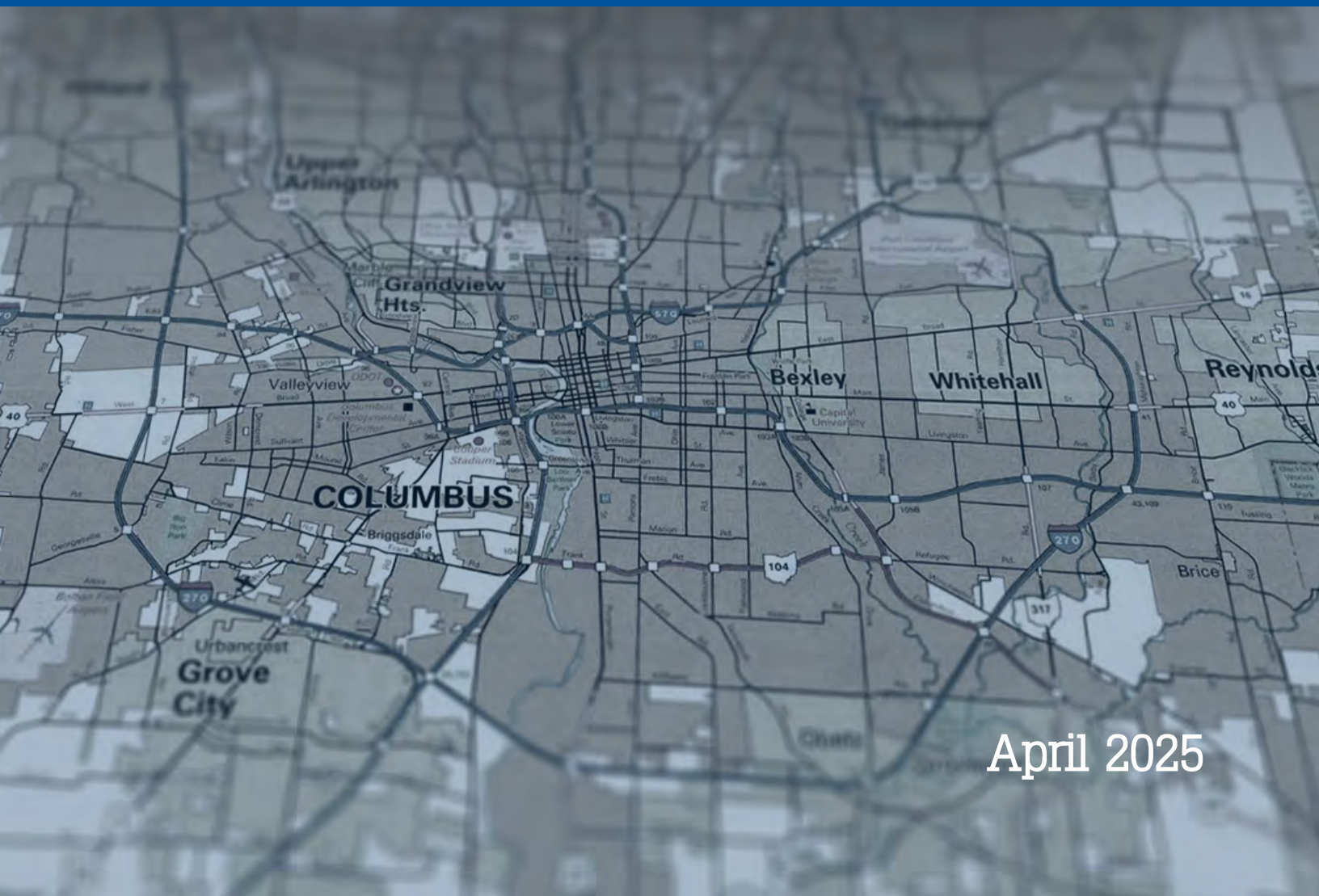
- Continuing to highlight the importance of safe sleep practices (ABC - Alone, on Back, in Crib) through Moms2B and STEPP education sessions and a video at discharge.
- Identifying women who currently smoke tobacco and refer them to Columbus Public Health's Baby & Me Tobacco Free program for cessation counseling.
- Increasing access to care through maternal fetal medicine expansion to Outpatient Care East and the use of the Community Care Coach.
- Collaborating with the other health systems to enhance prenatal and postpartum care through Ohio Better Birth Outcome's (OBBO) workgroups.
- Partnering with OBBO to offer community health workers in the McCampbell Outpatient Care Ob/Gyn clinic to provide linkages to care and wrap-around services for our patients.
- Offering prenatal and postpartum care on the Near East Side through the College of Nursing's Total Health Care Center FQHC, housed at East Hospital.
- Continuing a partnership with Nationwide Children's Hospital to support our first-time, low-income mothers from early pregnancy until the child's second birthday with nurse home visitation. The nurses have been trained by Nurse-Family Partnership to improve pregnancy outcomes by encouraging preventive health practices that enhance child health outcomes.
- Supporting Multimodal Maternal Infant Perinatal Outpatient Delivery System (MOMI PODS), a mom-baby dyad Care. MOMI PODS integrates a multimodal health engagement system (incorporating home visits, mobile health and telehealth) into traditional outpatient care models to provide high-quality primary and postpartum care to both the mother and child in the critical first 1,000 days after delivery.
- Continuing the Fourth Trimester Group Clinic, a family-centered approach to increasing breastfeeding rates among high-risk mothers.

There were no comments on the Ohio State Wexner Medical Center's 2022 CHNA.

Franklin County

HealthMap2025

Navigating Our Way to a Healthier Community Together



April 2025

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ABOUT HEALTHMAP2025

Introduction

The Franklin County Community Health Needs Assessment Steering Committee is pleased to provide residents of central Ohio with a comprehensive overview of our community's health status and needs via *Franklin County HealthMap2025*.

Franklin County HealthMap2025 is the result of a continuing, collaborative effort coordinated by the Central Ohio Hospital Council (COHC), Columbus Public Health (CPH), and Franklin County Public Health (FCPH). As part of its mission, COHC serves as the forum for community hospitals to collaborate with each other and with other community stakeholders to improve the quality, value, and accessibility of health care in the central Ohio region. Although COHC's not-for-profit member hospitals have service areas that extend across central Ohio, for the purposes of this report, the local geographic focus area is Franklin County, Ohio. CPH serves the residents of the City of Columbus and the City of Worthington, and FCPH serves the residents of all other cities, towns, and villages in Franklin County.

The intent of this effort is to help health departments, hospitals, social service agencies, and other community organizations identify and address the unmet health needs of Franklin County residents. By characterizing and understanding the prevalence of acute and chronic health conditions, access to care barriers, and other health issues, these community partners can ensure resources are focused so that they have the greatest impact.

To that end, central Ohio's hospitals and health departments will begin using the data reported in *Franklin County HealthMap2025* to inform the development and implementation of strategic plans (e.g., community health improvement plans; implementation plans) that address the community's health needs. Consistent with federal requirements, *Franklin County HealthMap2025* will be updated in three years.

The Franklin County Community Health Needs Assessment Steering Committee hopes *Franklin County HealthMap2025* serves as a guide to target and prioritize limited resources, a vehicle for strengthening community relationships, and a source of information that contributes to keeping people healthy.

Franklin County HealthMap2025's Process

The process for *Franklin County HealthMap2025* reflects an adapted version of Robert Wood Johnson Foundation's County Health Rankings and Roadmaps: Assess Needs and Resources process.[1] This process is designed to help stakeholders "understand current community strengths, resources, needs, and gaps," so they can better focus their efforts and

[1] See https://www.countyhealthrankings.org/take-action-to-improve-health/action-center/assess-needs-resources

collaboration. The primary phases of this process, as adapted for use with *Franklin County HealthMap2025*, included the following steps.

(1) Prepare to Assess. Members of the community were closely involved throughout the design and implementation of *Franklin County HealthMap2025*. On January 17, 2024, new members of the *Franklin County HealthMap2025* Community Health Needs Assessment Steering Committee[2] gathered via Zoom to learn about the upcoming community health needs assessment process and how their experience and involvement would be critical for the success of the effort.

On January 31, 2024, the full Steering Committee gathered in person to discuss their perspectives on emerging health issues in Franklin County, to participate in conversation with one another about the current state of health in the county (e.g., "What would a healthy Franklin County look like to you?"), and to identify potential health indicators for inclusion in *Franklin County HealthMap2025*. Both small group discussions and large group "report-outs" occurred during this session.

The *Franklin County HealthMap2025* Community Health Needs Assessment Executive Committee then used the information from these preceding working meetings and community visioning survey to identify which indicators could be assessed via secondary sources and which indicators could be gathered via primary data collection efforts.

(2) Collect and Analyze Secondary Data. Indicators identified by the Steering Committee for inclusion in the *Franklin County HealthMap2025* were collected and entered into a database for review and analysis. Quantitative secondary data for health indicators came from national sources (e.g., U.S. Census, Centers for Disease Control and Prevention's Behavior Risk Factor Surveillance System) and state sources (e.g., Ohio Department of Health's Data Warehouse, Ohio Hospital Association, Ohio Department of Public Safety, Ohio Department of Development). Rates and/or percentages were calculated when necessary.

To ensure community stakeholders can use this report to make well-informed decisions, only the most recent data available at the time of report preparation are presented. To be considered for inclusion in *Franklin County HealthMap2025*, quantitative secondary data must have been collected or published in 2021 or later; in most cases, the data reported in *HealthMap2025* are from 2022. In some instances, comparable state and/or national data were unavailable at the time of report preparation and therefore were not included.

The following table lists the quantitative indicators included in Franklin County's *HealthMap2025*.

[2] These individuals are listed on page 12 of this report.

Indicator	*Indicator Details*	Indicator	*Indicator Details*
COMMUNITY PROFILE			
Total population	*Number of people in Franklin County, Ohio*	**Educational attainment**	-
Sex	-	**Foreign-born status**	*Born outside of the United States*
Age	-	**English proficiency**	*Percent of people age 5+ who speak English less than "very well"*
Race	-	**Non-English languages spoken at home**	*Leading non-English languages spoken by people while at home*
Ethnicity	-	**Household size**	*Average household, family size*
Total households	*Number of households in Franklin County, Ohio*	**Household type**	*Family, nonfamily, single parents*
BASIC NEEDS			
Poverty status	*Less than 125% Federal Poverty Limit (FPL)*	**Eviction filing rate**	*Per 100 renter-occupied households*
Income distribution	*Less than 125% FPL; 125%-200% FPL; 200% FPL or below, 200%-400% FPL*	**Food insecurity**	*People who lack access, at times, to enough food for an active, healthy life*
Median household income	-	**Health insurance rate (insured; uninsured)**	*People who have health insurance*
Cost-burdened households	*Households that spend ≥30% of income on housing*	**Health insurance type**	*People who have different types of health insurance*
Renter-occupied housing	*Occupied housing units that are rented*	**Adverse childhood experiences (ACEs)**	*Adults who experienced an ACE before the age of 18*
Unhoused community members	*People who are homeless at a single point in time*		
CHRONIC CONDITIONS			
High cholesterol prevalence	*Adults told by a doctor that they have high cholesterol*	**Stroke prevalence**	*Adults told by a doctor that they had a stroke*
High blood pressure prevalence	*Adults told by a doctor that they have high blood pressure*	**Heart disease prevalence**	*Adults told by a doctor that they have heart disease*
Arthritis prevalence	*Adults told by a doctor that they have arthritis*	**Disability prevalence by type**	*Adults with different types of disabilities*
Diabetes prevalence	*Adults told by a doctor that they have diabetes*		
HEALTH BEHAVIORS			
Breast cancer screening	*Adult females (age 40+) who recently had a mammogram*	**Current cigarette smokers**	*Adults who smoke cigarettes some days or every day*
Colorectal cancer screening	*Adults (age 45-75) who recently had a colonoscopy*	**Current e-cigarette users**	*Adults who use e-cigarettes some days or every day*
Alcohol abuse	*Adults who binge drank in the past month*	**Obesity/overweight status**	*Per body mass index (BMI) categories*

Indicator	*Indicator Details*	Indicator	*Indicator Details*
MATERNAL AND INFANT HEALTH			
Prenatal chronic health conditions	*Anxiety; depression; gestational diabetes; or pregnancy-onset hypertension*	**Prenatal racial bias**	*Pregnant women who reported experiencing racial bias from a healthcare provider*
Pre-pregnancy vitamin usage	*Taking (multi)vitamins in month before pregnancy*	**Infant mortality rate**	*Deaths that occurred before 1 year of age, per 1,000 babies born*
Pre-pregnancy diabetes	*Type 1 or 2 diabetes in the three months before pregnancy*	**Low birthweight prevalence**	*Infants who weighed less than 2500 grams*
Unintended pregnancy	*Those who wanted to be pregnant later or did not want to be pregnant*	**Preterm birth prevalence**	*Infants who were delivered before 37 weeks gestation*
Prenatal healthcare	*Women who had a healthcare visit in year before pregnancy*	**Neonatal abstinence syndrome birth rate**	*Rate per 1,000 babies born*
Postnatal healthcare	*Women who had a healthcare visit in the 4-6 weeks after delivery*	**Teen fertility rate**	*Rate per 1,000 girls age 15-19 in the same age*
INFECTIOUS DISEASES			
Most common infectious disease rates: adults	*Rate per 1,000 individuals*	**New HIV diagnosis rate**	*Rate per 100,000 individuals*
Most common infectious disease rates: children	*Rate per 1,000 individuals*	**Kindergarten vaccinations**	*Youth who entered kindergarten with all required vaccines complete*
HEALTH CARE ACCESS			
Emergency Department utilization	*Treated & released; Admitted into the hospital; Visit severity; Top 10 diagnoses*	**Dental care access**	*Needed dental care but could not secure it (past 12 months)*
INJURY AND DEATH			
Mental/Social health	*Self-harm and suicide; loneliness; depression; alcohol attributable deaths; child abuse; domestic violence*	**Trauma hospitalization**	*Leading types of traumatic injuries*
Mortality	*Life expectancy; mortality rate*	**Cancer**	*Incidence and mortality*
Leading causes of death	*Rate per 100,000 individuals*	**Violent crime**	*Murder, rape, robbery, and aggravated assault, per 100,000 individuals*
		Overdose deaths	*Rate per 100,000 individuals*
ENVIRONMENTAL HEALTH			
Elevated blood lead level (EBLL)	*Among children under 6 years old*	**Lyme disease**	*Cases and rates, per 100,000 individuals*
Asthma prevalence	*Adults told by a doctor that they have asthma*		

Throughout the report, a (▲ or ▼) symbol next to the HM2025, Ohio, or US estimate indicates that estimate is at least 10% higher or at least 10% lower than the HM2022 estimate for that geography. A (▲ or ▼) symbol next to an age, sex, race/ethnicity, or disability estimate indicates that estimate is at least 10% higher than or at least 10% lower than the overall Franklin County estimate (i.e., HM2025).

(3) Collect and Analyze Primary Data. Qualitative primary data were obtained from a series of eleven 90-minute focus groups held from May 13, 2024 through July 26, 2024. Most of these focus groups were held in convenient, trusted locations throughout the community (e.g., Columbus Metropolitan Library branches; a community center; Columbus Public Health's administrative headquarters) and were facilitated by professional researchers. One focus group was held virtually via Zoom. A combination of professional/paid and grassroots/volunteer recruiting efforts were used to invite a diverse mix of Franklin County residents to participate in these sessions, including those with different types of disabilities.[3]

Overall, 111 Franklin County adults who reside within the primary jurisdictions of the COHC-member hospitals (as defined for this process), CPH, and FCPH participated in these focus groups, sharing their thoughts and observations about a wide range of health topics. These discussions included a focus on underlying factors that contribute to health issues, such as poverty and racism. Transcripts of these discussions can be provided upon request.

(4) Identify Priority Heath Needs. On October 22, 2024, the Steering Committee members received a draft copy of *Franklin County HealthMap2025*. They were asked to review the draft document and to record and share any comments or questions they had about it.

On October 31, 2024, the full Steering Committee met in person to review *Franklin County HealthMap2025* and to identify priority health issues. The meeting participants were divided into small groups, with each group asked to review a specific section of *Franklin County HealthMap2025* and, within that section, to identify potential priority health issues for consideration by the larger group. In addition to sharing their personal experience and history during these small-group conversations, meeting participants were asked to consider the following criteria when identifying potential priority health issues:

- **Equity:** Degree to which specific groups are disproportionately affected by an issue.
- **Size:** Number of persons affected, taking into account variance from benchmark data and targets.
- **Seriousness:** Degree to which the health issue leads to death or disability, and impairs one's quality of life.

[3] The Steering Committee wishes to acknowledge and thank the Ohio Department of Health's Center for Public Health Excellence for recruiting disabled residents to share their experiences and opinions in one of these focus groups and for providing ASL interpreters to help facilitate that conversation.

- **Feasibility:** Ability of organization or individuals to reasonably combat the health issue given available resources. Related to the amount of control and knowledge (influence) organization(s) have on the issue.
- **Severity of the Consequences of Inaction:** Risks associated with exacerbation of the health issue if not addressed at the earliest opportunity.
- **Trends:** Whether or not the health issue is getting better or worse in the community over time.
- **Intervention:** Any existing multi-level public health strategies proven to be effective in addressing the health issue.
- **Value:** The importance of the health issue to the community.
- **Social Determinant / Root Cause:** Whether or not the health issue is a root cause or social determinant of health that impacts one or more health issues.

Overall, a total of 29 potential priority health issues were identified by Steering Committee members. A multi-voting technique,[4] featuring three rounds of voting, was used to narrow down that list to **five priority health issues** that affect Franklin County residents.

On December 19, 2024, Steering Committee members received an invitation to participate in an online survey that would lead to the identification of the final set of priority health needs for the community. This prioritization survey was structured as follows. First, it provided an orientation to the purpose and intent of the effort. It presented an array of criteria that respondents should use when identifying priority health needs (e.g., the list of nine factors presented above). Then, after reading descriptions of the five priority health issues, respondents were asked to rank those issues. Overall, 28 Steering Committee members completed this survey. After tabulating the responses, there was clear consensus about the community's priority health needs. These priority health needs are reviewed in the next section of this report.

From these exercises, the Steering Committee was able to complete its charge to identify the prioritized health needs of Franklin County.

(5) Identify Community Assets and Resources. In December 2024, the Executive Committee identified community assets and resources that could potentially address the prioritized health needs, including existing healthcare facilities, community organizations, and programs or other resources. Inclusion of these potential partners and resources in *Franklin County HealthMap2025* is consistent with hospital requirements for conducting a needs assessment.

(6) Share Results with the Community. In December 2024, COHC conducted a review of *Franklin County HealthMap2025* to ensure that it was compliant with Internal Revenue Service

[4] See NACCHO's Guide to Prioritization Techniques, which can be accessed at https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf.

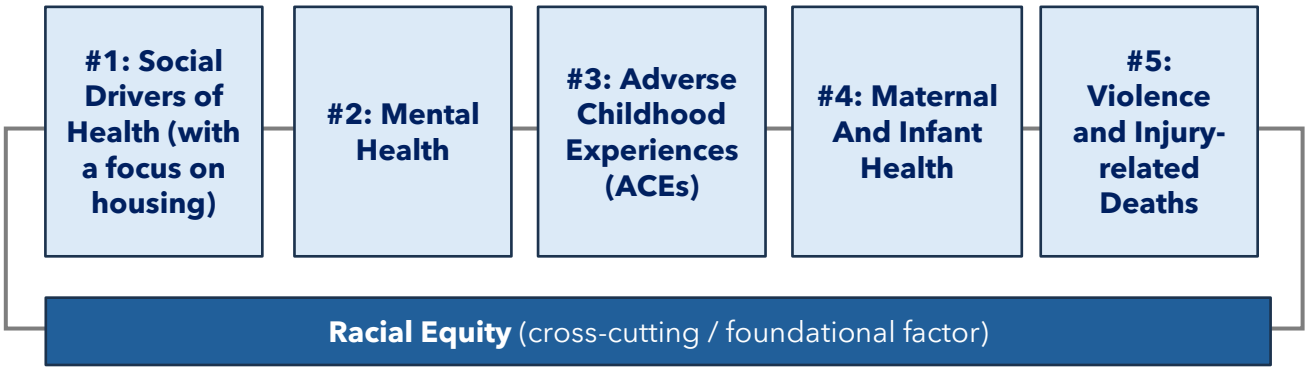
regulations for conducting community health needs assessments. CPH and FCPH also conducted internal reviews to ensure the report satisfied the requirements set forth by the Public Health Accreditation Board (PHAB). No information gaps that may impact the ability to assess the health needs of the community were identified during or after this process.

This report will be posted on COHC's, CPH's, and FCPH's websites, will be used in subsequent community prioritization and planning efforts, and will be widely distributed to organizations that serve and represent residents in the county.

Prioritized Health Needs

The five prioritized health needs affecting Franklin County residents, as identified by the Community Health Needs Assessment Steering Committee, are displayed below and discussed in this section.

Prioritized Health Needs Identified By *HealthMap2025*



Priority #1: Social Drivers of Health (with a focus on housing)

- Non-medical factors, such as economic stability, education and healthcare access, transportation and neighborhood safety, are key drivers of good health outcomes. According to Healthy People 2030, addressing the quality of housing as a public health issue may help prevent and reduce negative health outcomes. This is because poor housing quality and inadequate housing conditions can contribute to negative health outcomes, including chronic disease and injury. Furthermore, the presence of lead, mold, or asbestos, poor air quality and overcrowding can lead to irreversible health effects. In addition, overcrowded homes may be at risk for poor mental health, food insecurity, and infectious disease.
- Steering Committee members noted the many linkages between housing and health conditions and argued that policy changes are likely necessary to address varied challenges with the availability and affordability of different types of housing in Franklin County. Furthermore, Steering Committee members noted that cost-burdened households – those that spend more than 30% of their income on housing costs – tend to

be concentrated in zip codes that are associated with greater levels of racial and financial inequities, likely reflecting the historical practice of redlining in central Ohio.

Relevant indicators	See pages
Cost-burdened household prevalence	36
Unhoused community members (point-in-time count)	37

Priority #2: Mental Health

- According to the National Alliance on Mental Illness (NAMI), 23% of U.S. adults (1 in 5 adults) experienced mental illness in 2021 with 5.5% of adults (1 in 20 adults) experiencing a serious mental illness. And per the CDC, social isolation and loneliness are widespread problems in the U.S. and pose a serious threat to both mental and physical health. Social isolation can increase a person's risk for heart disease, self-harm, dementia and eventually may lead to an earlier death.
- Steering Committee members mentioned loneliness and depression as areas of concern, noting that over a quarter of residents report feeling lonely, and that the prevalence of loneliness is higher among recently pregnant women, individuals who have a household income that places them at or under the 100% federal poverty level, and among individuals with a disability. Furthermore, females, white (non- Hispanic) individuals, adults under the age of 65, and individuals with a disability are more likely than other groups to report ever being told by a healthcare professional that they have a depressive disorder (e.g., depression).
- Hospitalizations due to self-harm and deaths from suicide have both increased in Franklin County since the last HealthMap. The Franklin County Suicide Prevention Coalition has identified high-risk populations, including the Black and African-American community, older adults, refugees and immigrants, veterans, and youth.

Relevant indicators	See pages
Depression prevalence	136
Loneliness prevalence	135
Suicide death rate	135

Priority #3: Adverse Childhood Experiences (ACEs)

- Adverse childhood experiences, or ACEs, are traumatic events that occur during childhood (i.e., before age 18) and impact mental health. Examples of ACEs include violence, abuse, or neglect, as well as contextual factors that might negatively affect a child's sense of safety or stability, such as growing up in a household with people who have substance use problems, mental health problems, or parents who were separated or in jail. Research shows that ACEs can have lasting effects on health and wellbeing in childhood, as well as impact one's education and job potential into adulthood. These experiences can increase the risks of injury, maternal and child health problems including teen pregnancy, pregnancy complications, and fetal death. Also impacted are a range of chronic diseases and leading causes of death, such as cancer, diabetes, heart disease, and suicide.

- Steering Committee members noted that the prevalence of those who report having 4 or more ACEs when they were children is highest among black (non-Hispanic) individuals, those who are younger than age 65, and individuals with a disability. Furthermore, Steering Committee members noted that ACEs are considered a root cause for many physical and mental health issues and social determinant of health outcomes.

Relevant indicators	See pages
Adverse childhood indicators prevalence	52
Depression prevalence	136

Priority #4: Maternal and Infant Health

- Healthy children need healthy parents. The health of the mother – before, during, and after pregnancy – has a direct impact on the health of the child. Biological and neurological sciences show that the predictors of healthy child development begin before pregnancy, with the health of the mother, and continue after the birth, with the mother-child relationship.
- According to the CDC, each year, more than 50,000 pregnant people are affected by severe maternal morbidity, 800 women die due to pregnancy-related complications and over 20,000 infants die. And per CelebrateOne, a public/private impact collaborative addressing and reducing infant mortality, 126 babies died in Franklin County before their first birthday in 2023, with 20 due to sleep-related conditions.
- From the Steering Committee members' perspective, an increased focus on maternal health could lead to a reduction of the infant mortality rate, which unfortunately has not decreased significantly in recent years. Steering Committee members also suggested broadening the focus of maternal health to include the pre-pregnancy period, prenatal period, and well after delivery. Furthermore, Steering Committee members noted that many pregnant women report racial bias in the prenatal health care they received, which is a cross-cutting factor that also must be addressed.

Relevant indicators	See pages
Maternal health (multiple indicators)	96-112
Infant mortality rate	108

Priority #5: Violence and Injury-related Deaths

- Injury and violence affect everyone, regardless of age, race, or economic status. According to the CDC, Americans aged 1 to 44 die from injuries and violence – such as motor vehicle crashes, suicide, overdoses, or homicides - more than any other cause. Suicide is the second leading cause of death for this age group, while homicide remains in the top five leading causes of death. Overall, drug overdose remains the leading cause of injury-related death among adults in the United States.
- Steering Committee members noted that both drug overdose deaths and deaths from alcohol-attributable causes have increased since the last HealthMap. Additionally, Steering Committee members were concerned about traumatic injuries and the presence of numerous disparities by age, gender, and race.

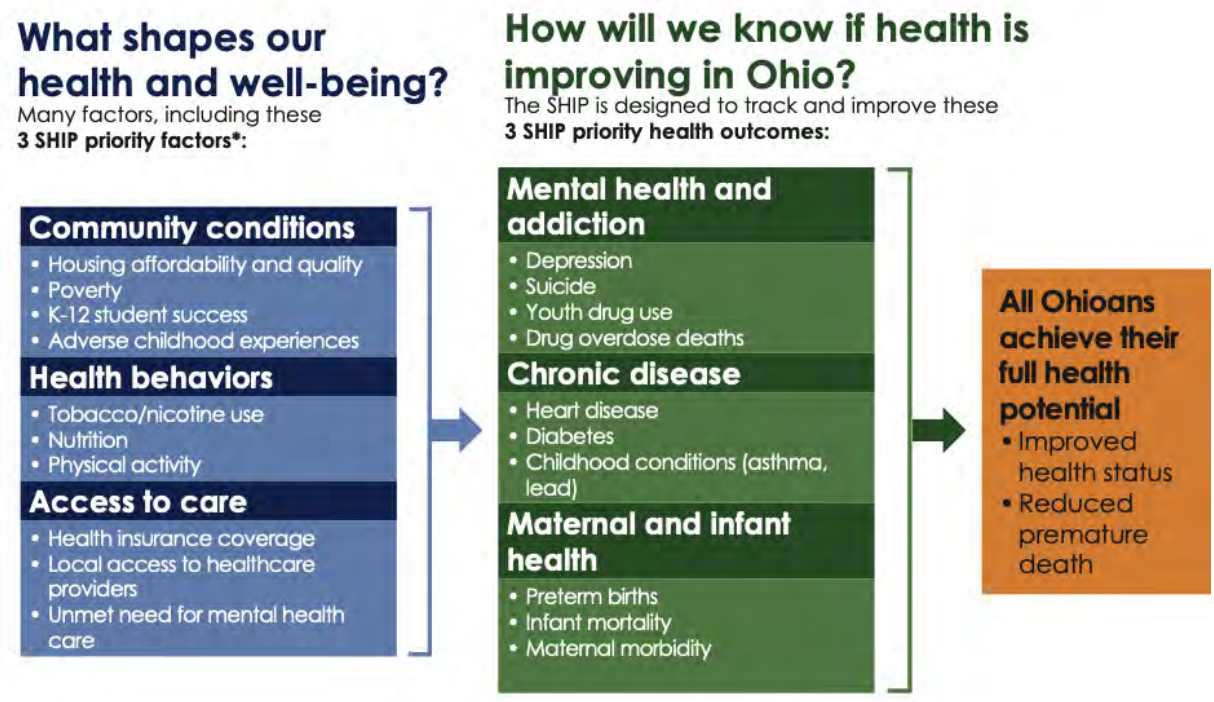
Relevant indicators	See pages
Drug overdose death rate	164
Alcohol-attributable death rate	138
Traumatic injury prevalence	151-157
Violent crime	162

Page 183 of this report presents a list of community assets and resources that could potentially help to address these prioritized health needs.

Note that these prioritized health needs are interrelated, and in many cases likely co-occur. Furthermore, the Steering Committee acknowledges that large scale coalitions currently address **infant mortality** and **addiction**, and that those efforts could be supplemented with an increased focus on the potential causes of those issues.

For context, Ohio's 2020-2022 State Health Improvement Plan (SHIP) identified three cross-cutting factors (i.e., social determinants of health that include community conditions, health behaviors, and access to care) as well three health outcome categories (i.e., mental health and addiction, chronic disease, and maternal and infant health) that should be considered when planning to improve the community's health (see next page). Overall, there is good alignment between *HealthMap2025's* prioritized health needs and Ohio's 2020-2022 SHIP.

Priority Factors And Outcomes Identified By Ohio's 2020-2022 SHIP



Source: Ohio's 2020-2022 State Health Improvement Plan (SHIP), available at https://dam.assets.ohio.gov/image/upload/odh.ohio.gov/SHIP/2020-2022/2020-2022-SHIP.pdf

Lastly, it should be noted that several other health issues were also considered by the Steering Committee as part of this prioritization process. Although these other issues play an important role in affecting the health of Franklin County residents, they did not receive the same level of endorsement as compared to the priority health needs reviewed previously.

The other health issues considered by the Steering Committee are listed below in no particular order.

- Racial bias in health care (note: this is mentioned as a cross-cutting factor affecting maternal health, above)
- Access to dental care
- Accessing care in the appropriate setting
- Overweight and obesity status
- Tobacco use (smoking and vaping)
- Life expectancy
- Cancer screening
- Motor vehicle accidents
- Food preparation knowledge
- Diversity of housing stock
- Asthma / respiratory disease
- Maternal & child health: Access to care; Cultural competence
- Maternal & child health: Chronic conditions
- Maternal & child health: Infant mortality
- Heart disease
- Stroke
- Diabetes
- Transportation
- Suicide deaths | Self-harm hospitalizations

Community Health Needs Assessment Steering Committee

Work on *Franklin County HealthMap2025* was overseen by a Steering Committee consisting of the following community members. Consistent with federal requirements for conducting health needs assessments, entities which represent specific populations within the community are identified. Executive Committee members are indicated with a * symbol.

ADAMH Board (Mental Health)
Kelly Bragg

B.R.E.A.D. Organization (Faith Communities)
Blanche Luczyk, Cora Harrison

Central Ohio Hospital Council (Hospital/Medical)
*Jeff Klingler**

Center for Public Health Practice at The Ohio State University (University System)
Andy Wapner

City of Columbus (Government)
Hannah Jones

Columbus City Schools (Education)
Sara Bode

Columbus Public Health (Public Health)
Kathy Cowen, Ann Mehl, Laurie Dietsch, Michelle Groux*

Community Shelter Board (Housing Insecure Community)
Steven Skovensky

Directions for Youth & Families (Mental Health)
Duane Casares

Educational Service Center (Education)
Wade Lucas

Equitas Health (LGBTQ+)
Francisco Caro

Ethiopian Tewahedo Social Services (Social Services; New American Communities)
Seleshi Ayalew Asfaw

Franklin County Coroner (Hospital/Medical)
Nathaniel Overmire, Patrick McLean, Jeremy Blake

Franklin County Office of Aging (Senior Community)
Caroline Rankin, Chanda Wingo

Franklin County Public Health (Public Health)
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United Way of Central Ohio (Low-income/Medically Underserved Communities)
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Workforce Development Board (Workforce Development)
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The following hospitals (listed by health system) participated in the *HealthMap2025* process:

Mount Carmel Health System
Mount Carmel East Hospital
Mount Carmel Grove City Hospital
Mount Carmel St. Ann's Hospital

Nationwide Children's Hospital

OhioHealth
OhioHealth Doctors Hospital
OhioHealth Dublin Methodist Hospital
OhioHealth Grant Medical Center
OhioHealth Grove City Methodist Hospital
OhioHealth Riverside Methodist Hospital

OSU Wexner Medical Center
University Hospital, Main Campus
University Hospital East
The James Cancer Hospital and Solove Research Institute

Input from all required sources was obtained for this report.

COHC, CPH, and FCPH contracted with various organizations to help create *Franklin County HealthMap2025*. Representatives of those organizations, along with their qualifications and addresses, are provided below.

Illuminology – located at 5258 Bethel-Reed Park, Columbus, OH 43220. Illuminology, represented by Orie V. Kristel, Ph.D., led the process for locating health status indicator data, for designing and moderating the focus groups, and for creating the summary report. Dr. Kristel is Illuminology's principal researcher and has 27 years of experience related to research design, analysis, and reporting, with a focus on community health assessments.

Center for Public Health Practice – located within the College of Public Health at The Ohio State University, 1841 Neil Avenue, Columbus, OH 43210. The Center, represented by Andy Wapner and Georgia Sasser, provided data collection, analysis support, and contributed to the summary report. The Center was also represented on the Steering Committee. Center staff combine for over 30 years of experience in local, state, and academic public health and routinely provide health needs assessment services.

INCompliance, an affiliate law firm of Bricker Graydon LLP – located at 100 South Third Street, Columbus, Ohio 43215. INCompliance provided overall guidance in ensuring that the conduct of the CHNA was compliant with the Internal Revenue Service regulations. Jim Flynn is a managing partner with Bricker Graydon and senior consultant to INCompliance. He and has 34 years of practice experience related to health planning matters, certificate of need, non-profit and tax-exempt health care providers, and federal and state regulatory issues. Christine Kenney is Director of Regulatory Services for INComplaince and has over 44 years of experience in health care planning and policy development, federal and state regulations, certificate of need, and assessment of community need.

The Community Health Needs Assessment Steering Committee wishes to acknowledge and thank the following people who contributed their time and expertise to assist with some of the analyses and maps included in *HealthMap2025*: Sierra MacEachron (Franklin County Public Health); Kathy Cowen, Michelle Groux, Emily Alexy, and Becky Zwickl (Columbus Public Health's Office of Epidemiology).

Community Profile

Overall, Franklin County's total population continues to increase. Compared to the last *HealthMap*, the county's demographic profile has remained similar, with three notable exceptions: the proportion who identify as Hispanic or Latino has increased; the proportion who were born in another country has increased; and the proportion of people age 5+ who speak English less than "very well" has increased.

Franklin County Residents[1-3]

		Franklin County		
		HM2019	HM2022	HM2025
Total population	Population of Franklin County	1,264,518	1,316,756	1,321,820
Sex	Male	48.8%	48.8%	49.2%
	Female	51.2%	51.2%	50.8%
Age	Under 5 years	7.3%	7.0%	6.5%
	5-19 years	19.0%	19.1%	19.2%
	20-64 years	62.3%	61.4%	61%
	65 years and over	11.3%	12.4%	13.3%
Race (any ethnicity)	White	68.1%	66.5%	65.1%
	Black	23.1%	23.9%	24.9%
	Asian-American/Pacific Islander	5.4%	6.0%	6.0%
	American Indian/Alaskan Native	0.1%	0.3%	0.4%
	Two or more races	3.2%	3.4%	3.7%
Ethnicity	Hispanic or Latino (of any race)	5.4%	5.8%	7.3% ▲
Foreign-born	Foreign-born	-	11.4%	12.6% ▲
	(Among foreign-born) Naturalized	-	*48.2%*	*45.4%*
	(Among foreign-born) Not a U.S. citizen		*51.8%*	*54.6%*
English proficiency	Percent of people age 5+ who speak English less than "very well"	-	5.3%	6.4% ▲
Most common languages spoken by people who speak a non-English language at home	Spanish	-	49,949	56,793▲
	Amharic, Somali, or other Afro-Asiatic languages	-	25,051	27,074
	Arabic	-	8,437	15,285▲
	Yoruba, Twi, Igbo, or other languages of Western Africa	-	10,904	12,435▲
	Nepali, Marathi, or other Indic languages	-	9,668	11,076▲
	Chinese (incl. Mandarin, Cantonese)	-	13,072	8,188 ▼
	French (incl. Cajun)	-	5,789	7,579 ▲
	Swahili or other languages of Central, Eastern, and Southern Africa	-	3,608	6,634▲

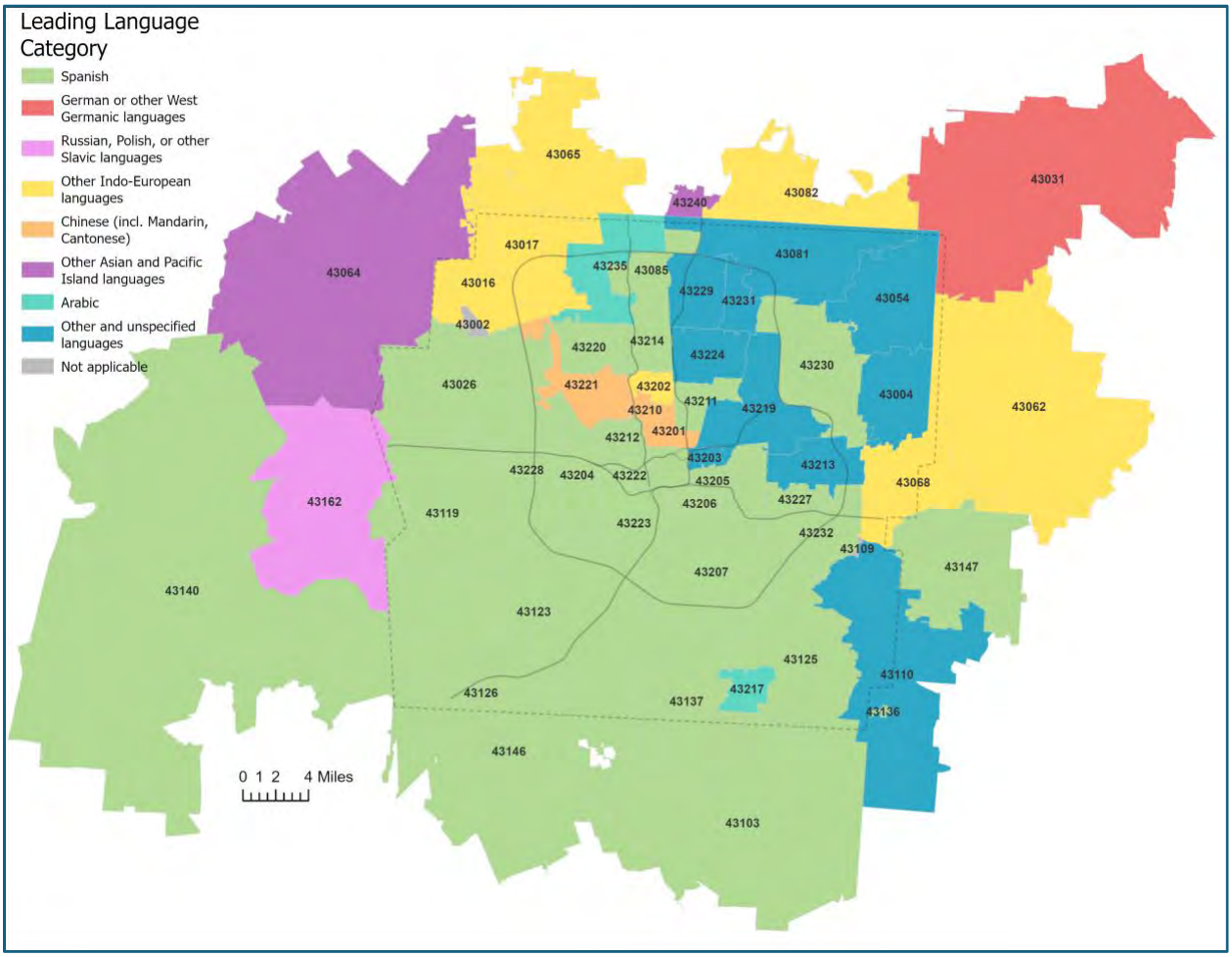
		Franklin County		
		HM2019	HM2022	HM2025
Educational Attainment	No/Some high school, no degree	9.7%	8.8%	8.7%
	High school graduate	25%	24.6%	24.5%
	Some college (no degree)	20.2%	19.6%	18%
	Associate's degree	6.8%	6.9%	6.5%
	Bachelor's degree	24.4%	25.3%	25.8%
	Graduate/Professional degree	14%	14.8%	16.5% ▲

Although the number of households in Franklin County has increased over time, other household characteristics remained relatively stable over time (e.g., household size, household type).

Franklin County Households[1]

		Franklin County		
		HM2019	HM2022	HM2025
Total households	Number of households	502,932	522,383	550,153
Household size	Average household size	2.5	2.5	2.4
	Average family size	3.2	3.2	3.1
Household type	Family households	58.0%	58.5%	55.8%
	Nonfamily households	42.0%	41.5%	44.2%
	Single parent households	-	18.4%	18.3%

The leading non-English language category spoken at home[4] in each Franklin County zip code is shown below.

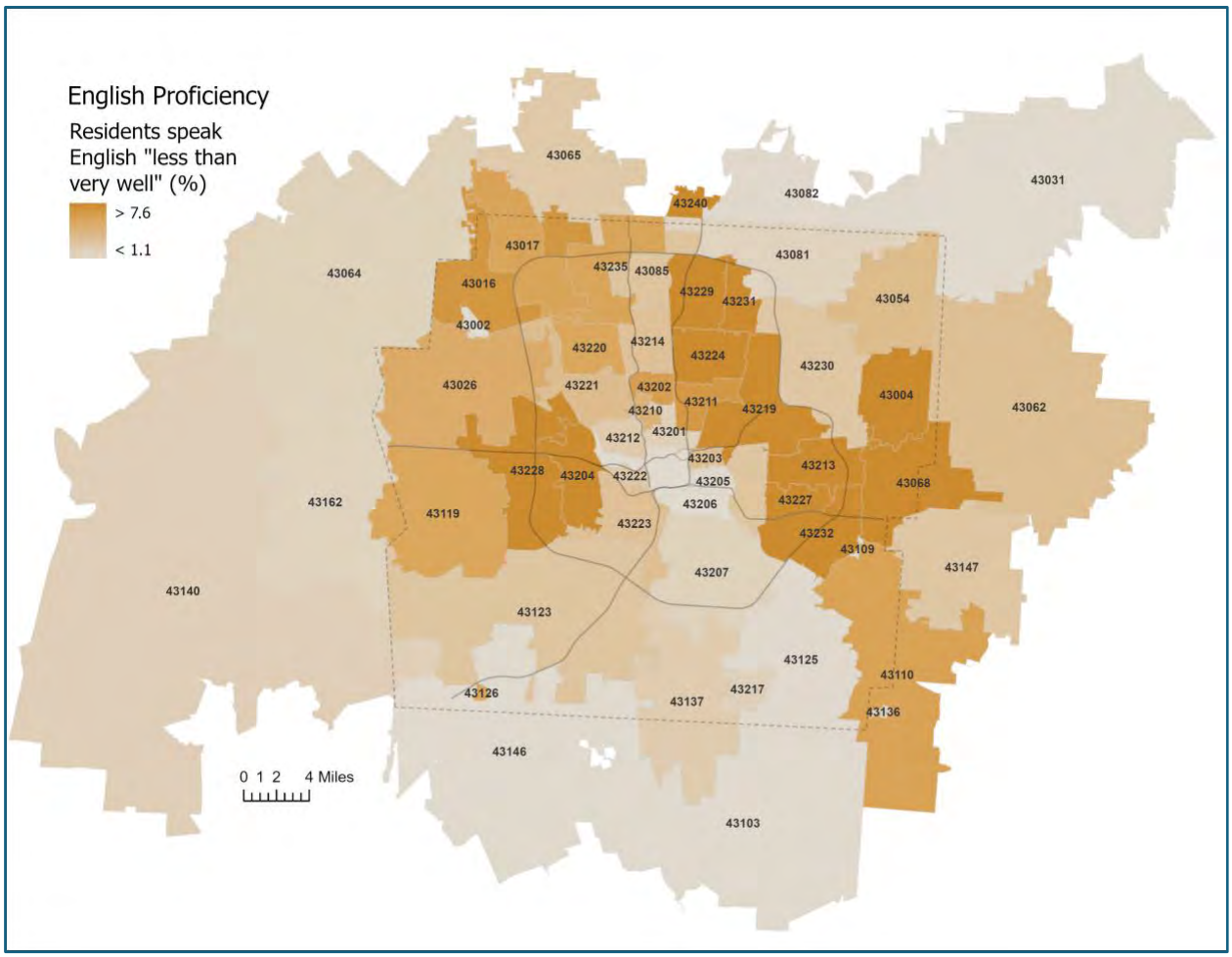


The following zip codes have the highest percentage of residents who speak a non-English language at home. Per the United States' Census Bureau[4]:

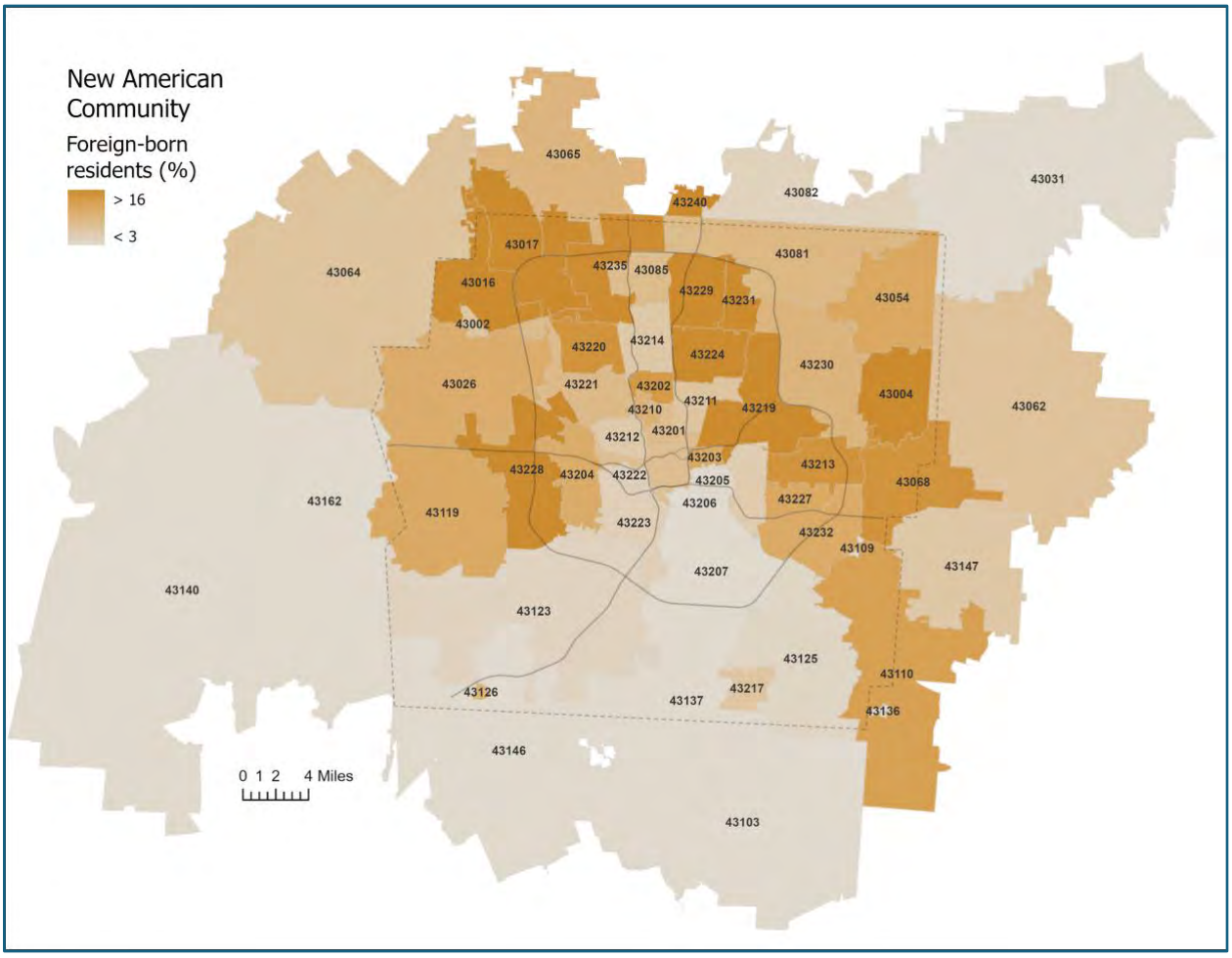
- 26% of residents in zip code **43231** speak a language other than English at home. In that zip code, the most common countries of birth besides the United States are Somalia, Ghana, and Kenya.
- 21% of residents in zip code **43229** speak a language other than English at home. In that zip code, the most common countries of birth besides the United States are Ghana, El Salvador, and Somalia.
- 20% of residents in zip code **43224** speak a language other than English at home. In that zip code, the most common countries of birth besides the United States are Somalia, Ghana, and Mexico.
- 16% of residents in zip code **43219** speak a language other than English at home. In that zip code, the most common countries of birth besides the United States are Somalia, Mexico, and India.

- 14% of residents in zip code **43068** speak a language other than English at home. In that zip code, the most common countries of birth besides the United States are Bhutan, Nepal, and Ethiopia.

As shown in the map below, those residents who speak English less than "very well" are relatively more likely to be located in Franklin County's far eastern zip codes (e.g., 43068, 43004, 43232, 43227, 43213), its western zip codes (e.g., 43204, 43228, 43119), and its north-central zip codes (e.g., 43219, 43224, 43229, 43231).



Those residents who report being born in another country are relatively more likely to be located in Franklin County's north-central zip codes (e.g., 43219, 43224, 43229, 43231), in the 43228 zip code, and its northwestern zip codes (e.g., 43016, 43017, 43220, 43235).



Additional Information & References

Over the past 15 years, the U.S. Census Bureau has been working to improve how it measures race in America, including those who identify with two or more racial groups. This process resulted in numerous changes to the questionnaires it uses, starting in 2020. If HM2025 used recent American Community Survey data (i.e., 2022 vintage) to estimate the proportion of Franklin County residents who identify with two or more racial groups, that statistic would be 9.3%, representing a 250% increase from what was measured in 2019 (i.e., 3.7%). Because those questionnaire changes produced a substantial change in this statistic over time, HM2025 used a different U.S. Census Bureau dataset to estimate Franklin County residents' race/ethnicity status.[2,3]

Household size includes all people occupying a housing unit, while family size includes the family householder and all other people in the housing unit related to the householder by birth, marriage, or adoption.

To map the prevalence of these indicators at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the Census Bureau's American Community Survey.[4]

Data Gap: The Community Health Needs Assessment Steering Committee requested recent data about the proportion of residents who obtained technical training / certification. Unfortunately, the U.S. Census Bureau does not appear to measure that type of vocational activity.

[1] U.S. Census Bureau, American Community Survey 1-Year Estimates, 2022 (HM2025), 2019 (HM2022), 2016 (HM2019)
[2] U.S. Census Bureau. (2020). *County Population by Characteristics: 2010-2020, Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin [Dataset]. https://www.census.gov/programs-surveys/popest/technical-documentation/research/evaluation-estimates/2020-evaluation-estimates/2010s-county-detail.html*
[3] U.S. Census Bureau. (2022). *County Population by Characteristics: 2020-2023, Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin [Dataset]. https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-detail.html*
[4] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2022 (HM2025)

BASIC NEEDS

Income And Poverty

Socioeconomic status is one of the most well documented influences on health. Lower income is associated with greater chronic illness, more healthcare needs, worse health-related quality of life, and higher mortality.[1-4]

The median household **income** in Franklin County in 2022 was **$69,681**.	≈ Similar to HM2022 ($64,713)
18.8% of Franklin County residents have an income below 125% of the **poverty level**.	≈ Similar to HM2022 (17.7%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Children more likely	None observed	Non-white more likely	Observed (see map)

Community Voices

Many Franklin County residents feel they are vulnerable to poverty, perceiving basic needs as increasingly expensive and their overall financial stability as precarious.

> *"Most of us now, with inflation rates and the way everything is mildly expensive, we are all a couple bad weeks away from being as homeless as the other people on Broad Street. People who feel like they have had a more stable setup or a more conventional foundation, I don't think that is the same as it maybe was five or ten years ago."*

Community members feel that the effort to make ends meet precludes individuals from thinking about their health needs, as well as financially prevents them from accessing health care, nutritious food, and other things needed to lead healthy lives.

> *"If you are someone who's trying to make ends meet and you're working several jobs, oftentimes it's really hard to find the time, to find the motivation to do the things that are ultimately going to improve your health. So you might be fully employed, working 60, 80 hours a week just to keep a roof over your head. And the other things kind of take a back seat to that. You don't have access necessarily to healthy food. You don't have access to doctors in your area where it's a quick trip to that. And our society really pats people on the back who work a lot, basically themselves to death."*

> *"Being stuck on that bottom rung of Maslow's hierarchy of needs. Yes, healthcare should be down there, but it isn't. It's another step up. If you're trying to just subsist and you can't get out of that, you're not going to think about things that are actually problems with your body or mental health."*
>
> *"You can't afford everything. You try to do one thing, because if you try to do it all, and then it's a trickle-down effect and you're in a hole, you can't get yourself out of it. So, you can only do so much for yourself. And if you have a family, it's even harder. You just have to pick and choose what's most important at that right time."*
>
> *"If you're sick, you're not gonna have the energy to make healthy meals, you're not gonna follow the doctor's orders, like take a rest, or do this type of treatment, because you have to work and make money to provide for your family."*

While resources exist to help individuals in poverty, community members say that accessing them is not easy enough; individuals may be unaware what resources exist and unable to get connected to an individual who can help them in a timely manner.

> *"If you are living in poverty, you may not have the ability to know where to access the resources. Because I do think that there are a lot of resources, but I don't think people know how to get to the resources, and people are not helping them get to those resources."*
>
> *"A lot of people are having such a hard time getting a hold of, like, [government agency]. I've heard people call and call. You put your request in for a call back. You never get a call back. There's just no communication. And I don't feel like there's really a willingness to help either."*

There are social ramifications to living in poverty as well, as a community member pointed out. It is difficult for families to spend time together when parents must work multiple jobs to maintain financial stability.

> *"And people working multiple jobs to bridge the gap between the generations, [there's a gap] between parents and their kids. It's hard to see the kids because I'm working multiple jobs and my kid goes to bed before I come back from work. Stuff like that creates this huge gap among ourselves."*

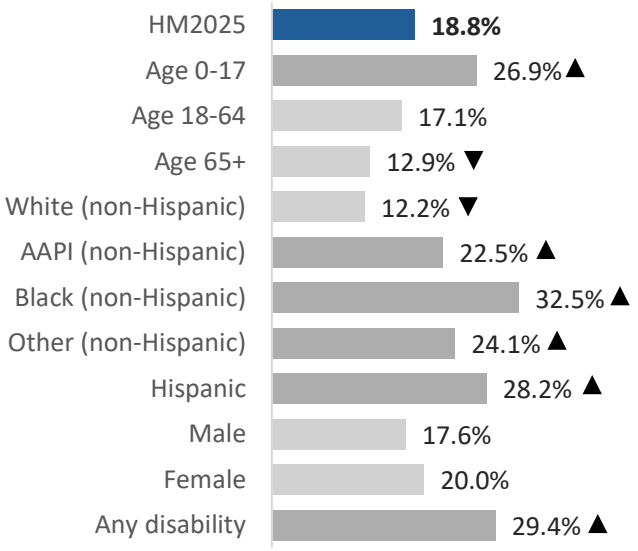
Overall, the median household income among Franklin County residents is higher than Ohio residents overall but lower than US residents overall. However, after adjusting for inflation, the average household income in Franklin County for HM2025 is *slightly less* than what was observed six years ago (i.e., HM2019).

Children, non-white individuals (especially those who are black non-Hispanic, those who are Hispanic, and those who have an other non-Hispanic racial background), and disabled individuals are at increased risk of living near or below the federal poverty level.

Median Income

	Average income	Adjusted for inflation
HM2025	**$69,681**	**$69,681**
HM2022	**$64,713**	**$76,170**
HM2019	**$56,055**	**$70,100**
Ohio	**$65,720 ▲**	**$65,720**
US	**$74,755 ▲**	**$74,755**

Less than 125% Federal Poverty Level

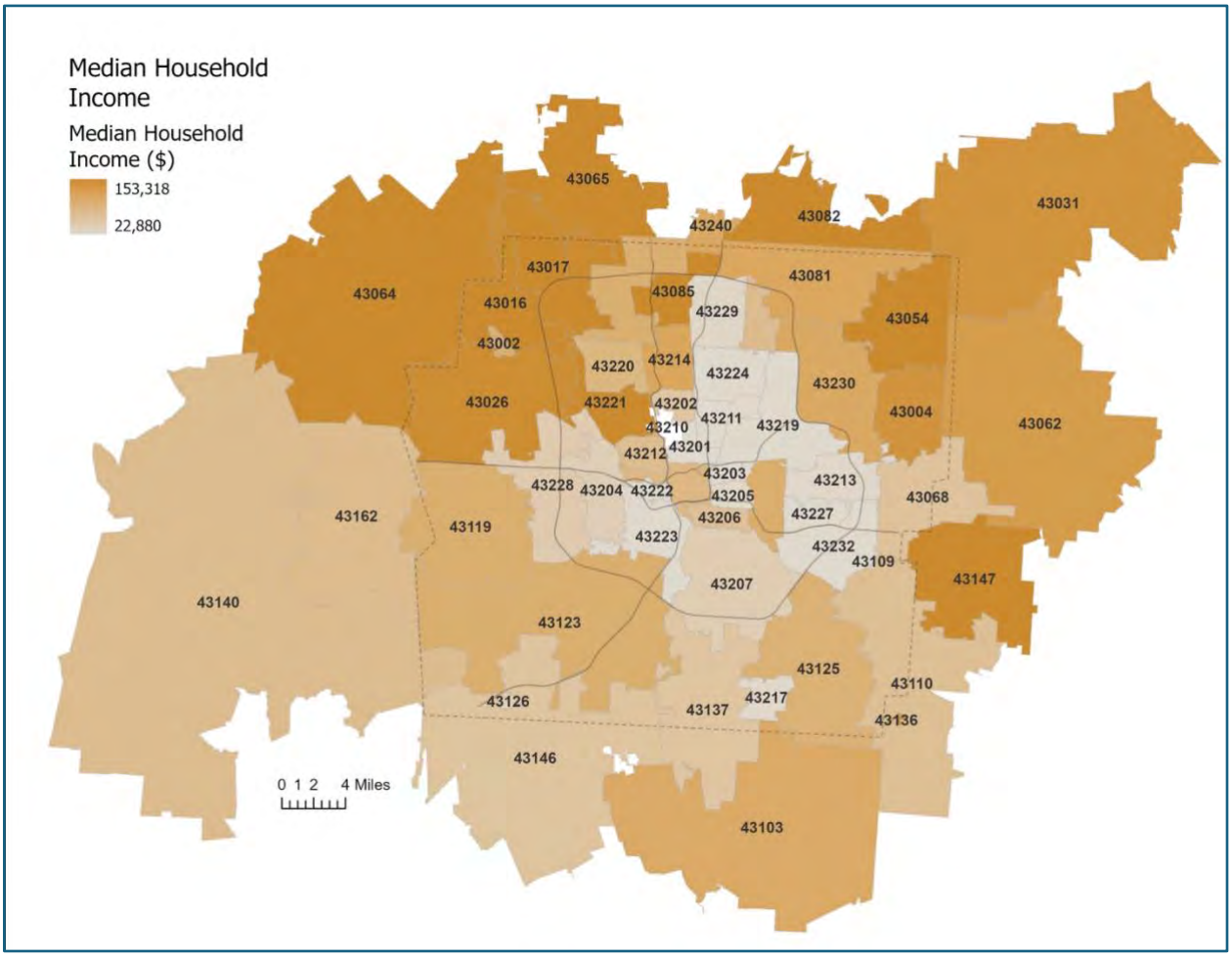


As shown below, income distribution near a variety of federal poverty level thresholds has remained relatively consistent over time. Compared to both the United States and Ohio, Franklin County does have a slightly higher proportion of people in the below 125% bracket.

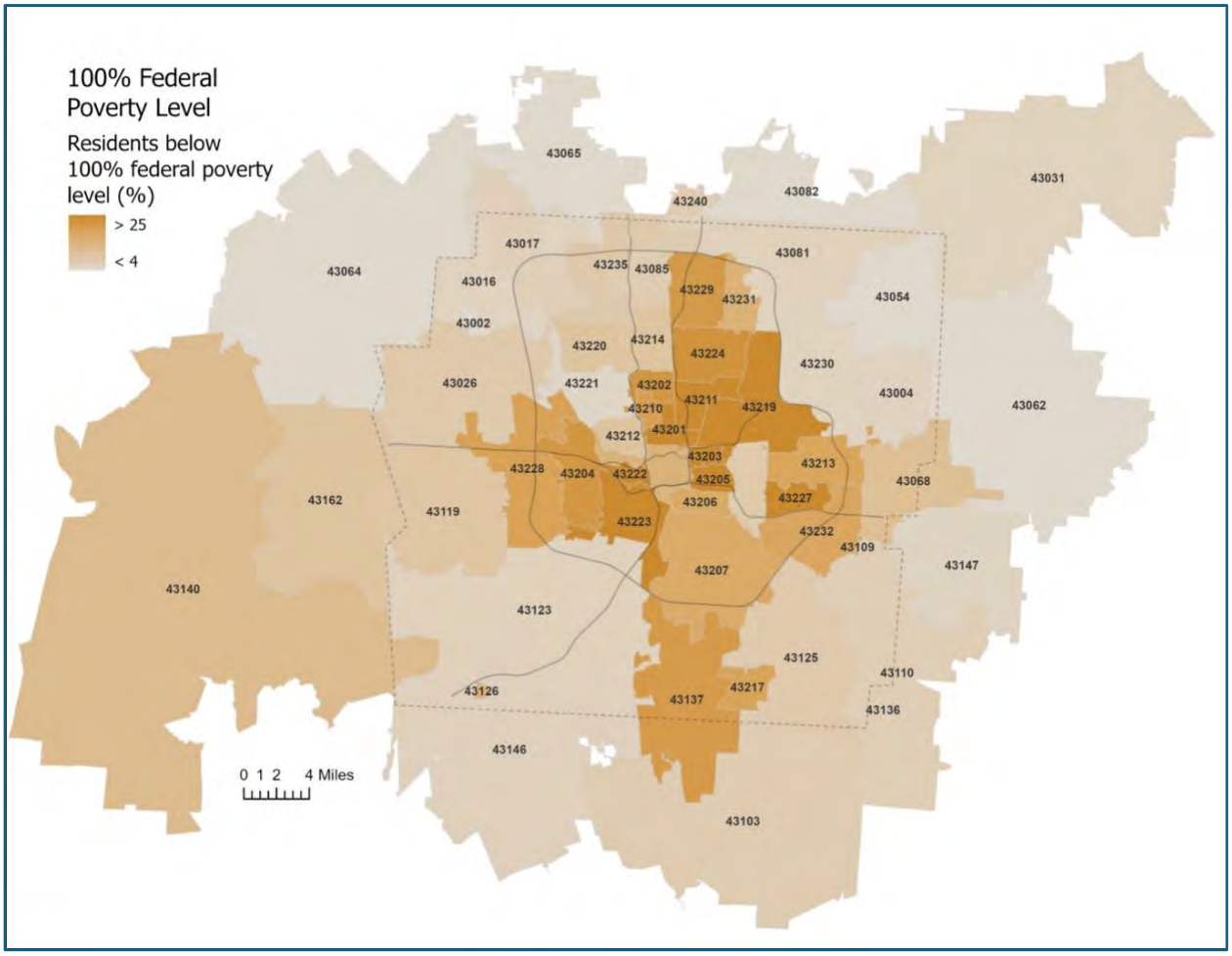
Income Distribution

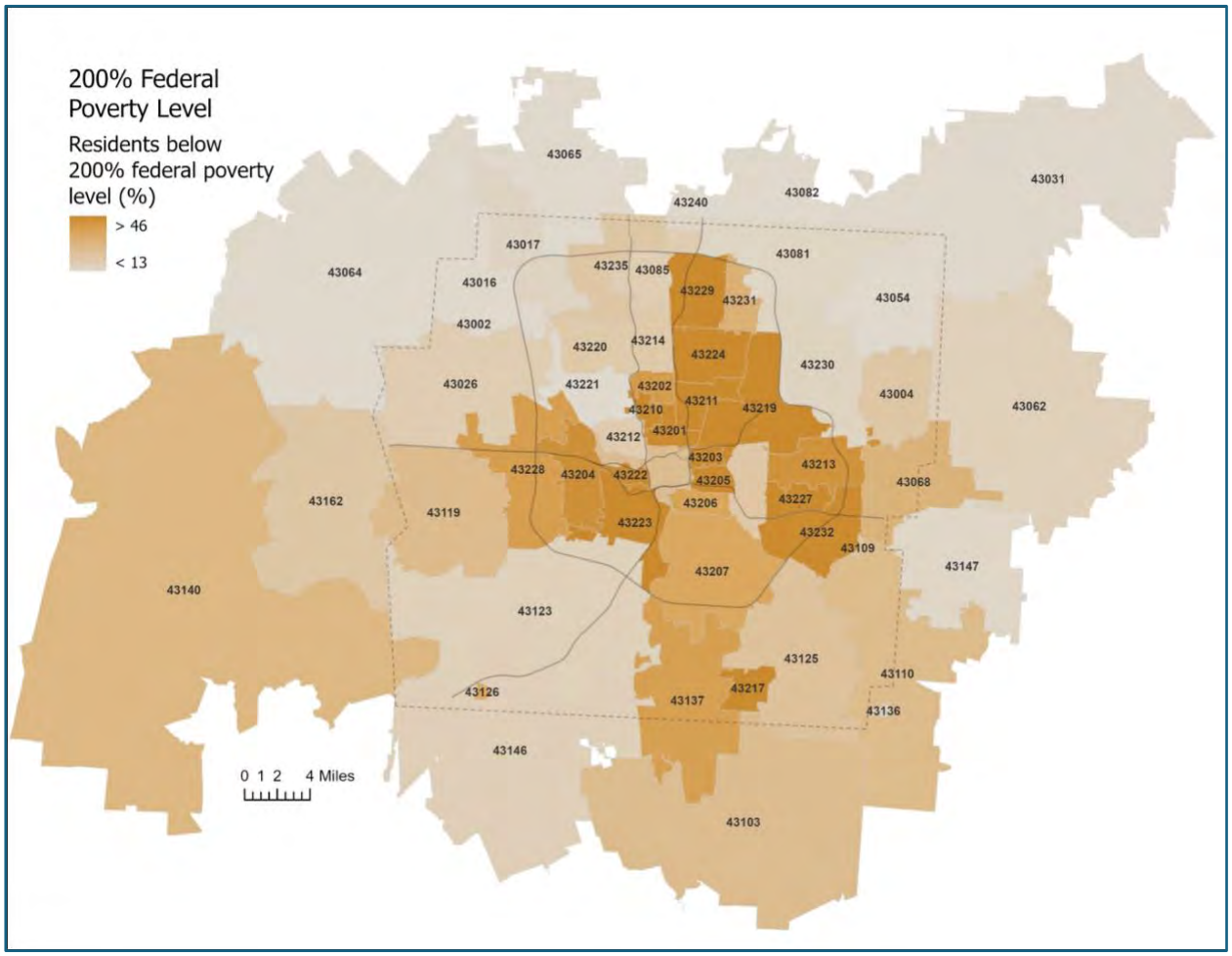
	Below 125% FPL	125%-200% FPL	200% FPL or Below	201%-400% FPL
HM2025	**243,546 (18.8%)**	**147,662 (11.4%)**	**391,208 (30.3%)**	**377,029 (29.2%)**
HM2022	**227,330 (17.7%)**	**162,267 (12.6%)**	**389,597 (30.3%)**	**379,629 (29.5%)**
HM2019	**263,627 (21.4%)**	**143,589 (11.7%)**	**407,216 (33.0%)**	**365,366 (29.6%)**
Ohio	**1,955,282 (17.0%)**	**1,400,699 (12.2%)**	**3,355,981 (29.3%)**	**3,653,884 (31.8%)**
US	**53,141,624 (16.3%)**	**39,178,320 (12.1%)**	**92,319,944 (28.6%)**	**96,703,365 (29.9%)**

As shown in the map below, the zip codes with the lowest median household incomes are concentrated in the north-central part of Franklin County (e.g., 43229, 43224, 43211, 43219), some eastern zip codes (e.g., 43213, 43227, 43232), and some central zip codes (e.g., 43222, 43223).



The next two maps show the percentage of central Ohio residents in each zip code who have an income that is (1) below 100% of the federal poverty level and (2) below 200% of the federal poverty level. Each map tells a similar story: zip codes located in the central-east and central-north areas of Franklin County have greater percentages of residents in poverty.





Additional Information & References

Readers who are interested in learning more about this topic should also read the *HealthMap2025* section that focuses on individuals with disabilities (see page 65).

Data about income and poverty were obtained from the American Community Survey (ACS).[5-7] For *HealthMap2025*, special attention is paid to median income, the percent of individuals near or below the Federal Poverty Level (FPL) as determined by the U.S. Census Bureau, and the number of individuals at specified income brackets.

The income categories 125-200% and 200-400% of the FPL were calculated by subtracting the numbers for 200%-125% and 400%-200%, respectively. Total numbers at each income category were converted into percentages by dividing by the total number for which poverty status was determined in the applicable geographic unit and year.

$$\%(125 - 200\%\ FPL) = \frac{[(n = 200\%FPL) - (n = 125\%FPL)]}{Total\ population\ for\ whom\ poverty\ status\ is\ determined}$$

For example, the HM2025 Franklin County estimate for those with an income at or below the 125-200% FPL was calculated as follows:

$$11.4\% = \frac{[391{,}208 - 243{,}546]}{1{,}290{,}258}$$

The Bureau of Labor Statistics CPI Inflation Calculator[8] was used to adjust the average income values for HM2022 and HM2019 for inflation.

To map the prevalence of these indicators at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the Census Bureau's American Community Survey.[9]

[1] Bosworth B. (2018). Increasing Disparities in Mortality by Socioeconomic Status. *Annual review of public health*, *39*, 237–251. https://doi.org/10.1146/annurev-publhealth-040617-014615

[2] Robert, S. A., Cherepanov, D., Palta, M., Dunham, N. C., Feeny, D., & Fryback, D. G. (2009). Socioeconomic status and age variations in health-related quality of life: results from the national health measurement study. *The journals of gerontology. Series B, Psychological sciences and social sciences*, *64*(3), 378–389.

[3] Kivimäki, M., Batty, G. D., Pentti, J., Shipley, M. J., Sipilä, P. N., Nyberg, S. T., Suominen, S. B., Oksanen, T., Stenholm, S., Virtanen, M., Marmot, M. G., Singh-Manoux, A., Brunner, E. J., Lindbohm, J. V., Ferrie, J. E., & Vahtera, J. (2020). Association between socioeconomic status and the development of mental and physical health conditions in adulthood: a multi-cohort study. *The Lancet. Public health*, *5*(3), e140–e149. https://doi.org/10.1016/S2468-2667(19)30248-8

[4] Begley, C., Basu, R., Lairson, D., Reynolds, T., Dubinsky, S., Newmark, M., Barnwell, F., Hauser, A., & Hesdorffer, D. (2011). Socioeconomic status, health care use, and outcomes: persistence of disparities over time. *Epilepsia*, *52*(5), 957–964. https://doi.org/10.1111/j.1528-1167.2010.02968.x

[5] U.S. Census Bureau. (2022). Median Income in the Past 12 Months (in 2022 Inflation-Adjusted Dollars). *American Community Survey, ACS 1-Year Estimates Subject Tables, Table S1903*. https://data.census.gov/table/ACSST1Y2022.S1903?q=Income and Poverty&g=010XX00US_040XX00US39_050XX00US39049.

[6] U.S. Census Bureau. "Selected Characteristics of People at Specified Levels of Poverty in the Past 12 Months." *American Community Survey, ACS 1-Year Estimates Subject Tables, Table S1703*, 2022, https://data.census.gov/table/ACSST1Y2022.S1703?q=s1703&g=010XX00US_040XX00US39_050XX00US39049.

[7] U.S. Census Bureau. (2022). Poverty Status in the Past 12 Months. *American Community Survey, ACS 1-Year Estimates Subject Tables, Table S1701*. https://data.census.gov/table/ACSST1Y2022.S1701?q=s1701&g=010XX00US_040XX00US39_050XX00US39049.

[8] U.S. Bureau of Labor Statistics. CPI Inflation Calculator. Accessed September 1, 2024 at https://data.bls.gov/cgi-bin/cpicalc.pl?

[9] U.S. Census Bureau. American Community Survey 5-Year Estimates, 2022 (HM2025)

Housing Insecurity

Housing insecurity is associated with decreased healthcare access, increased hospital and emergency department utilization, and worse overall health.[1,2] When individuals must focus on basic needs such as housing, the seemingly "secondary" needs of healthcare may be neglected and cause further downstream health challenges.

31.9% of Franklin County households spend at least 30% of income on **housing**.

↑ Up from HM2022 (28.2%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Unavailable	Unavailable	Unavailable	Observed (see map)

47.5% of Franklin County households are **renting** their housing.

≈ Similar to HM2022 (46.6%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Unavailable	Unavailable	Black, Hispanic more likely	Observed (see map)

2,337 Franklin County residents are **unhoused**.

↑ Up from HM2022 (2,036)

There were **8.7 eviction filings per 100 renter-occupied households in** Franklin County.

↑ Up from HM2022 (7.5)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Unavailable	Unavailable	Unavailable	Observed (see map)

Community Voices

Community members believe it is far too difficult to find an affordable apartment, due not only to the cost of rent, but also to the stipulations of being accepted for low-income apartment options and apartments in general.

> *"I was in an apartment for 18 years, and they put a note on my door and said, we sold the apartment complex, and you have 60 days to move. I had just had surgery, and I found my new apartment, and it was $800 more than what I was paying. And it was the cheaper option. And they sold my apartment to make it low-income housing. But I was out of range for that apartment. But then I wind up paying almost double what I was paying in the old apartment. And it's smaller. I had to rent a garage because I couldn't even fit everything I had in the new apartment, but I'm paying almost double. The pricing is ridiculous."*
>
> *"If you go to just a regular apartment complex and you try to get an apartment, they want you to have a 720 credit score and they want you to have three times the amount of rent every month. And it's like, I don't know anybody who can pay $1,500 or $1,800 and have three times that amount of money a month…and the amount to move in which is like six or seven thousand, because you have to have first month's rent, last month's rent, and security deposit."*

Community members see housing being purchased in their communities by outside investors and say this contributes to the inability of people to buy homes in Franklin County.

> *"There's a guy over here. His name is on everything. I looked him up. He's an investor from New York, and he is buying up everything. Everything. And setting those prices stupid high…I asked the mayor, why can't you guys control [that]? They can't control who buys. I don't know why, but I think that's a horrible thing."*
>
> *"Half of the housing has been bought up by corporations to rent them out. They'll come in all cash, 20% above asking. There's no way in which a person can afford to buy."*
>
> *"Even here on the South Side, it's a lot of gentrification. Houses over here on Thurman Ave, back in the day, you could easily get one of those houses. Now there's nowhere for regular working folks to go."*

Community members believe the quality of housing that is more "affordable" is in poor condition; structural, aesthetic, and security issues go unaddressed by landlords, and the environment overall negatively impacts mental and physical health.

"Say you don't have the money to get the thing that you want. So you only make $1,000 in your paycheck. So you can only afford $500. But the $500 [place], the wall is coming down, the paint peeling. The landlord doesn't care about what it looks like. So now you're living in something that you really don't want to be there. You're stressing about it. 'Oh my God, I need to get out of here. But I can't afford to get out of here.'"

"From what I heard, they're closing all the housing down because they haven't been taking care of it. They've been ran down. Yeah there's affordable housing. At what price? You don't have running water, the hot water goes out, or the locks don't work. And then what? Then you got the people that live there who don't care, who just terrorize the neighborhood. So do you want to live [in] affordable housing where you might get shot when you walk outside, you might have mice, the health department might not even come when you call them? It's one thing if it's just you, but if you got your family, you got kids, you don't want your kids to live like that."

"A lot of these affordable housing units don't have access to doctor's offices that you can get to using public transportation or by walking, or even grocery stores. You can't get fresh food. And so it becomes really difficult for people who maybe don't always have access to a car to get to places where they can take care of their physical or mental health or have access to other things that will improve those things."

"So landlords are just renting and the places are terrible, which is affecting the kids. We have them sign they don't have a lead-based paint, but it doesn't matter because they're not even really doing the repairs, the plumbing. They're letting water sit and kids are coming in with asthma. Our clients have something with the lungs because of black mold. The lack of affordable housing [relates to] the health disparities, especially in the black and brown communities."

Community members also spoke to the difficulty of finding accessible housing for individuals with mobility issues. This causes extra stress on caretakers and can cause unhoused individuals to spend more time in shelters due to the lack of accessible housing in the county.

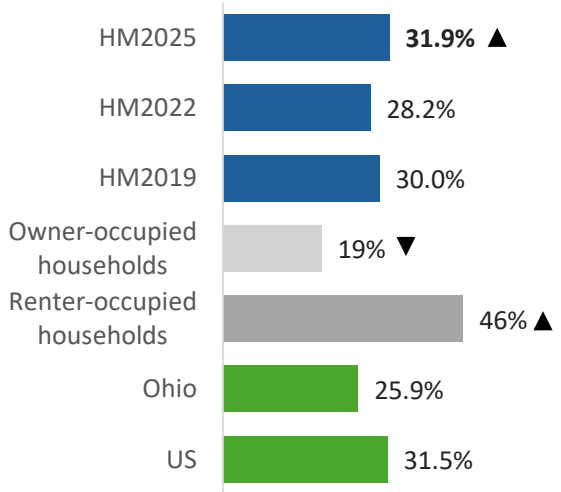
"I work for the homeless shelter, so when it comes to housing, the ones that are on canes, using walkers, it's very hard to find handicap accessible housing. It's not that many options. And the ones that are, they're already filled. So we might have someone who is on a walker who, their stay might be a year and a half because we've been looking for handicapped accessible housing."

> *"Finding housing that's even suitable for somebody who has a lot of healthcare issues has been hard. For example, my mom, she has mobility issues and can't do steps. So finding a ranch home or something just one story was really hard for a long time. And then once you do find a one-story place, you need hallways to be wider to get wheelchairs through. And then you need shower stalls. So I think just in general, if you're disabled and you need housing, where can you find something that's accessible to your needs? That's really hard."*

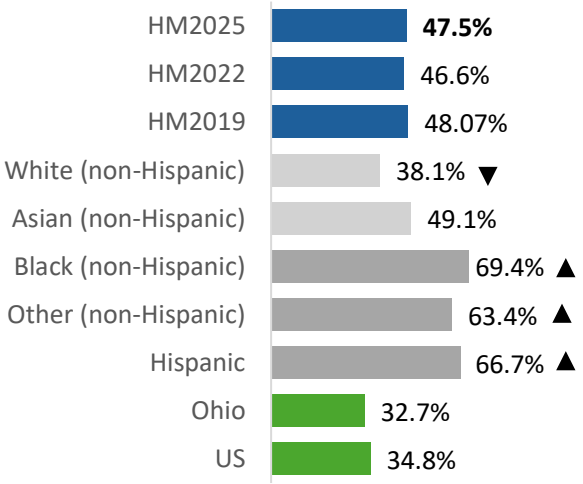
Unfortunately, housing insecurity has not improved since *HealthMap2022*. The percentage of cost-burdened households – those that spend 30% or more of their monthly household income on housing costs – has increased. Furthermore, nearly half of renter-occupied households in Franklin County are cost-burdened.

Homeownership offers an opportunity to for individuals and families to build wealth and economic security.[4] Unfortunately, significant racial disparities were noted among those who don't yet live in (or choose not to live in) owner-occupied housing. Black (non-Hispanic) individuals, Hispanic individuals, and individuals with an other (non-Hispanic) racial background were more likely than white (non-Hispanic) individuals or individuals with an Asian racial background to be renters.

Cost Burdened Households (≥30%)



Renter-occupied Housing Units



The most recent "point-in-time" estimate of unhoused individuals in Franklin County found that this number has increased substantially compared to previous years. Relatedly, the eviction rate in Franklin County has increased since *HealthMap2022* and is above the state average. Per data provided by the Franklin County Municipal Court and collated by the Eviction Lab[3], there were 23,762 evictions in 2023, a 14% increase from 2022.

Unhousked Community Members

	Point in Time Estimate
HM2025	2,380 ▲
HM2022	2,036
HM2019	1,229
Ohio	11,386
US	653,104 ▲

Eviction Filing Rate

	Rate per 100 renter households
HM2025	8.7% ▲
HM2022	7.5%
Ohio	6.2%

Healthy People 2030

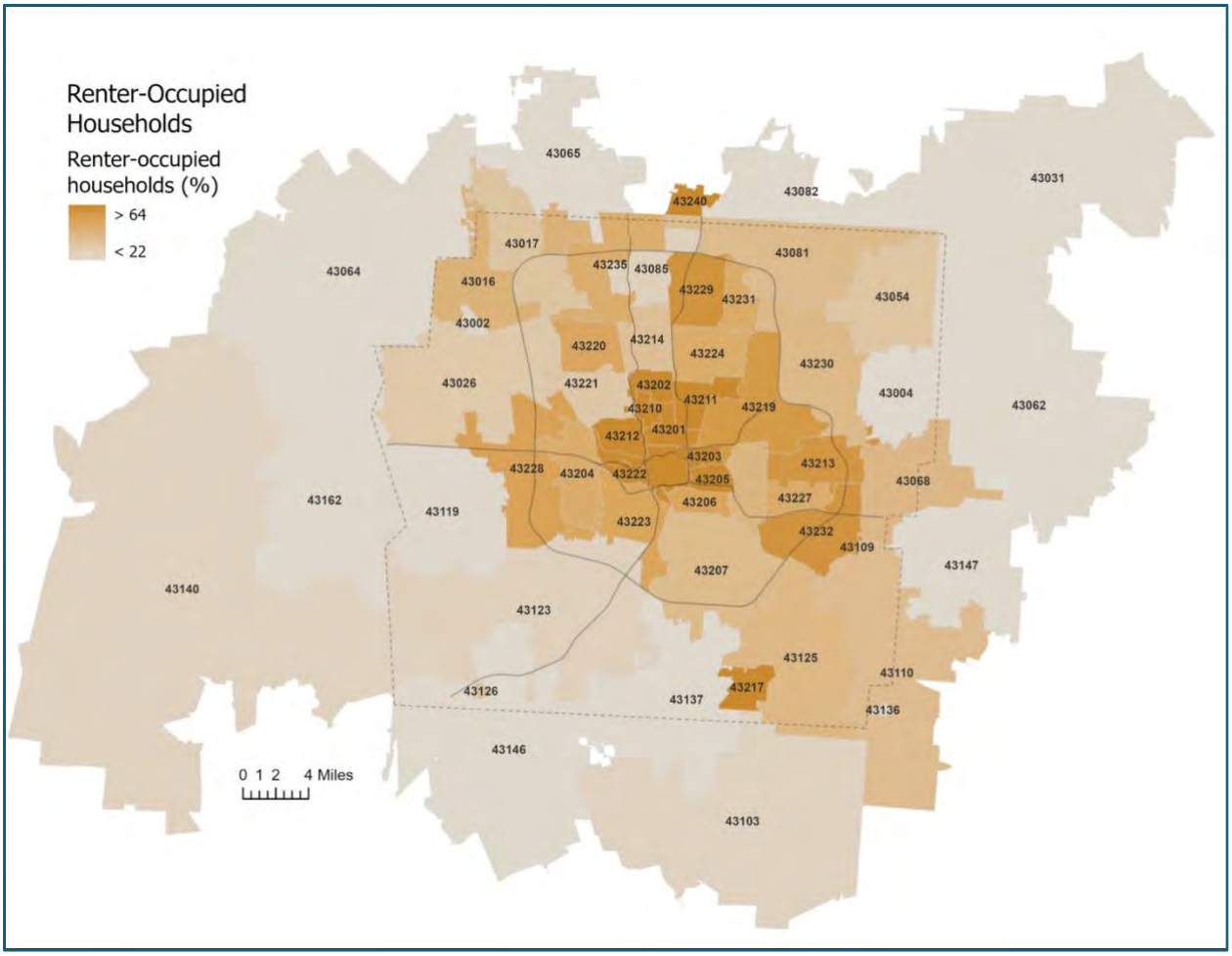
Unfortunately, Franklin County is moving further away from the Healthy People 2030 objective on housing cost burden.[5] Further intervention is likely needed to address this issue facing many Franklin County residents.

HP2030 objective for families spending ≥ 30% of income on housing: Not met

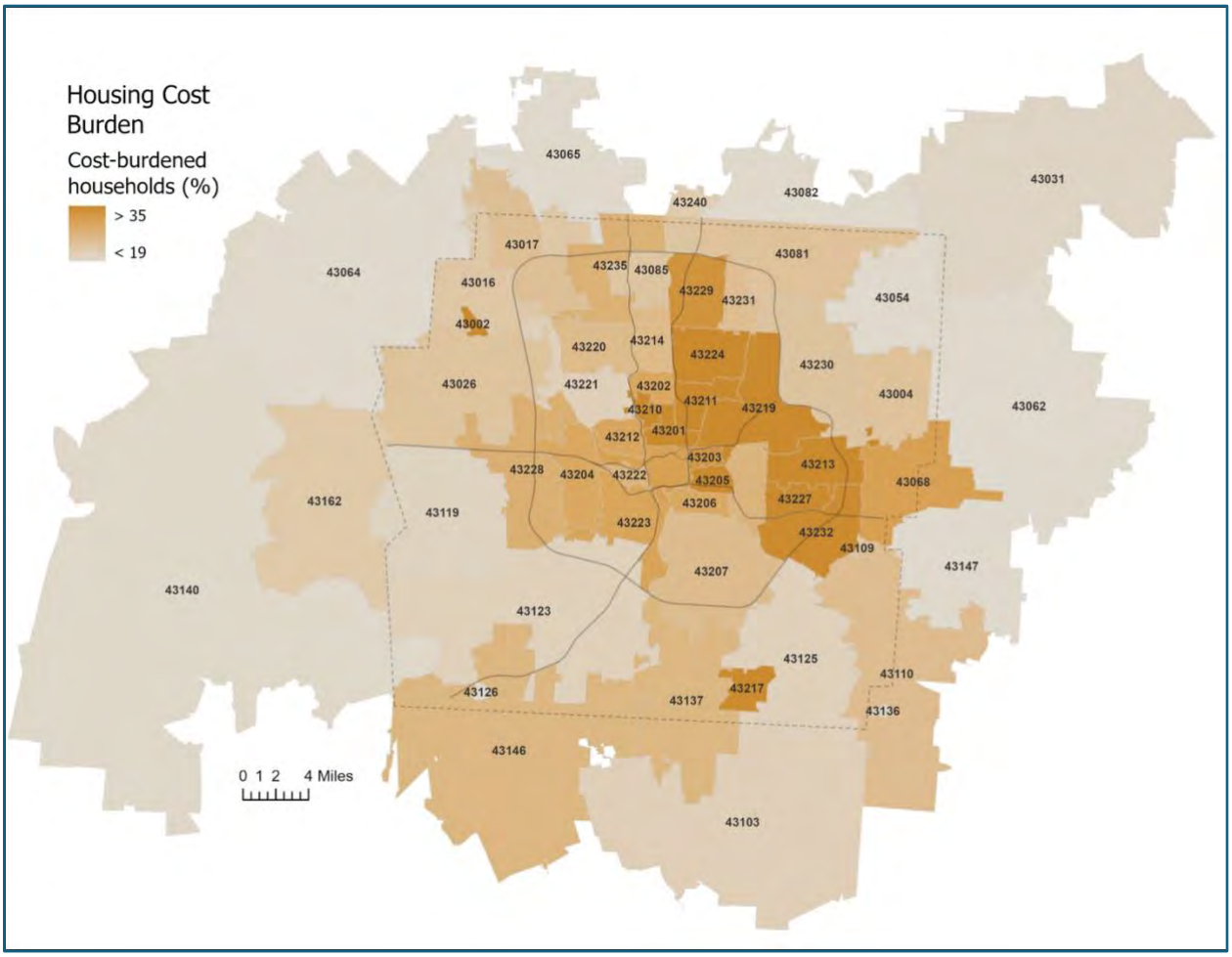
Healthy People Objective:
25.5%

Most recent Franklin County data (HM2025)
31.9%

As shown in the map below, the zip codes with the greatest percentage of renter-occupied housing units are concentrated in the central part of Franklin County (e.g., 43222, 43212, 43201, 43203, 43205, 43210, 43202, 43211).



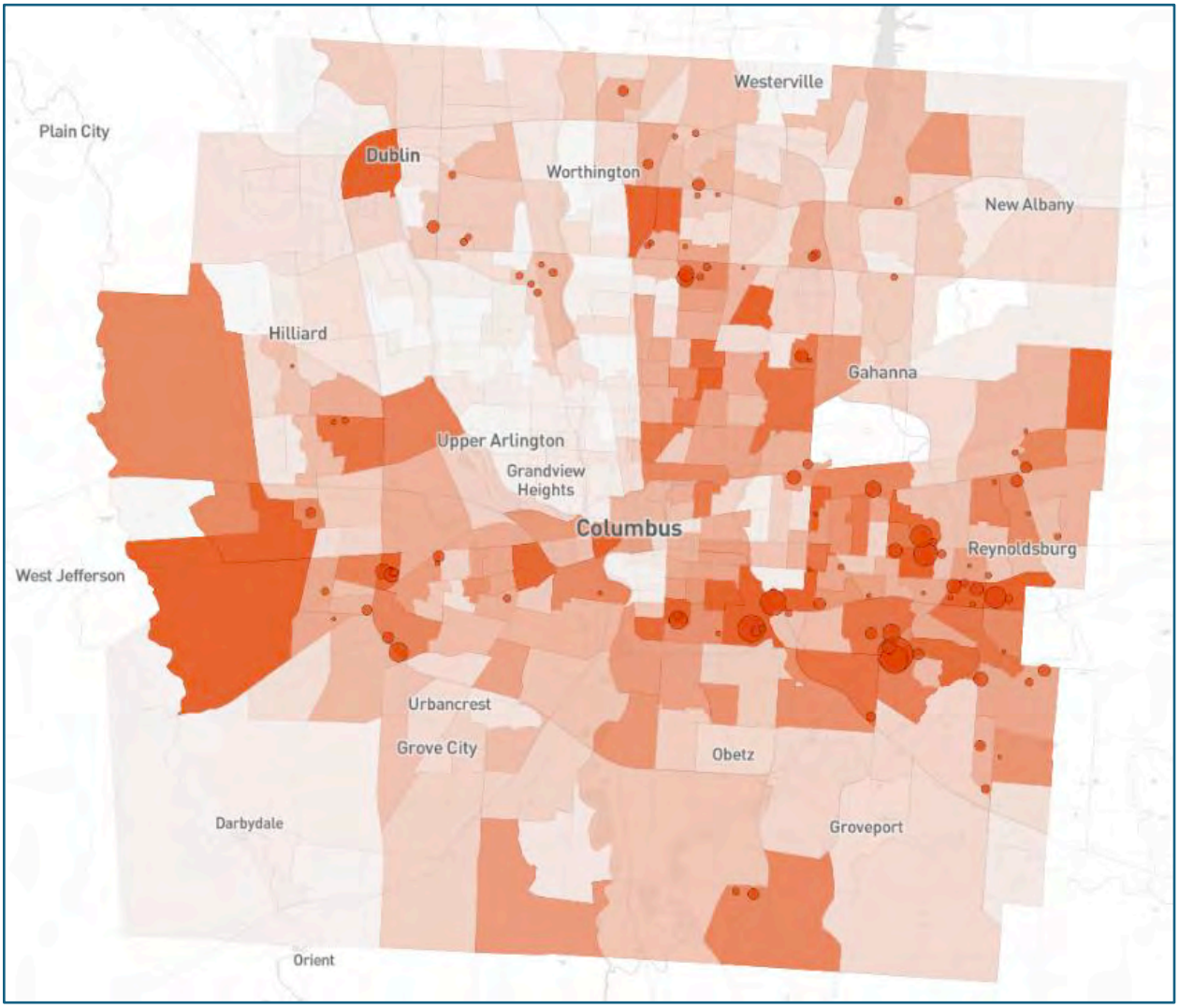
The zip codes with the greatest percentage of cost burdened households (i.e., an overall burden of 30% or higher) are concentrated in the eastern and north-central parts of Franklin County (e.g., 43213, 43227, 43232, 43219, 43211, 43224).



The map below is a screenshot of the eviction filing rate across Franklin County's census tracts since August 1, 2023, as mapped by the Eviction Lab. Census tracts with relatively higher rates of eviction filings are shown in darker colors.

Additionally, the "top 100 eviction hotspots" in the county are shown in the map as circles, with each circle representing a building that had a relatively large number of eviction filings. As the size of a circle increases, the number of evictions associated with that building also increases. Within Franklin County, many eviction hotspots are in east-central and far eastern census tracts (corresponding roughly to zip codes 43205, 43206, 43213, 4327, 43232, and 43068) as well as in western census tracts (corresponding roughly to zip codes 43228, 43123, 43119).

Readers who are interested in learning more about this topic are encouraged to visit the Eviction Lab's interactive map, which can be accessed by **clicking here**.



Additional Information & References

Readers who are interested in learning more about this topic should also read the *HealthMap2025* section that focuses on individuals with disabilities (see page 65).

Data about housing insecurity were obtained from the American Community Survey.[6,7] To assess the count of unhoused individuals, Point-In-Time (PIT) estimates were sourced from the Community Shelter Board of Franklin County and the U.S. Department of Housing Annual Homeless Assessment Report to Congress.[8,9] In this assessment, "unhoused" includes sheltered, unsheltered, and transitional housing residents. Eviction data were obtained from the Ohio Housing Finance Agency and from the Eviction Lab.[3,10,11]

Readers should be cautious when comparing estimates between different geographic regions such as Franklin County and Ohio. For example, estimates of people in renter-occupied housing may differ simply due to how Franklin County is largely a dense, urban/suburban area. The statewide estimate, of course, includes many rural areas that are less populated as well as highly populated urban/suburban areas.

The eviction filing rate is the number of new eviction filings per 100 renter-occupied households. Unfortunately, there are no centralized, recent sources of eviction data at the national level. At the time of this report's writing, the best source for information at that geographic level was the Eviction Lab, which offered nationwide estimates from 2018.

To map the prevalence of these indicators at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the Census Bureau's American Community Survey.[12]

[1] Bhat, A. C., Almeida, D. M., Fenelon, A., & Santos-Lozada, A. R. (2022). A longitudinal analysis of the relationship between housing insecurity and physical health among midlife and aging adults in the United States. *SSM - population health*, *18*, 101128. https://doi.org/10.1016/j.ssmph.2022.101128

[2] Kushel, M. B., Gupta, R., Gee, L., & Haas, J. S. (2006). Housing instability and food insecurity as barriers to health care among low-income Americans. *Journal of general internal medicine*, *21*(1), 71–77. https://doi.org/10.1111/j.1525-1497.2005.00278.x

[3] Eviction Lab. Eviction Tracking > Columbus, OH. https://evictionlab.org/eviction-tracking/columbus-oh/

[4] Urban Institute. (2021). Tracking Homeownership Wealth Gaps. https://apps.urban.org/features/tracking-housing-wealth-equity/

[5] Healthy People 2030 objective SDOH-04, U.S. Department of Health and Human Services

[6] U.S. Census Bureau. (2022). Financial Characteristics. American Community Survey, ACS 1-Year Estimates Subject Tables, Table S2503. https://data.census.gov/table/ACSST1Y2022.S2503?q=housing&g=010XX00US_040XX00US39_050XX00US39049.

[7] U.S. Census Bureau. (2022). Demographic Characteristics for Occupied Housing Units. American Community Survey, ACS 1-Year Estimates Subject Tables, Table S2502. https://data.census.gov/table/ACSST1Y2022.S2502?q=housing&g=010XX00US_040XX00US39_050XX00US39049&y=2022.

[8] Community Shelter Board. (2023). *Columbus region leaders introduce new action on homelessness*. https://www.csb.org/cdn/files-Columbus-region-leaders-introduce-new-action-as-data-shows-increase-in-homeless-count.pdf

[9] De Sousa, T., Andrichik, A., Cuellar, M., Marson, J., Prestera, E., & Rush, K. (2022). *The 2022 annual homelessness assessment report (AHAR) to Congress.* US Department of Housing and Urban Development.

[10] Ohio Housing Finance Agency. (2023) FY 2024 Housing Needs Assessment [Interactive Tool]. Retrieved in 2024 from https://ohiohome.org/research/housinginsecurity-23.aspx

[11] Ohio Housing Finance Agency. (2021) FY 2021 Housing Needs Assessment [Interactive Tool]. Retrieved in 2024 from https://ohiohome.org/research/housinginsecurity-hna.aspx

[12] U.S. Census Bureau. American Community Survey 5-Year Estimates, 2022 (HM2025)

The Eviction Lab's interactive map can be accessed at https://evictionlab.org/eviction-tracking/columbus-oh/.

Food Insecurity

Food insecurity increases the risk for a variety of physical and psychological illnesses, including heart disease and depression.[1,2] This risk is particularly notable for children, who are at risk for developmental and health consequences related to prenatal and early childhood food insecurity.[3]

13.5% of Franklin County residents experience **food insecurity**.

≈ Similar to HM2022 (12.8%)

Community Voices

Community members emphasized that being able to source and prepare healthy foods is related to income status. While the expense of healthy food is one thing that precludes food security, the energy and time it takes to ensure that their families eat healthy also hinders families' efforts to eat nutritious meals.

> *"It takes a certain amount of bandwidth to deal with nutrition. Like if you're already worn out from your day working and you have all these other stresses going on, and you might not necessarily have the finances to buy the more expensive food that's organic or healthier for you…So in our experience, you only have so much energy, whether it's physical, emotional… and you spend it where you spend it. Maybe it would better to spend it on nutrition, but that's usually the last thing or one of the last things that we think about."*
>
> *"In my family, I've seen children who are in a lower income status that [their] parents have to work these multiple jobs, so then they're left to their own devices of microwavable things, air fry things, quick things. So then you're not getting proper nutrition. So then your brain is not even really developing to be of attention at school. So it's all connected."*

Many community members mentioned that their neighborhoods in Franklin County are still healthy food deserts, because grocery stores and healthy restaurant options are not accessible within a short distance of their homes. Residents also mentioned that the quality and variety of healthy food sold by grocery stores is lacking in lower income communities as compared to more affluent communities.

> *"I noticed in my neighborhood, I'm not in a bad area, but it's a lot of fast food and fried stuff. So, when we go out to eat, we go to Bexley, eight minutes' drive west of us. We go there. I grocery shop there. I do everything there."*

"This [grocery store] down here is like the nearest thing to me that has a variety, but they don't have that much either. They limit what we can get there. If you go to another [grocery store], they've got so much more."

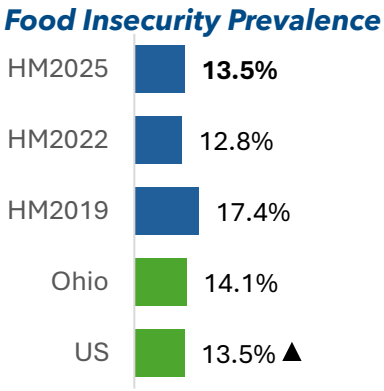
"A grocery store is here, but it's far away from the inner community, so they either have to have somebody bring it to them, or they have to drive. It's not within walking distance. And then there's not a lot of fresh stuff. Like, everything is packaged or processed."

Personal work schedules and transportation issues also contribute to the ability of community members to access nutritious food easily.

"I get off work usually late at night, sometimes 10:00 p.m., even later. There's very few restaurants open that late, especially on weekdays. And your choices if you need to pick up a bite to eat on the way home from work are—since the pandemic, most restaurants I used to go to, they've cut their hours just in order to save money, but that doesn't help me."

"I didn't have a car for three months, and I found myself trying to figure out dinner from Family Dollar because it was the only thing I could walk to. Sometimes you just can't get to some of the other places to do that."

Although food insecurity prevalence in Franklin County has improved since *HM2019* (which reported 2016 data), progress has seemingly stalled since *HM2022* (which reported 2019 data). The slight increase from *HealthMap2022* and *HealthMap2025* (which reports 2022 data) may be attributable in part to the onset of the COVID-19 pandemic, which disrupted food systems for many households. Food insecurity has risen significantly nationwide.



Healthy People 2030

As communities continue their recovery from the COVID-19 pandemic, Franklin County's progress towards the Healthy People 2030 objective for reducing food insecurity should be monitored. [5]

HP2030 objective for Food Insecurity: Not met

Healthy People Objective:	Most recent Franklin County data (HM2025)
6%	**13.5%**

Additional Information & References

Readers who are interested in learning more about this topic should also read the *HealthMap2025* section that focuses on individuals with disabilities (see page 65).

Food insecurity data were gathered from the Feeding America interactive tool. That report estimates the percentage of individuals who lack access, at times, to enough food for an active, healthy life, per a set of variables that correspond with the U.S. Department of Agriculture's definition of "food security" as well as known risk factors.

Data Gap: The Community Health Needs Assessment Steering Committee requested recent data about the proportion of residents who qualify for WIC but who are not enrolled. Unfortunately, the Ohio Department of Health does not currently have a method for estimating the number of eligible WIC participants at the county level; such an estimate can only be generated for the state overall.

[1] Parekh, T., Xue, H., Cheskin, L. J., & Cuellar, A. E. (2022). Food insecurity and housing instability as determinants of cardiovascular health outcomes: A systematic review. *Nutrition, metabolism, and cardiovascular diseases : NMCD*, *32*(7), 1590–1608. https://doi.org/10.1016/j.numecd.2022.03.025

[2] Pourmotabbed, A., Moradi, S., Babaei, A., Ghavami, A., Mohammadi, H., Jalili, C., Symonds, M. E., & Miraghajani, M. (2020). Food insecurity and mental health: a systematic review and meta-analysis. *Public health nutrition*, *23*(10), 1778–1790. https://doi.org/10.1017/S136898001900435X

[3] Simonovich, S. D., Pineros-Leano, M., Ali, A., Awosika, O., Herman, A., Withington, M. H. C., Loiacono, B., Cory, M., Estrada, M., Soto, D., & Buscemi, J. (2020). A systematic review examining the relationship between food insecurity and early childhood physiological health outcomes. *Translational behavioral medicine*, *10*(5), 1086–1097. https://doi.org/10.1093/tbm/ibaa021

[4] Feeding America. (2022) Food Insecurity among the Overall Population in the United States [Interactive Map]. Retrieved in 2024 from https://map.feedingamerica.org/

[5] Healthy People 2030 objective NWS-01, U.S. Department of Health and Human Services

Health Insurance

Health insurance is a vital component of healthcare, particularly in the market-based healthcare model of the United States. Individuals who do not have insurance receive less and poorer quality healthcare, worse health outcomes, and a lower life expectancy.[1] A high proportion of uninsured patients also strains the healthcare system when services are used without subsequent payment, which can reduce overall healthcare availability in the community.[1]

92.4% of Franklin County residents are **insured**.

≈ Similar to HM2022 (92%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
18-64 less likely	Male less likely	Black, Hispanic less likely	Observed (see map)

Community Voices

Members of the community who have Medicaid or Medicare find it difficult to get reliable health care because many organizations do not accept their insurance, or they stop taking it.

> *"Most of our clients have Medicaid, but some of our clients are still under parents' insurance, which that doesn't help. So it doesn't matter if you have Medicaid or private insurance, because a lot of the places that accept private insurance, they don't accept Medicaid, or they accept Medicaid, but they don't accept private insurance. And either way, the waitlist is over six months."*
>
> *"When I moved here trying to get a counselor, I found a counselor and I have insurance from my retirement which is Medicare, but through an employer. So it's decent insurance. Well, then they stopped taking it."*

Community members spoke about the difficulty of affording medications whether they do or do not have insurance.

> *"I have a friend who has to work a second job just for her insulin, just to pay for her insulin. Like, that's it. Her primary job is a good job."*
>
> *"Not being able to afford certain medications or you have a certain medication, they take you off that medication because they can't cover it anymore."*

> *"One of the medications that I was on when we lost our insurance and we didn't have any insurance, it was $1,646 for one month. So obviously, I stopped taking it, and I couldn't even afford to go to the doctor to get a replacement sort of thing. So it's ridiculous how much things cost."*
>
> *"You have to go through this step-by-step process for the insurance to cover it."*

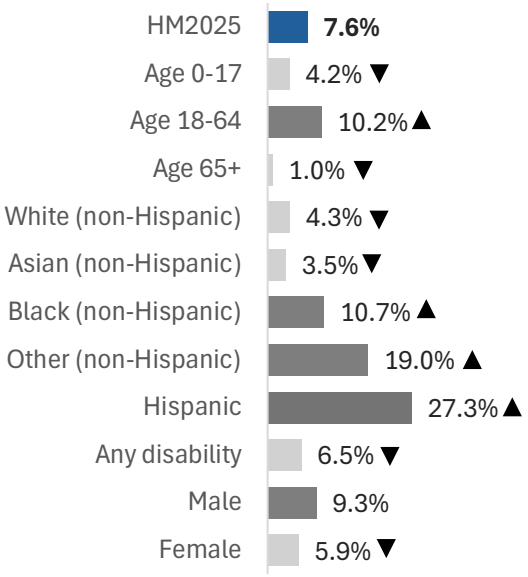
Franklin County residents also perceive that the quality of health care they receive depends on their health insurance. Specifically, they think those with Medicaid are more likely to experience rudeness from medical staff and inadequate treatment.

> *"Because they know that you're on Medicaid, 'Oh this your fifth baby. We tired of you.' I'm a staff member. I see it so much. Because what happens is, 'Is this your fifth baby? You should know what you're doing. You should get your tubes tied.' I've seen a lot of judgment."*
>
> *"I've had [this child] for a year now and with the insurance, you do get different treatment. I found out just last week that she has a brain bleed that has gone untreated for a whole year. So now I'm fighting with them about that. Like, why haven't we seen neurology? Why hasn't there been a follow up MRI or anything? So, yeah, I don't feel confident with the hospital. My kids always had private insurance. So when I would hear people tell me the horror stories about children and the care they've received, I was like, 'we don't go through that.' But since having her I've seen it."*

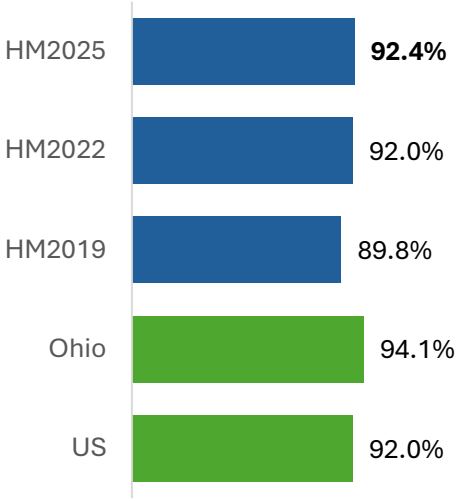
The vast majority of Franklin County residents are insured. The greatest disparities can be seen through the lenses of race and ethnicity, with Hispanic residents being significantly more likely to be uninsured than any other group. This may indicate the presence of cultural, language, or legal/political barriers. Adults age 18-64 are more likely to be uninsured than children or elderly people, which likely reflects the differences in eligibility for government-subsidized insurance plans.

Compared to Ohio or the United States, Franklin County has a higher rate of insured children as well as higher Group VIII Medicaid participation (i.e., an expansion that provided insurance access to adults who were between the ages of 19-64, who had an income less than 138% FPL, and who weren't eligible for another Medicaid category).

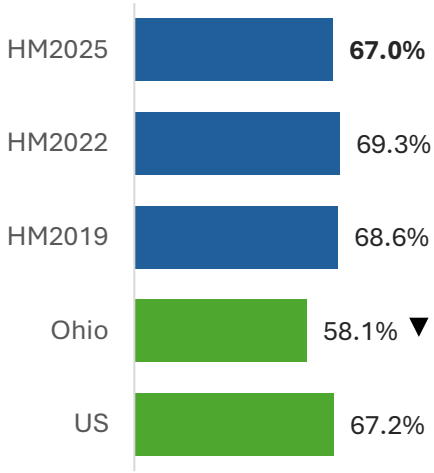
Uninsured Rate



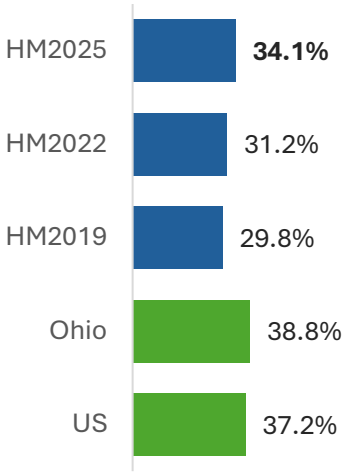
Insured Rate



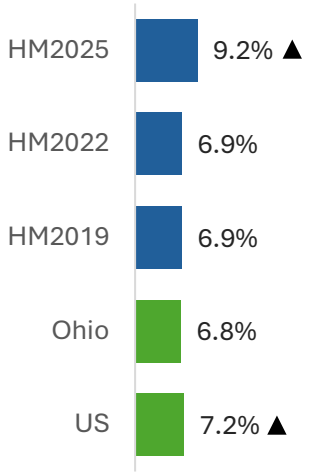
Private Health Insurance



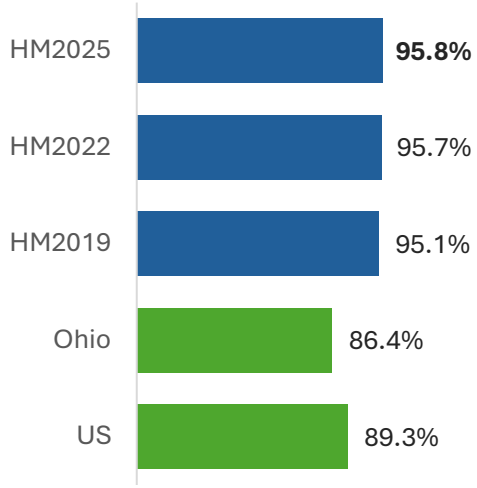
Public Health Insurance



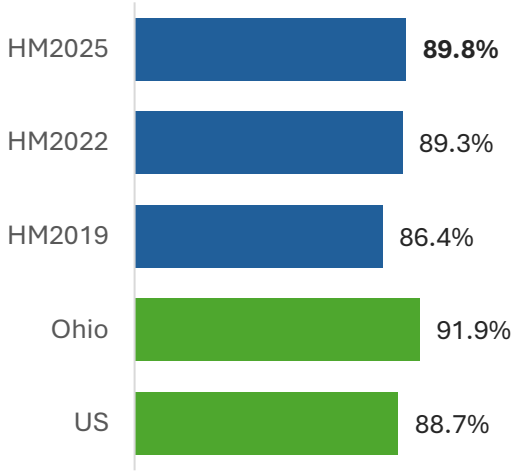
Group VIII Medicaid Insured



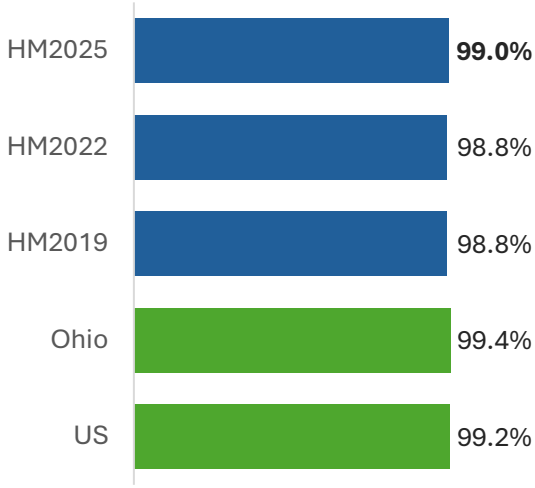
Insured Rate (ages 0-17)



Insured Rate (ages 18-64)



Insured Rate (ages 65+)



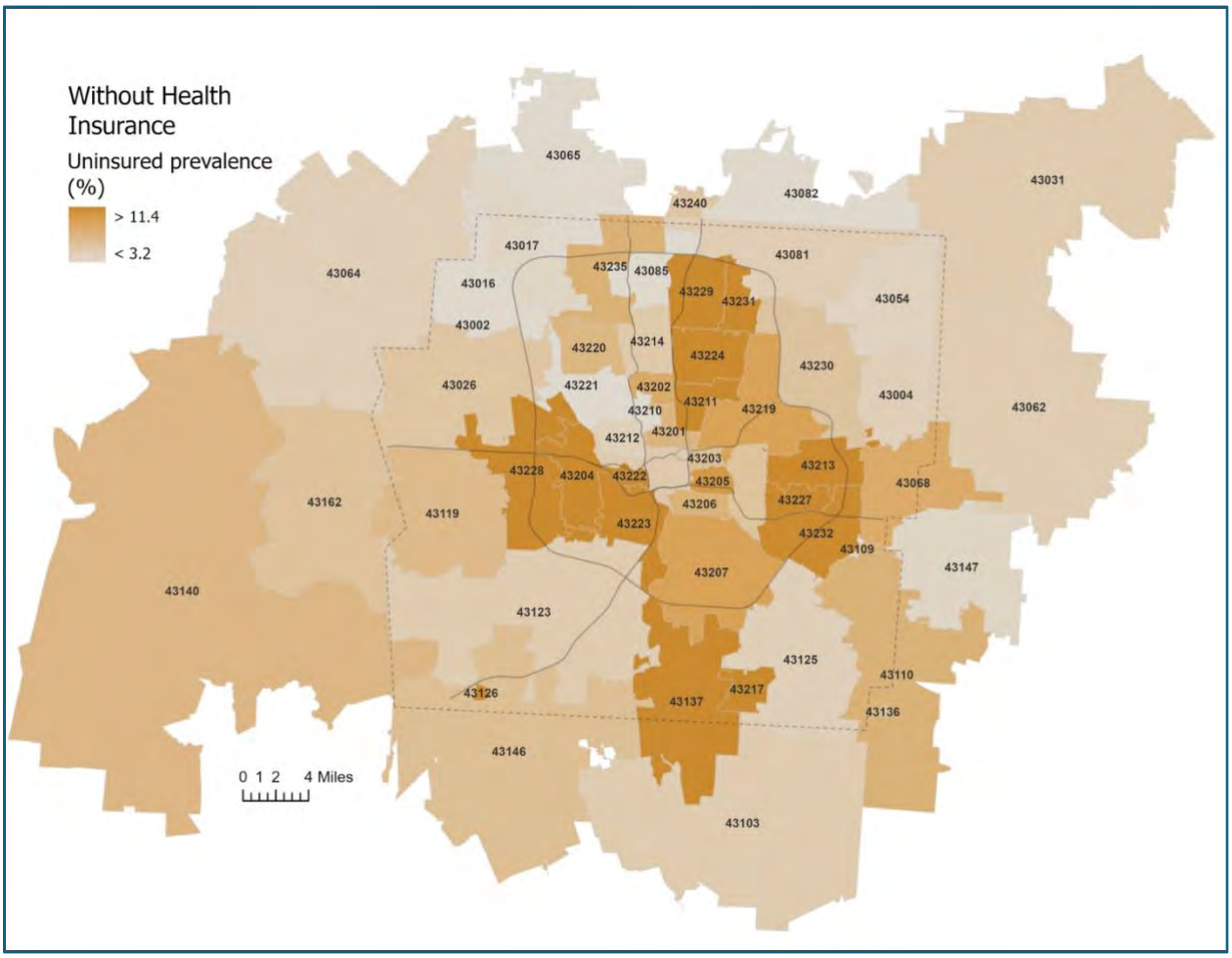
Healthy People 2030

Since HM2022, Franklin County has officially met the Healthy People 2030 objective for health insurance rates.[2] There is still progress to be made among adults age 18-64 as well as for racial and ethnic minorities, but this is a significant achievement for Franklin County.

HP2030 objective for proportion of people with health insurance: Met

Healthy People Objective:	Most recent Franklin County data (HM2025)
92.4%	**92.4%**

Franklin County zip codes with the greatest percentage of people without health insurance are concentrated in west-central zip codes (e.g., 43222, 43223, 43204, 43228), north-central zip codes (e.g., 43211, 43224, 43229, 43231), far eastern zip codes (e.g., 43213, 43227, 43232), and far southern zip codes (e.g., 43137, 43217).



Additional Information & References

To measure the insured status of residents, we used data from the American Community Survey.[3-5] For Medicaid Group VIII (Medicaid Expansion), we used the Ohio Department of Medicaid Annual Enrollment Dashboard and the federal Medicaid enrollment dataset.[6,7] The data for all metrics were collected for 2022, 2019, and 2016.

To map the prevalence of this indicator at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the Census Bureau's American Community Survey.[8]

[1] Institute of Medicine (US) Committee on the Consequences of Uninsurance. (2004). *Insuring America's Health: Principles and Recommendations*. National Academies Press (US).

[2] Healthy People 2030 objective AHS-01, U.S. Department of Health and Human Services

[3] U.S. Census Bureau. (2022). Selected Characteristics of Health Insurance Coverage in the United States. *American Community Survey, ACS 1-Year Estimates Subject Tables, Table S2701*. https://data.census.gov/table/ACSST1Y2022.S2701?q=s2701&g=010XX00US_040XX00US39_050XX00US39049.

[4] U.S. Census Bureau. (2022). Private Health Insurance Coverage by Type and Selected Characteristics. *American Community Survey, ACS 1-Year Estimates Subject Tables, Table S2703*. https://data.census.gov/table/ACSST1Y2022.S2703?q=Health Insurance&g=010XX00US_040XX00US39_050XX00US39049&y=2022.

[5] U.S. Census Bureau. (2022). Public Health Insurance Coverage by Type and Selected Characteristics. *American Community Survey, ACS 1-Year Estimates Subject Tables, Table S2704*. https://data.census.gov/table/ACSST1Y2022.S2704?q=Health Insurance&g=010XX00US_040XX00US39_050XX00US39049&y=2022.

[6] Ohio Department of Medicaid. (2022). Annual Medicaid Demographic and Expenditure Dashboard [interactive tool]. Retrieved in 2024 from https://analytics.das.ohio.gov/t/ODMPUB/views/MDE-AnnualView/Home?%3AshowAppBanner=false&%3Adisplay_count=n&%3AshowVizHome=n&%3Aorigin=viz_share_link&%3AisGuestRedirectFromVizportal=y&%3Aembed=y

[7] U.S. Centers for Medicare & Medicaid Services. (2022). Medicaid Enrollment - New Adult Group [interactive tool]. Retrieved in 2024 from https://data.medicaid.gov/dataset/6c114b2c-cb83-559b-832f-4d8b06d6c1b9

[8] U.S. Census Bureau. American Community Survey 5-Year Estimates, 2022 (HM2025)

Adverse Childhood Experiences (ACEs)

Adverse childhood experiences (ACEs) are traumatic events that occur during childhood (i.e., before age 18), including violence, abuse, or neglect.[1] ACEs also include contextual factors that might negatively affect a child's sense of safety or stability, such as growing up in a household with people who have substance use problems, mental health problems, or parents who were separated or in jail.

Per the Center on the Developing Child at Harvard University, "There is a powerful, persistent correlation between the more ACEs experienced and the greater the chance of poor outcomes later in life, including dramatically increased risk of heart disease, diabetes, obesity, depression, substance abuse, smoking, poor academic achievement, time out of work, and early death."[2]

17% of Franklin County adults have **4 or more ACEs**.

New metric for HM2025

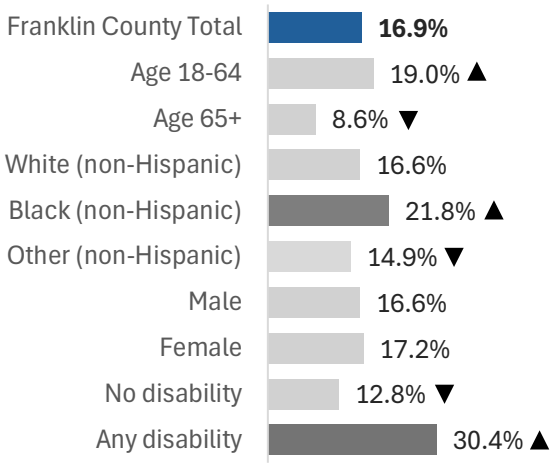
Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
18-64 more likely	None observed	Black more likely	Observed (see map)

Adults with any type of disability are more likely than others to report having 4 or more ACEs when they were children, as are those aged 18-64 and black (non-Hispanic) individuals.[4]

As shown on the next page, the four most frequently reported types of ACEs among Franklin County adults include (1) emotional abuse; (2) parents' separation/divorce; (3) living with someone who was a problem drinker / used illegal drugs / abused prescription medication; and (4) physical abuse.

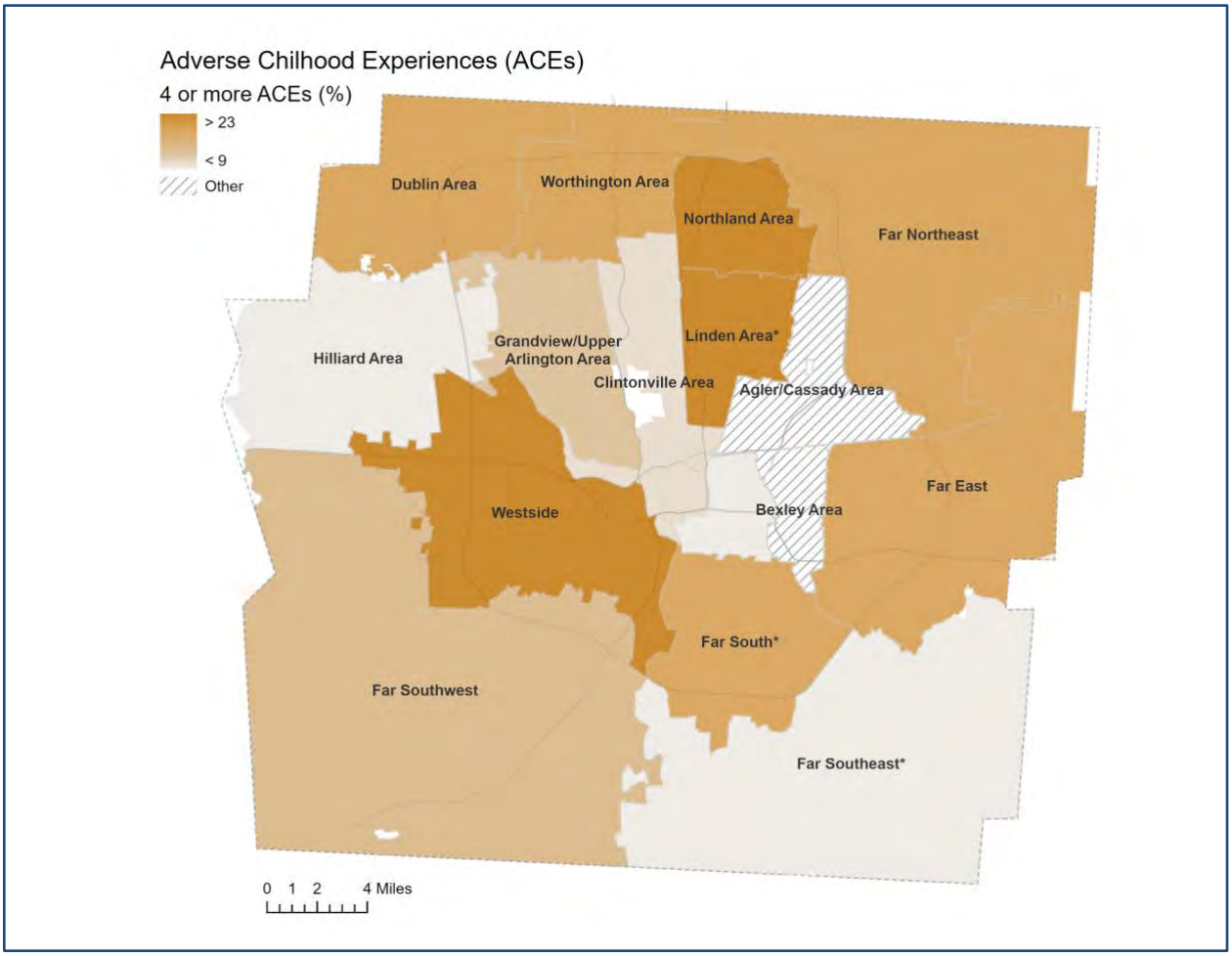
Four or more ACEs among adults 18+ in Franklin County



ACEs prevalence among adults 18+ in Franklin County

Experienced emotional abuse	**40.8%**
Parents separated or divorced (*excludes those whose parents were not married*)	**35.1%**
Someone in household was a problem drinker or alcoholic, or used illegal drugs or abused prescription medication	**30.7%**
Experienced physical abuse	**29.8%**
Someone in household was depressed, mentally ill, or suicidal	23.7%
Parents physically hurt each other	18.2%
Someone in household served time in prison, jail, or other correctional facility	10.9%
Experienced sexual abuse	5.9%

As shown in the map below, a greater percentage of adults in the Linden, Northland, or Westside areas report having experienced 4 or more ACEs as a child, compared to adults in other areas. Estimates marked by an asterisk (*) are based on fewer than 50 respondents and are considered statistically unreliable; therefore, caution should be used when interpreting these estimates.



The Agler/Cassady and Bexley areas are shown in a crosshatch pattern because the estimates for those areas are based on <40 respondents, and therefore are not reported.

Additional Information & References

To assess the prevalence of ACEs among Franklin County's adult population, Columbus Public Health staff obtained recent data from the Behavioral Risk Factor Surveillance System, which completes structured survey interviews with residents via telephone. In addition to combining and analyzing several years of data (2019, 2021, 2022), Columbus Public Health also combined the data from several contiguous zip codes in order to create larger geographic areas; most of those geographic areas then had a sufficient sample size that would permit an analysis and mapping of the indicator.[3] Franklin County Public Health staff then mapped the prevalence of this indicator across the selected geographic areas that had a sufficient sample size.

[1] Centers for Disease Control and Prevention. (n.d.) About Adverse Childhood Experiences. https://www.cdc.gov/aces/about/index.html

[1] Harvard University, Center on the Developing Child. (n.d.) ACEs and Toxic Stress: Frequently Asked Questions. https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions/

[3] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data, 2022 (HM2025), 2019 (HM2022), 2016 (HM2019)

[4] Swedo EA, Aslam MV, Dahlberg LL, et al. Prevalence of Adverse Childhood Experiences Among U.S. Adults — Behavioral Risk Factor Surveillance System, 2011–2020. MMWR Morb Mortal Wkly Rep 2023;72:707–715. DOI: http://dx.doi.org/10.15585/mmwr.mm7226a2

CHRONIC CONDITIONS

Chronic Condition Prevalence

The U.S. Centers for Disease Control and Prevention defines chronic diseases as conditions that last 1 year or more and require ongoing medical attention and/or place limits on one's daily activities. Such diseases are thought to be a major contributor to the nation's annual health care costs, which in recent years has approached $4.5 trillion.[1]

32% of Franklin County adults reported having **high cholesterol**.

≈ Similar to HM2022 (30.2%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
65+ more likely	None observed	White more likely	Observed (see map)

32% of Franklin County adults reported having **high blood pressure**.

↓ Down from HM2022 (36.2%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
65+ more likely	None observed	Black more likely	Observed (see map)

25.4% of Franklin County adults reported ever having **arthritis**.

≈ Similar to HM2022 (27.5%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
65+ more likely	Female more likely	White more likely	Observed (see map)

11.2% of Franklin County adults reported ever having **diabetes**.

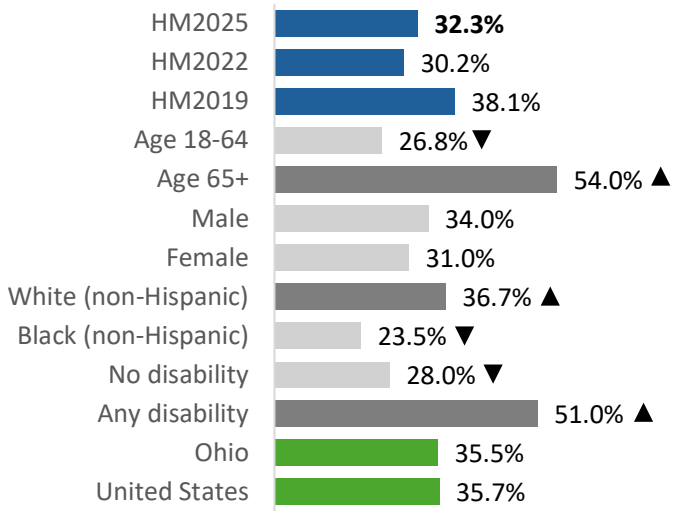
≈ Similar to HM2022 (10.6%)

Disparities by selected social determinants of health

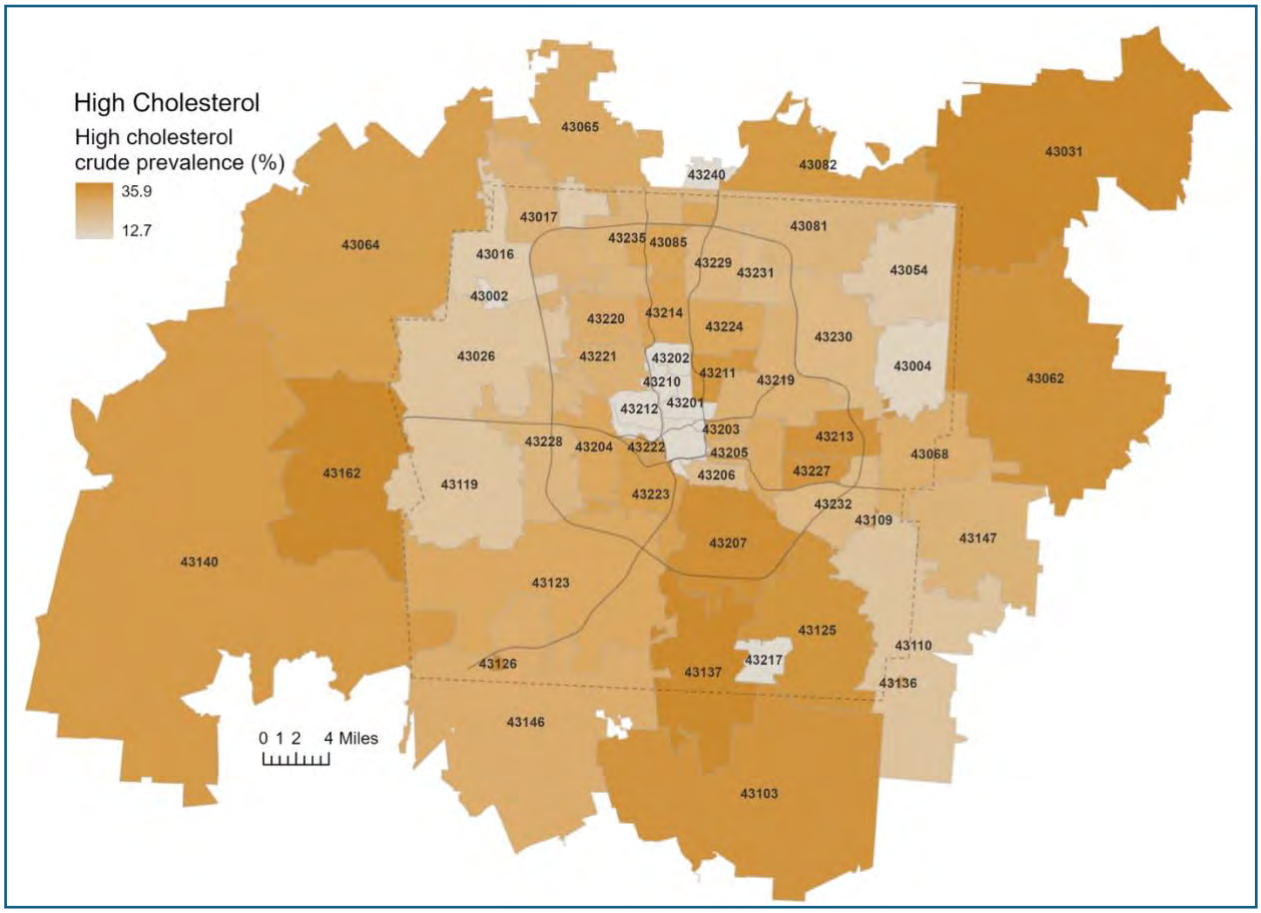
Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
65+ more likely	None observed	Black more likely	Observed (see map)

HIGH CHOLESTEROL

Older adults and individuals with a disability are more likely to report this health condition. Note there is an increased rate of high cholesterol among white (non-Hispanic) residents as opposed to black (non-Hispanic) residents. This is a condition that may not present with urgent symptoms, instead being caught via blood tests that often occur in the context of primary/preventative care. Therefore, the disparities observed among racial groups might also partially reflect healthcare access disparities.[2]



High cholesterol prevalence is higher in most Franklin County zip codes that are to the east and south, especially 43211, 43213, 43227, 43207, and 43137.

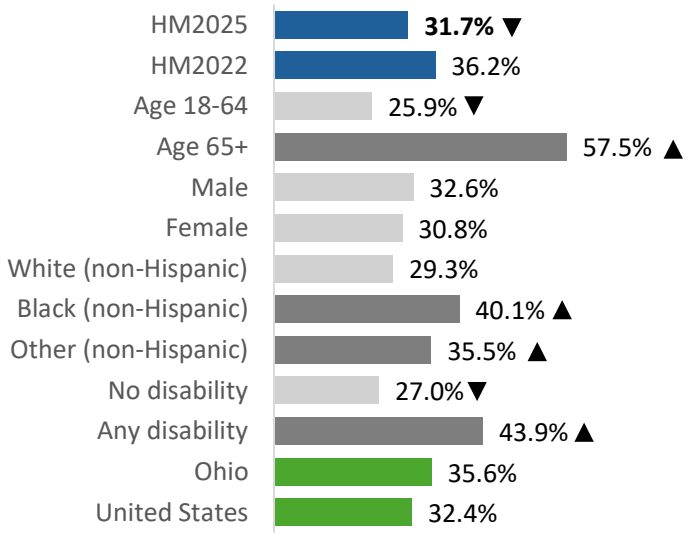


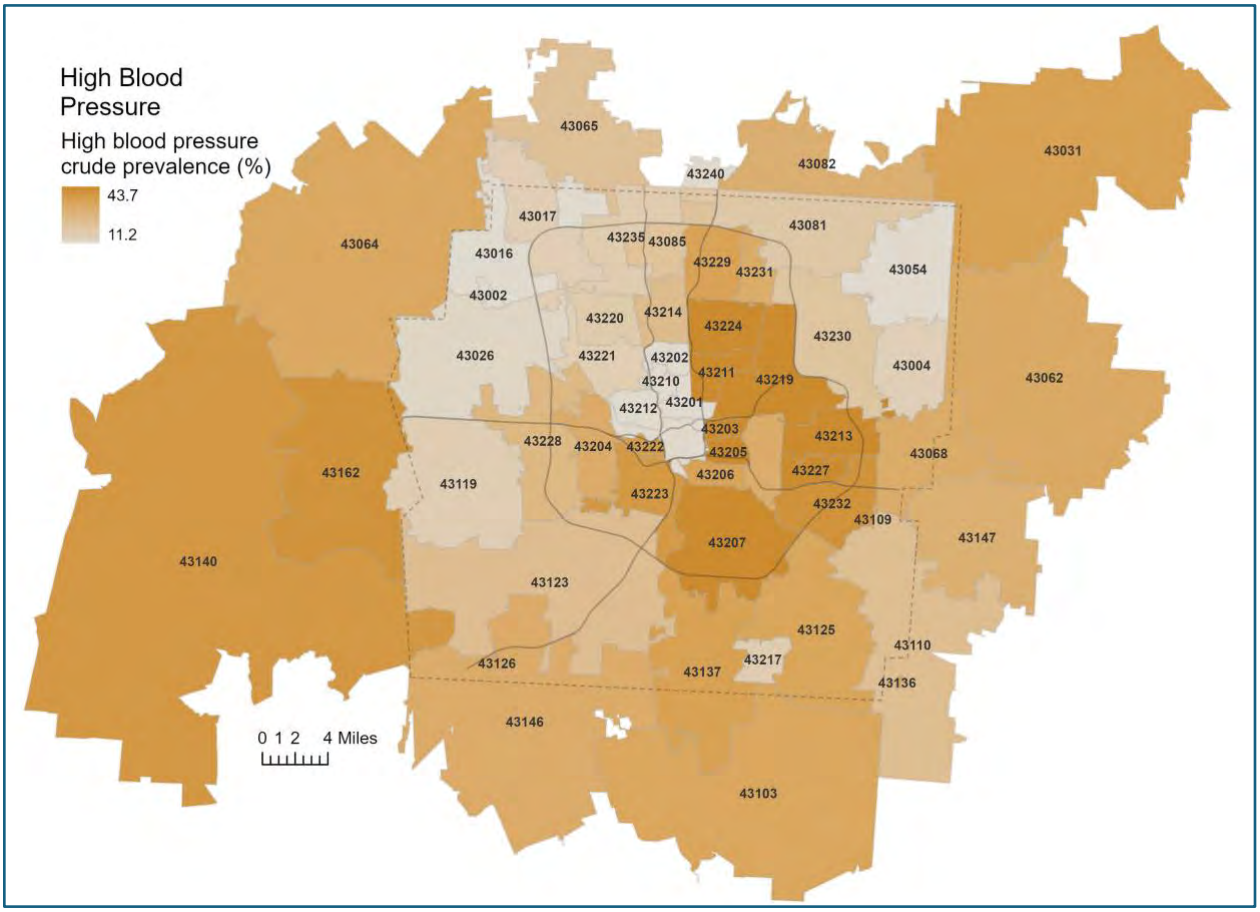
HIGH BLOOD PRESSURE

Older adults, black (non-Hispanic) residents, and individuals with a disability are more likely to report this health condition.

Fortunately, recent data suggest that among those Franklin County residents who have been diagnosed with high blood pressure, most (73%) are taking medicine to address/manage this health condition.

High blood pressure prevalence is higher in east-central Franklin County, especially 43224, 43211, 43219, 43203, 43205, 43213, 43227, and in 43207

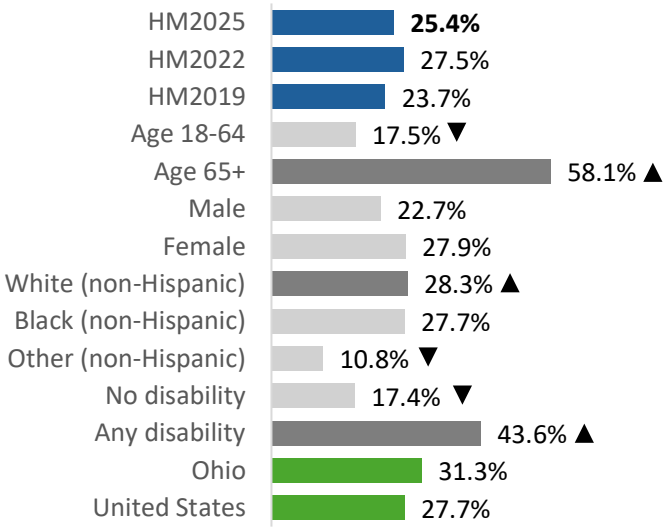


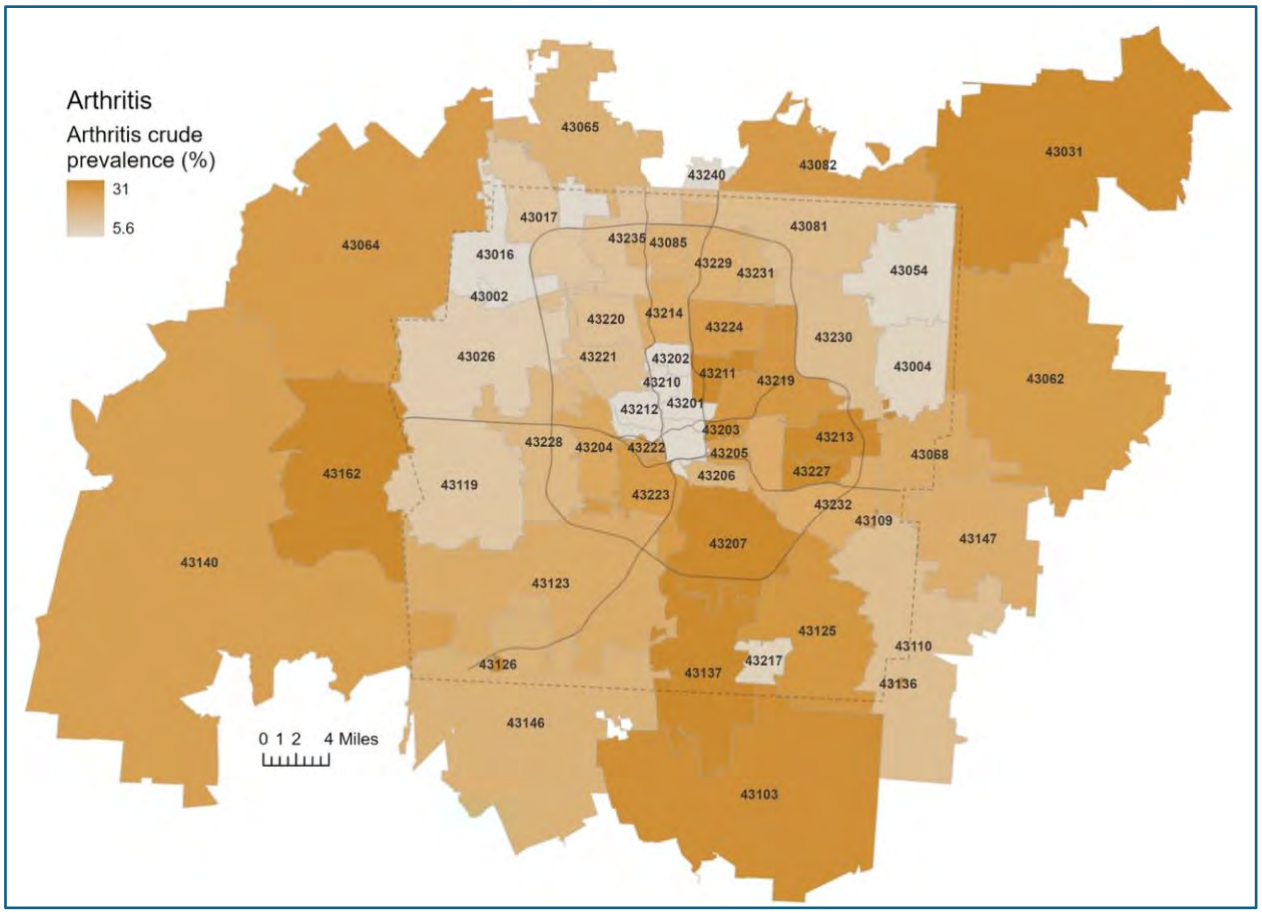


ARTHRITIS

As expected, older adults have a far higher prevalence of arthritis than younger adults, and individuals with a disability are also more likely to report this chronic health condition. Interestingly, individuals with an other (non-Hispanic) racial background had a significantly lower rate of arthritis than either the white or black (non-Hispanic) populations.

Arthritis prevalence is higher in Franklin County zip codes that are east of I-71 and west of I-270, and is especially high in 43211, 43213, 43227, and 43207.

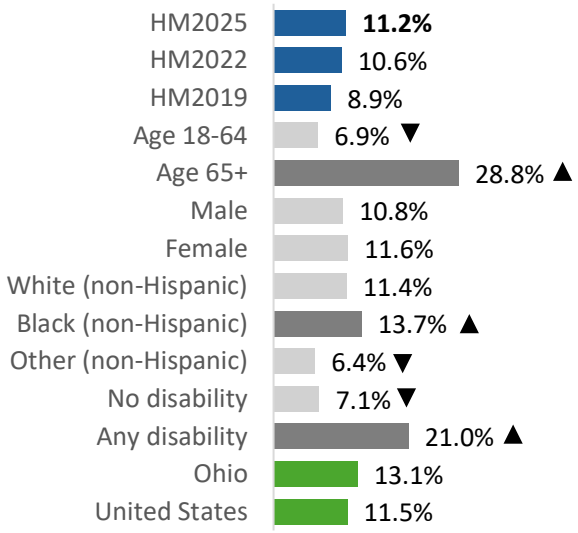


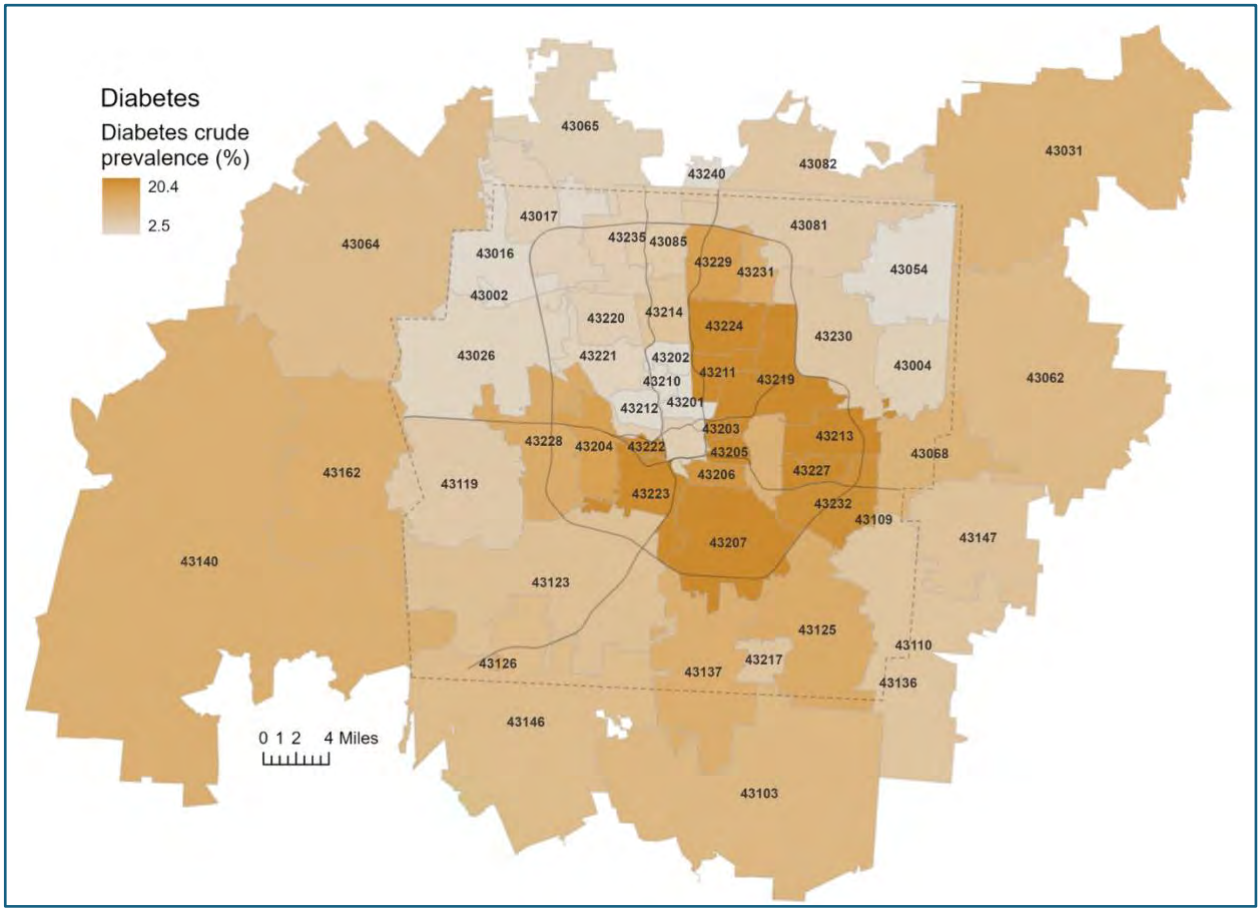


DIABETES

Diabetes is more common among older adults than younger adults. Note that this analysis does not distinguish between type 1 and type 2 diabetes. As was the case with arthritis prevalence, individuals with an other (non-Hispanic) racial background were significantly less likely than those in other groups to have been diagnosed with diabetes.

Diabetes prevalence is higher in most Franklin County zip codes that are within I-270, except for those zip codes in the northwestern quadrant.





Community Voices: Diabetes

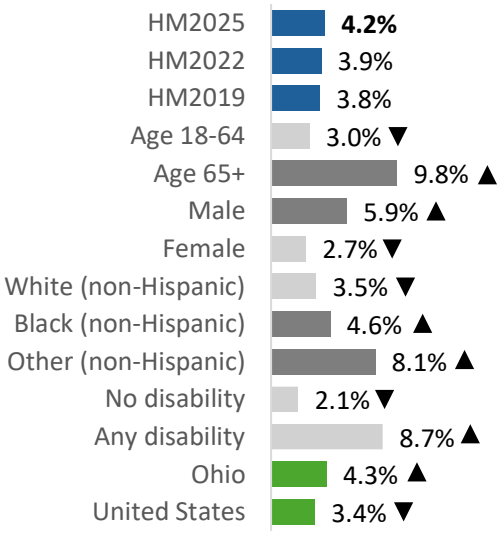
For community members, diabetes is at the forefront of their chronic condition concerns in the community. They perceive this condition to be increasing among the community's youth, and also noted how this condition co-occurs with other chronic conditions.

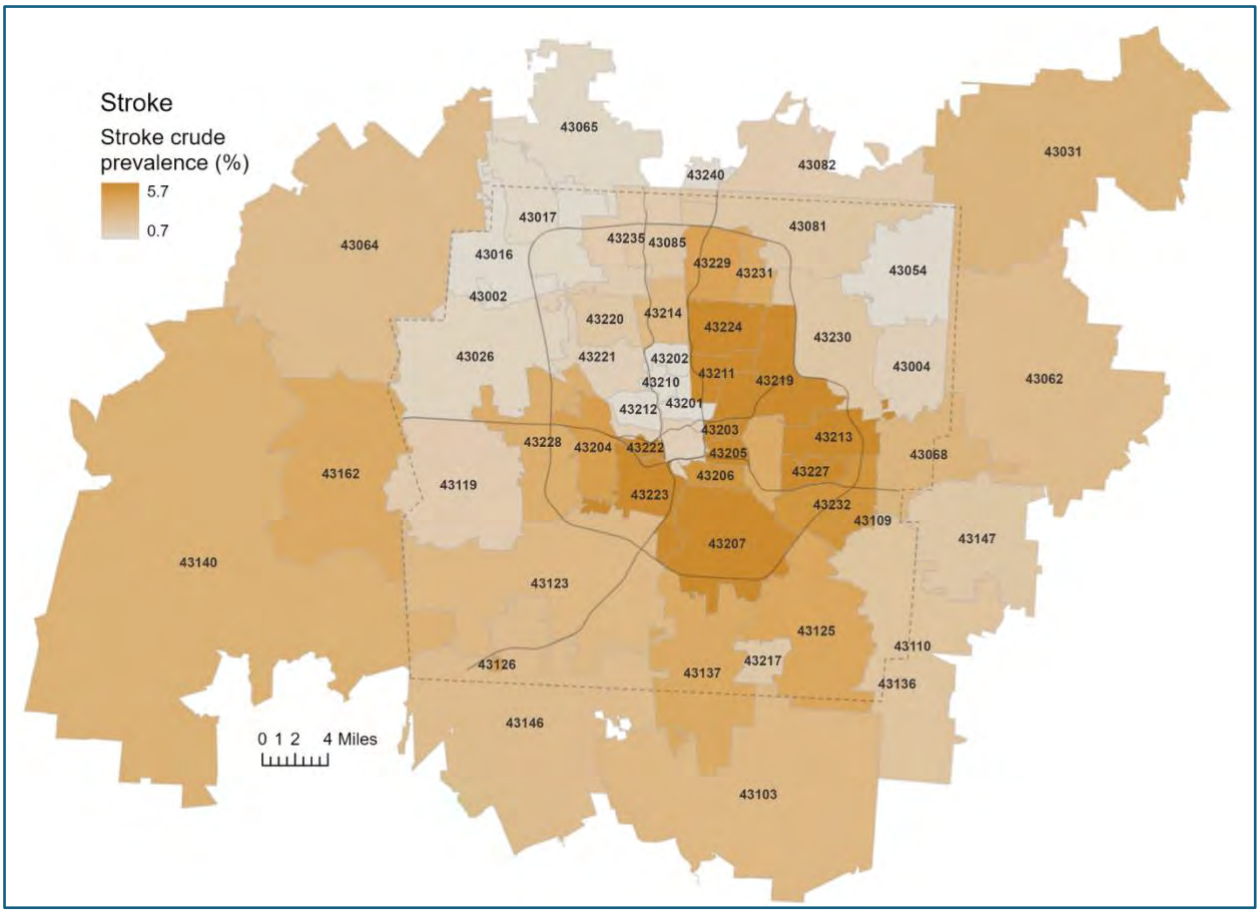
> *"Type two diabetes has become more prevalent than before…And insulin resistance can start younger. Even if type two is not there, we can have the metabolic syndrome. The hypertension strokes are even happening younger, and it seems that doctors will focus on an older population. A lot of kids won't be heard."*
>
> *"A lot of kids I see have juvenile diabetes, probably more than what I even remember. And if you have a disability, you tend to have those kind of issues."*

STROKE

Lifetime experience of stroke is more common among older adults. Disparities between gender and racial groups are likely due in part to disparities in risk factors such as heart disease.

Stroke prevalence is higher in most Franklin County zip codes that are within I-270, except for those zip codes in the central and northwestern quadrants.

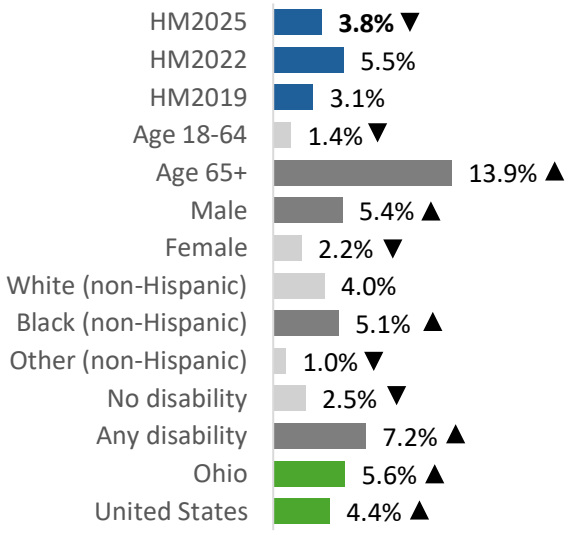


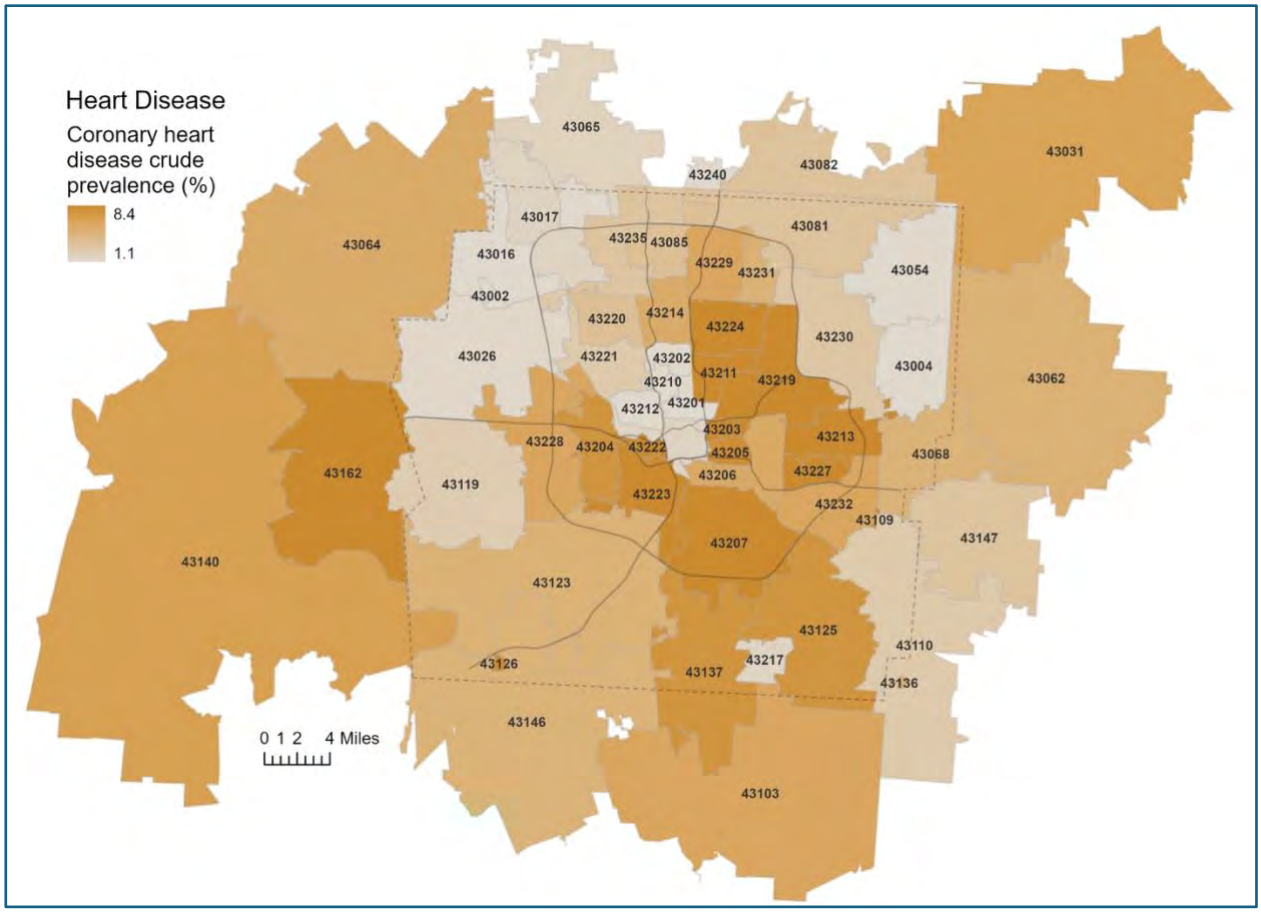


HEART DISEASE

Within Franklin County, the prevalence of heart disease is highest among older adults. Heart disease prevalence is also higher among males, which is consistent with national research on this topic. Lastly, the prevalence of heart disease is also higher among the black (non-Hispanic) population than among the white (non-Hispanic) population.

Heart disease prevalence is higher in most Franklin County zip codes that are within I-270, except for those zip codes in the northwestern quadrant.





Community Voices: Other Chronic Conditions

Community members also spoke about other chronic conditions that affect the black community disproportionately, including sickle cell traits, HIV, and fibroids.

> *"There's a lot of people in the black community who don't realize the difference between sickle cell traits, sickle cell, or that they even have sickle cell. They don't have the educational component. So they're just out there, trying to figure out what's best. And with sickle cell, you can actually die. And a lot of people don't know that. If one parent has it and the other one doesn't, it doesn't necessarily mean you're going to get it versus two parents having it. And so a lot of people have unnecessary worry."*
>
> *"I've experienced family members with sickle cell, and when they go into hospitals, they're looked at as drug seekers. It's because they're not educated on what exactly they are supposed to be doing. So when they're having a crisis and they are in pain and really do need those medications, it's like, 'Well, the only time we see you is when you're in pain.'"*
>
> *"There are a lot of healthcare disparities with race, specifically with African Americans. I would say HIV is one, too."*
>
> *"A big one that affects African American women is fibroids. And they often get overlooked or mistreated when they are going to the doctor."*

Additional Information & References

Readers should note that data focusing on another chronic condition – asthma – is presented in the environmental health chapter of *HealthMap2025* (see page 166).

To assess the prevalence of these chronic conditions, *HealthMap2025* obtained recent data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS), which completes structured survey interviews with residents via telephone.[3] In most cases, survey respondents were asked if a doctor, nurse, or other health professional ever told them that they had a specific chronic health condition.

To enable comparisons by demographic subgroups (e.g., age, sex, race), Columbus Public Health staff analyzed BRFSS data using the most recent year or two available (typically 2021 & 2022). To map the prevalence of these indicators at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the CDC's PLACES[4] resource, which uses BRFSS data (2021 or 2022), Census Bureau data (either the 2020 decennial census or 2022 annual population estimates), and American Community Survey data (2018-2022 estimates).

[1] Centers for Disease Control and Prevention. (n.d.) About Chronic Disease. https://www.cdc.gov/chronic-disease/about/index.html

[2] Nelson K, Norris K, Mangione CM. Disparities in the Diagnosis and Pharmacologic Treatment of High Serum Cholesterol by Race and Ethnicity: Data from the Third National Health and Nutrition Examination Survey. Arch Intern Med. 2002;162(8):929–935. doi:10.1001/archinte.162.8.929

[3] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data, 2022 (HM2025), 2018 (HM2022), 2016 (HM2019). [Note: For high blood pressure prevalence, HM2025 data were collected in 2021 and HM2022 data were collected in 2019.]

[4] Centers for Disease Control and Prevention, PLACES: Local Data for Better Health. (n.d.). https://www.cdc.gov/places/index.html

Disability Status

Disability is a significant public health concern. As the mean age of the United States population increases, older adults who have a disproportionately higher likelihood of disability become a greater proportion of the population. Individuals with disabilities face a variety of increased costs of living, barriers to engaging in work and the community, and additional health disparities than the rest of the population.[1,2]

12.2% of Franklin County residents reported **any disability**.

≈ Similar to HM2022 (11.1%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
65+ more likely	None observed	None observed	Observed (see map)

Community Voices

Members of the disability community think how others in the broader community perceive and react to disability causes their overall wellbeing to be unconsidered or ignored.

> *"Our wellbeing as people with disabilities is grossly ignored. Grossly overlooked and never considered. Whether it's the mental wellbeing, or the physical wellbeing, or the emotional wellbeing, or the economic wellbeing, we're not considered."*

Community members spoke to the specific challenges faced by individuals who identify as DeafBlind or have multiple disabilities.

> *"DeafBlind people suffer the most in my experience, in my community. They do not have a lot of the training. For example, they do not have access to braille training."*
>
> *"Developmental disability services here in Ohio, they are not accessible to DeafBlind people, not friendly to them at all. Takes a long time to get services. People who are deaf and have additional disabilities are very isolated. They haven't been able to find the place where they feel that they belong."*
>
> *"I fit into the DeafBlind community. And I will agree there's not a lot of acknowledgement of those who have dual disabilities, whether it's deaf and blind or any other combination of one or more disabilities. And there's not enough acknowledgement of, even though one disability may be the dominant disability, that doesn't mean you should ignore the other ones."*

Community members spoke about how there are some conditions that are not classified as a disability, even though they affect people's lives in similar ways.

> *"Ehlers Danlos syndrome. It's a connective tissue disorder, and most people will think of it as hypermobile. But the connective tissue is with the heart, with the brain, with the eyes, the spine, everything. [She has] a list of like ten different mini diagnoses that don't count as a developmental disability. So she's in bed a lot, wearing an eye mask or unable to function in a normal life, and then people are telling me, she doesn't have a developmental disability because she doesn't fit in that umbrella."*

Members of the wider Franklin County community also mentioned how caretaking responsibilities for family members who are disabled impact them.

> *"My mother has dementia. I know an awful lot of folks who are in their late sixties, mid-seventies, and older with that. Her husband is caring for her now, but when the day comes, he can't do that, she'll be moving in with me, and I will not be able to really leave her. She can be left home a little bit at home now, but that won't last for long, and I'll be her primary caretaker. So it's something I have to plan for because it's coming down the road."*
>
> *"I would say as a caregiver, that impacts me, my health. I constantly worry about my mom. Back in March, she had a fall. I was in the house, she got dizzy, she fell, and we had to take her to the hospital. It was really scary. So as a caregiver, I've experienced a lot of mental health issues through that, and I think through that, a lot of physical health issues have bubbled up."*

Community Voices: Issues related to accessing health care

Disabled individuals face difficulty filling out paperwork and accessing information about their health due to the high reliance on technology that many medical providers have. When it comes to having interpreters for health appointments, disabled individuals say lack of resources prevents best practices of using co-interpreters to ensure patient understanding.

> *"One issue when it comes to accessing care is accessing information. So, for example, if you go to the doctor and they want to give you a summary of your doctor's visit, a lot of times doctors just want to hand you paperwork and they're not always explaining things with you or to you."*
>
> *"A lot of systems such as computer systems at doctor's offices and things are not digitally accessible. Medicare professionals still don't know a lot of times how to help you as far as filling out paperwork. They don't see the value of doing certain things over the phone. There's always this thing that if one person with a disability can get it...There's no looking at each patient on a case-by-case basis."*

> *"So many doctors are moving to putting things on an iPad, but still, that's just as bad as traditional paperwork. If you're blind and you can't fill that out on your own, you got to have somebody to help you. And some doctors, they always think you come with a caregiver. They don't understand, that's really your job as the nurse. Your job is to take down the health information and help the patient out."*
>
> *"We encourage having co-interpreters. One hearing interpreter who signs to a deaf interpreter, and that deaf interpreter would sign to the deaf individual. And it's very effective, and it makes communication so much easier. It can be expensive, you know, having those two interpreters, but it will save you time in terms of effective communication and the [medical] provider being able to make that connection with their patients and make sure that their language needs are met. It's focusing on respect for that patient, and it's very effective, and that's something that providers need to accept more and provide."*

Finding providers who are competent and respectful when providing care for disabled individuals can be difficult.

> *"My problem is I've been with established care people for 14 years, and what happened was I just had some retire, and I'm having a problem finding doctors that take my insurance, let alone help with my medical needs."*
>
> *"I've even been turned away from a local hospital, because they said that none of the doctors here understand disability at all, and we should not be seeing that in 2024. And most of the things that I go in for are not even related to my disability. They're just normal things…I even left the medical space for 20 years because of the difficulty I was having. I didn't see doctors until I turned 40 again…A lot of times, people with disabilities have to search and search before we find a doctor that will, in fact, listen to us and realize that we know more about our own bodies than they might."*
>
> *"I just changed my primary care doctor because she started making me feel like I was a problem for her."*
>
> *"We become so afraid to even seek help sometimes."*

Disabled individuals face a number of other specific issues with health care, including providers' unwillingness to provide telehealth appointments, misdiagnosis and lack of understanding of complex care needs, difficulty getting health screenings, and difficulty providing feedback on health care surveys about their experiences.

> *"If you're an established patient and staff changes, there's no real training or continuity kind of training that teaches them that not everybody that's coming here may come here in person. Some people are using telehealth*

> *for various reasons. I've been almost threatened that I got to come into the office. And I've been told to my face that, well, another client with a disability is able to make it in, but that client may live in the Dublin area, and I don't. And I don't have the money all the time to travel across town."*
>
> *"People who perhaps have low language within the deaf community, meaning they are a deaf child raised within a hearing family and that family does not provide access to American Sign Language, they face language deprivation...that leads to mental health issues. So counselors then are saying he has a diagnosis of learning disabilities. Well, really, it's not the learning disability. The problem is the language deprivation, the exposure that they never had. And so that diagnosis doesn't really fit the situation in and of itself. There is a lack of advocacy and the resources that are needed for individuals to learn about the diverse community."*
>
> *"I think there needs to be doctors out there, individuals who understand complex care. My daughter has multiple disabilities. She has seven specialists. And when I went from trying to move her from pediatric care to adult care, I'm going through doctors like water because they can't handle the complexity of her needs…We need to have adult hospitals with complex care units that are willing to provide healthcare for these individuals."*
>
> *"We are still so behind the times when it comes to treating people with disabilities, any disability, really, with the machinery that they use. I mean, I'm 55 and have only had half of a mammogram done because the machines are still not accessible. And when you go there and you ask for them to help position you, they yell at you and ask if you've brought a caregiver with you to be able to do that. That's just one experience. But they are not trained to understand disability. They get a very short training period to learn about disability."*
>
> *"When we try to take the surveys that speak to our experience, if you're blind and depend on screen readers, you have to get your PIN number from your discharge papers first by using app to read that or have someone come over and do it for you. Then you have to enter that online. And then the online surveys are not accessible with the voiceover screen readers that we're using. The only other alternative is to bother someone, have them take the survey for us. Well, that violates our own privacy."*

Community Voices: Stigmas related to disabilities and/or mental health

Disabled individuals say that mental health issues like anxiety and depression are common due to the misperceptions people have about them.

> *"There's a big myth when you're dealing with the medical professional or people in general, that because we're blind, we're also dumb. Like our brain*

> *doesn't work. And that's not a fair assumption. Just because someone is blind doesn't mean they have a cognitive disability as well."*
>
> *"Anxiety and depression are two big ones [we suffer with]. I suffer from clinical depression and clinical anxiety. And that comes from the way that we are isolated, left out and beaten up for things that we don't have any control over, whether it's our economic status, our employment status, our housing status, or just the fact that we simply are asking for help and people make us feel bad for wanting help…the perception and assumptions are just wrong and rude."*
>
> *"Anxiety is a huge problem. And then in our culture, disability is too often seen as inferior or frightening, and the wellbeing of a disabled person is sometimes seen as not all that important."*
>
> *"Medical providers, in particular, live with that same fear and fright of people with disabilities. And when they focus on the, 'You must need home health services. There must be someone who has to do for you and speak for you.' At times it's very distressing when you're already not feeling good about yourself and you're there to get help, to have that magnified by other people's fears and perceptions, because they can't imagine how they would live with our disabilities, but they're directly not understanding how we adapt."*

These misperceptions also influence the ability of disabled individuals to find employment, even though they have valuable experience and skills to offer.

> *"We have to deal with employer perception all the time. They'll put us through trial periods. They'll ask us if we can find the restrooms and things that someone equal to us without obvious disabilities doesn't have to go through. All these excuses will be made about why we're not interviewed or why we're not contacted after the interview. Hospitality, caregiving and advocacy, independent living help. I'm good at all these things, especially environments that I'm familiar with. And I started getting experience around 16 years old, and I cannot prove that because so many people think that I need things done for me."*

Community Voices: Issues accessing social services/resources

Lack of knowledge about available resources are an issue, not only among disabled individuals but among case managers meant to help them access these resources. Some individuals also perceive there is an unwillingness to provide pathways to these resources.

> *"I think lack of resources is an issue, but also knowledge about the resources available to people is an issue."*

> *"It's knowing what programs are out there, whether it's for finding a job, whether it's for getting food, whether it's for getting help with paying for medical costs, just knowing those resources and where they are and how to apply for them, and people giving you the honest answer about how to apply for them, that's one of the biggest challenges."*
>
> *"When I'm advocating for others, people think I'm wonderful, I am knowledgeable, I'm skillful. When I advocate for myself, there's always this push because, no, we can't do that. But at my office, I get calls from other case managers asking me to do the things I'm wanting and they are doing for other people, but they don't want to do for me because I'm intimidating. And when I say, 'You can do this,' I get a very negative pushback and the dragging of the feet and the, 'Oh, I'm sorry, I'm busy. I've had too many crises to deal with.' I don't regret doing the work to get an MSW, but it doesn't necessarily help you as an individual get your services."*

Community members with disabilities also pointed out that many available resources have restrictions about who can qualify. They believe income-based programs effectively keep them in poverty and from making life changes like moving in with others or obtaining better employment that could improve their quality of life.

> *"People assume because you have a disability, that you're qualified for all of these things in the community that you're not. People assume because I had SSI when I had that, and then I eventually got SSDI, that I should get section eight housing, I should get a whole bunch of food stamps. I should be able to have all these things."*
>
> *"There is a program called iCanConnect, but that is federally funded and that's income based, which is really ridiculous because there are a lot of people that are suffering that can't hear, can't see, and they have a lack of services."*
>
> *"If our legislators got ill, they would never go through the same thing that a lot of us do because they have the money to hire the best doctors and providers so they could never thoroughly understand disability like us that really are in the poverty level and are kept in the poverty level because of rules governing SSI and SSDI. And the other programs like Medicaid, you can only have so much money to be able to qualify. People who have a disability and are fortunate to get a job and have a good job and good insurance, they can afford the money [for good care]."*
>
> *"The way SSI is set up now is if you want to make more money, you're scared to take that because you know they're going to take all your benefits versus there's not any program that allows for people to gradually grow away from the SSI to SSDI because they now have a job and they're starting to make more money. They just snatch the whole check away instead of*

> *taking away a dollar or two at a time as your income grows, so you have a chance to grow into that and save and be able to take care of your needs."*
>
> *"Right now, I have a friend who is terminal who has 28+ additional conditions besides blindness. We're both having the issue of Social Security and perception and all this keeping us from moving together and combining resources. Maybe we could make it if we had each other. We could both save each other's lives because we've experienced a lot of the same systemic troubles and find commonality."*

Individuals with disabilities also say they are prevented from accessing helpful resources due to where they live, and some see evidence that race impacts who receive resources.

> *"Some of the programs that are out there, whether they're for people with disabilities or for people who are on lower income, if you don't live in that area, you can't get those services. Just because I live in the suburbs doesn't mean I don't need them."*
>
> *"We get less of the resources that somebody in our same condition [gets] who happens to be white or maybe of another nationality or race. I have a friend that's in the same situation as me, but he's getting things that I can't get. We're both blind, we both have SSDI, but he's white and I'm black."*

Community Voices: Resources needed for the disabled community

Access to food and affordable housing are specific areas of need for the disability community. For example, they need people who can help them access healthy food more easily, and more accessible housing options.

> *"Food stamps doesn't buy you much, especially when you only get less than $100 a month because they assume, based on your bills, that as one person that you don't need a lot of money for food. If you don't cook that food fast enough, it's going to spoil in two days…I don't eat food as fast as probably maybe I should, because I'm blind and I'm teaching myself how to cook…there's no food service that if you need to go to the pantry [as a blind person], that somebody can get you there or that the food can be delivered only. The delivered food is frozen with all the sodium in it…And that's not always a healthy option for everybody either."*
>
> *"The DeafBlind community does not have access to someone who could go food shopping with the individual or perhaps read something to them if necessary, so on and so forth. We want to be able to bring that to the attention of the Ohio legislation within this year. And our goal is to convince legislation really to wake up to the needs, provide that funding, provide those outreach services in the near future."*

> *"Affordable housing. That's what I have a problem with. [For] people with special needs or people with low income families."*
>
> *"I find sometimes that it's hard to get a wheelchair around anywhere…they built new apartments about seven years ago in downtown, and there's no elevator. How is that fair to anyone with a disability who can't physically walk downstairs? It seems like we've been pushed aside…we're not seeing the things that should be in place to allow people like my daughter to go and live a full life and go to the places that we'd like to go."*

Individuals with disabilities had specific advice about how to improve their experiences in Franklin County: better training for all medical professionals about working with the disability community, connecting individuals with people who can advocate for them, providing better pathways to existing resources, and providing more help accessing the wider community for those with limited mobility options.

> *"Public health departments, to me, need to work with the disability community to start creating educational things for doctors. Whether you're a nurse, whether you're a nurse practitioner, whether you're a surgeon, whether you're a medical tech assistant. The whole medical community, from the bottom to the top of it, needs some serious long-term disability training. To me, public health department needs to even push, if they can, for it to be stuck in the medical school curriculum…They need to come to our community and hear from us the things people need to know, not make up your own disability training for doctors and medical professionals in your own head."*
>
> *"I think they need to provide advocators for those who don't have family or friends that can help advocate for them."*
>
> *"If doctors or PCPs have an individual who has several complex issues, the health department [could] create a database that the doctor. With the patient's permission, can put that person in the database, and then there's a case manager or someone there that reaches out to them and helps them find the services and the things that are available to them…I find a lot of the service coordinators just aren't educated on what's out there…Advocation, and maybe a database that doctors can refer people to the health department, and they can help.*
>
> *"Collaborate with the local centers of independent living. Independent living, housing for people with disabilities is often nowhere near resources like transportation and bus stops, communities, doctors. This is a physical divide between people with disabilities and non-disabled people."*

To assess the disability status of Franklin County, Ohio, and US residents, *HealthMap2025* obtained recent data from the American Community Survey.[3] The ACS estimates the prevalence of many different types of disabilities:

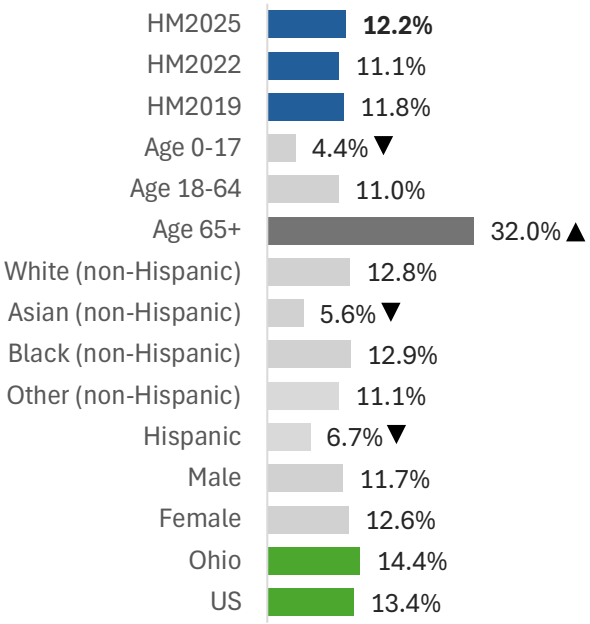
- *Hearing difficulty*, which is defined as "deaf or [having] serious hearing difficulty") and is measured among people of all ages;
- *Vision difficulty*, which is defined as "blind or [having] serious difficulty seeing even while wearing glasses" and is measured among people of all ages;
- *Cognitive difficulty*, which is defined as having "serious difficulty concentrating, remembering, or making decisions") and is measured among people aged 5 years or older;
- *Ambulatory difficulty*, which is defined as having "serious difficulty walking or climbing stairs" and is measured among people aged 5 years or older;
- *Self-care difficulty*, which is defined as having "difficulty dressing or bathing" and is measured among people aged 5 years or older;
- *Independent living difficulty*, which is defined as having "difficulty doing errands alone such as visiting a doctor's office or shopping" and is measured among people aged 15 years or older (but only reported for those aged 18 years and older).

Franklin County has a slightly lower rate of disabled individuals as compared to Ohio or the United States.

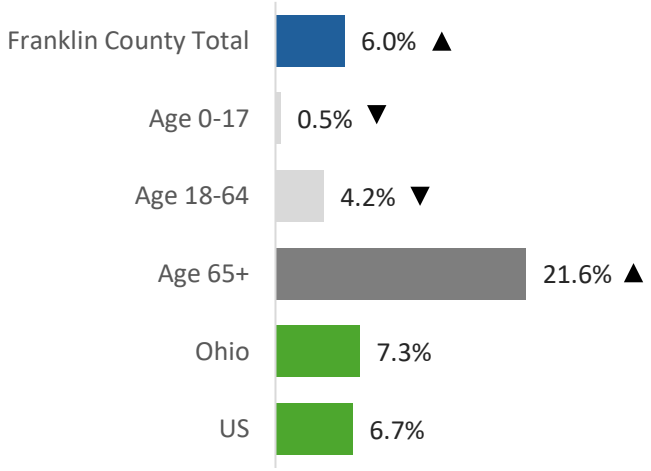
Those aged 65 or over have the highest percentage of residents with at least one disability, with ambulatory difficulties and independent living difficulties being most prevalent. Among children and younger adults, cognitive difficulties are more prevalent.

Of note, Asian (non-Hispanic) individuals and Hispanic individuals have less than half the disability rate as the general population and multiple subgroups.

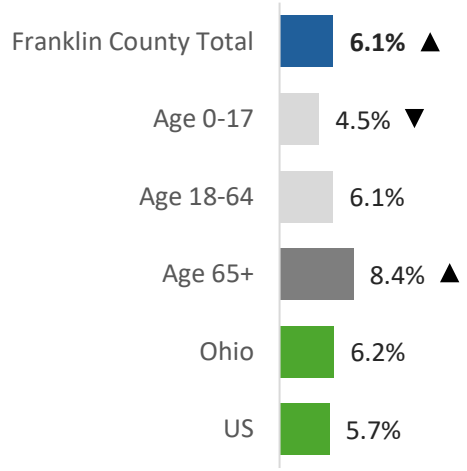
Disability Status Prevalence



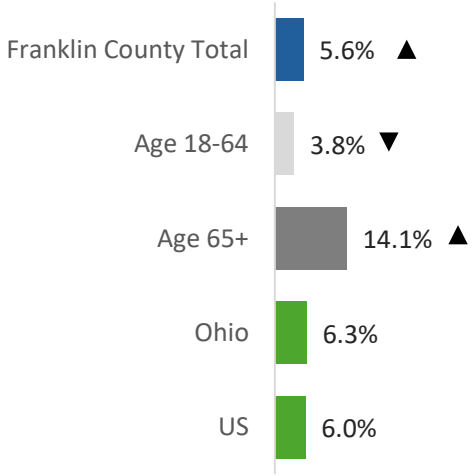
Ambulatory Difficulty



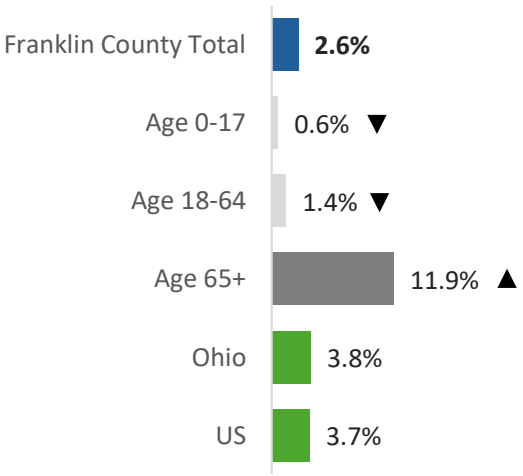
Cognitive Difficulty



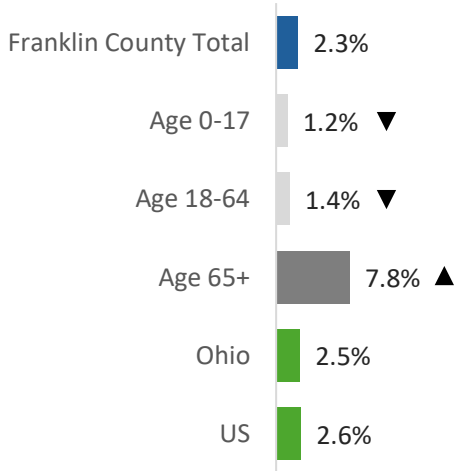
Independent Living Difficulty Age 18+



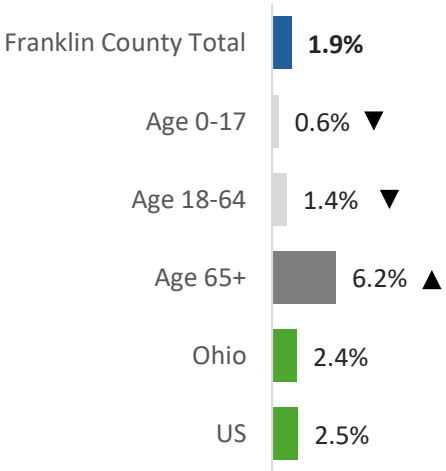
Hearing Difficulty



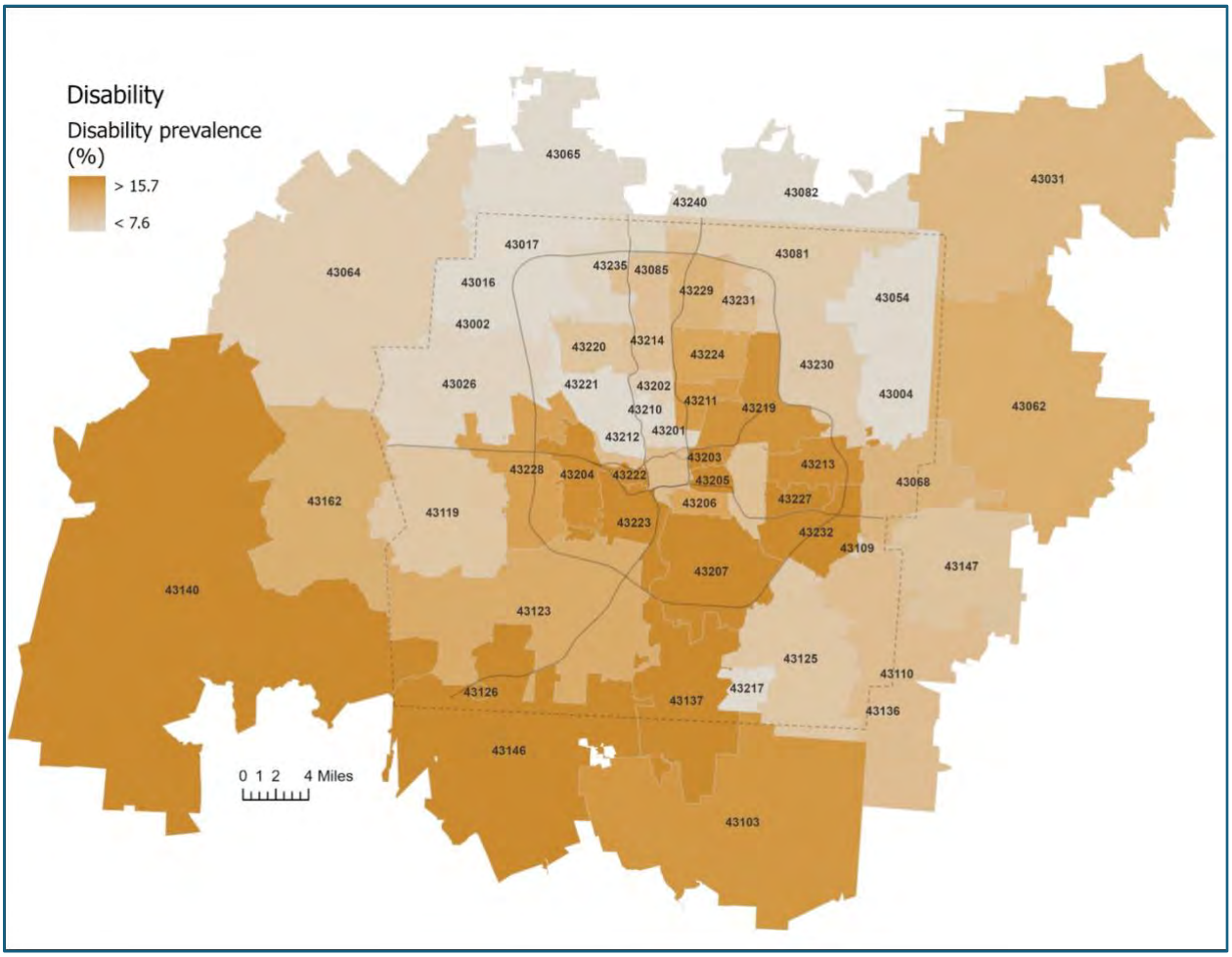
Self-Care Difficulty



Vision Difficulty)



As shown in the map below, disability prevalence is greater in eastern zip codes within I-270, western zip codes within I-270, and in southern / southwestern zip codes.



Additional Information & References

To map the prevalence of this indicator at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the Census Bureau's American Community Survey.[3]

[1] Carrie L Shandra, Disability as Inequality: Social Disparities, Health Disparities, and Participation in Daily Activities, Social Forces, Volume 97, Issue 1, September 2018, Pages 157–192, https://doi.org/10.1093/sf/soy031

[2] Mitra, S., Palmer, M., Kim, H., Mont, D., & Groce, N. (2017). Extra costs of living with a disability: A review and agenda for research. *Disability and health journal*, *10*(4), 475–484. https://doi.org/10.1016/j.dhjo.2017.04.007

[3] U.S. Census Bureau. (2022). Disability Characteristics. American Community Survey, ACS 1-Year Estimates Subject Tables, Table S1810. Retrieved May 29, 2024, from https://data.census.gov/table/ACSST1Y2022.S1810?q=disability&g=010XX00US_040XX00US39_050XX00US39049.

HEALTH BEHAVIORS

Cancer Screening

Breast cancer and colorectal cancer are among the leading causes of cancer death in the United States.[1,2] Regular and timely screening are among the most powerful tools for prevention and early detection of both breast and colorectal cancers.

61% of Franklin County adults aged 45-75 reported having a **colonoscopy** in the last 10 years.

Metric changed since HM2022

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Unavailable	Unavailable	None identified	Observed (see map)

69.7% of Franklin County women age 40+ reported having a **mammogram** in the last 2 years.

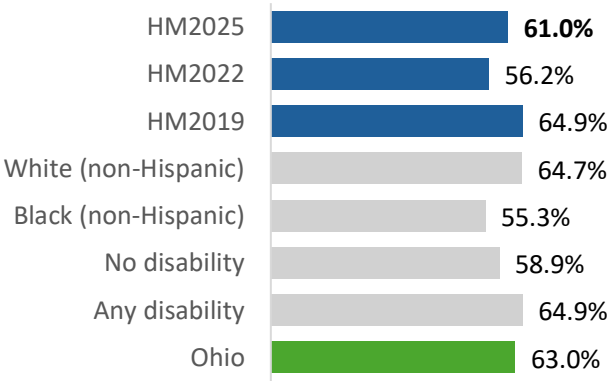
≈ Similar to HM2022 (74%)

Disparities by selected social determinants of health

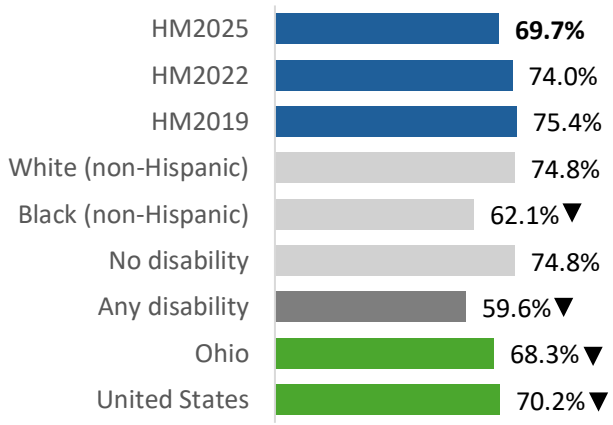
Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Unavailable	N/A	Black less likely	Observed (see map)

For both types of cancer screening, black (non-Hispanic) residents were less likely than white (non-Hispanic) residents to have completed the recommended screening. Franklin County's screening rates were fairly similar to the screening rates for Ohio and the United States.

Colorectal Cancer Screening



Breast Cancer Screening



Healthy People 2030

The Healthy People 2030 objectives for both colorectal cancer screening and breast cancer screening are designated as the number of adults who are meeting the current guidelines for cancer screening.[3,4]

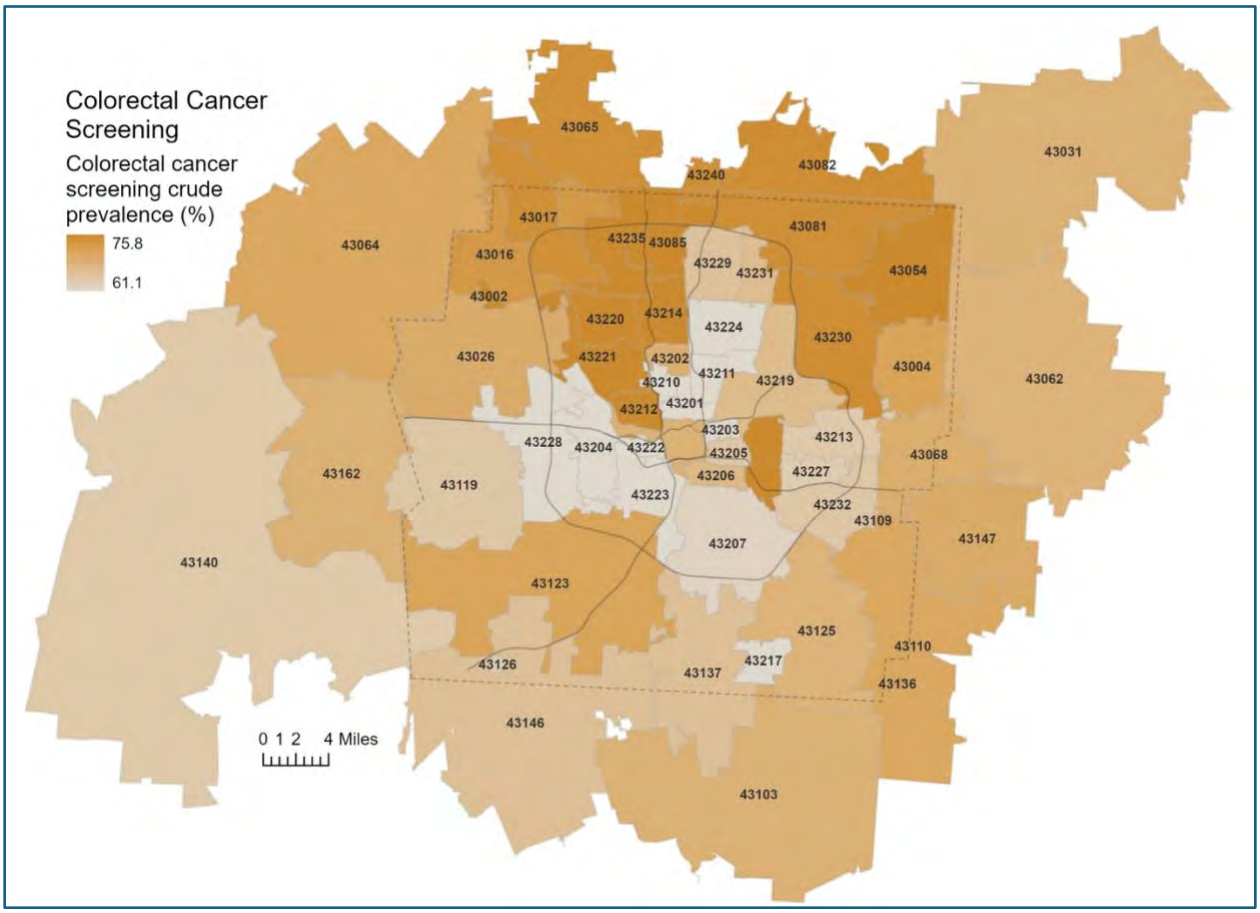
HP2030 objective for Colorectal Cancer Screening: Not met (but improving)

Healthy People Objective:	Most recent Franklin County data (HM2025)
68.3%	**61%**

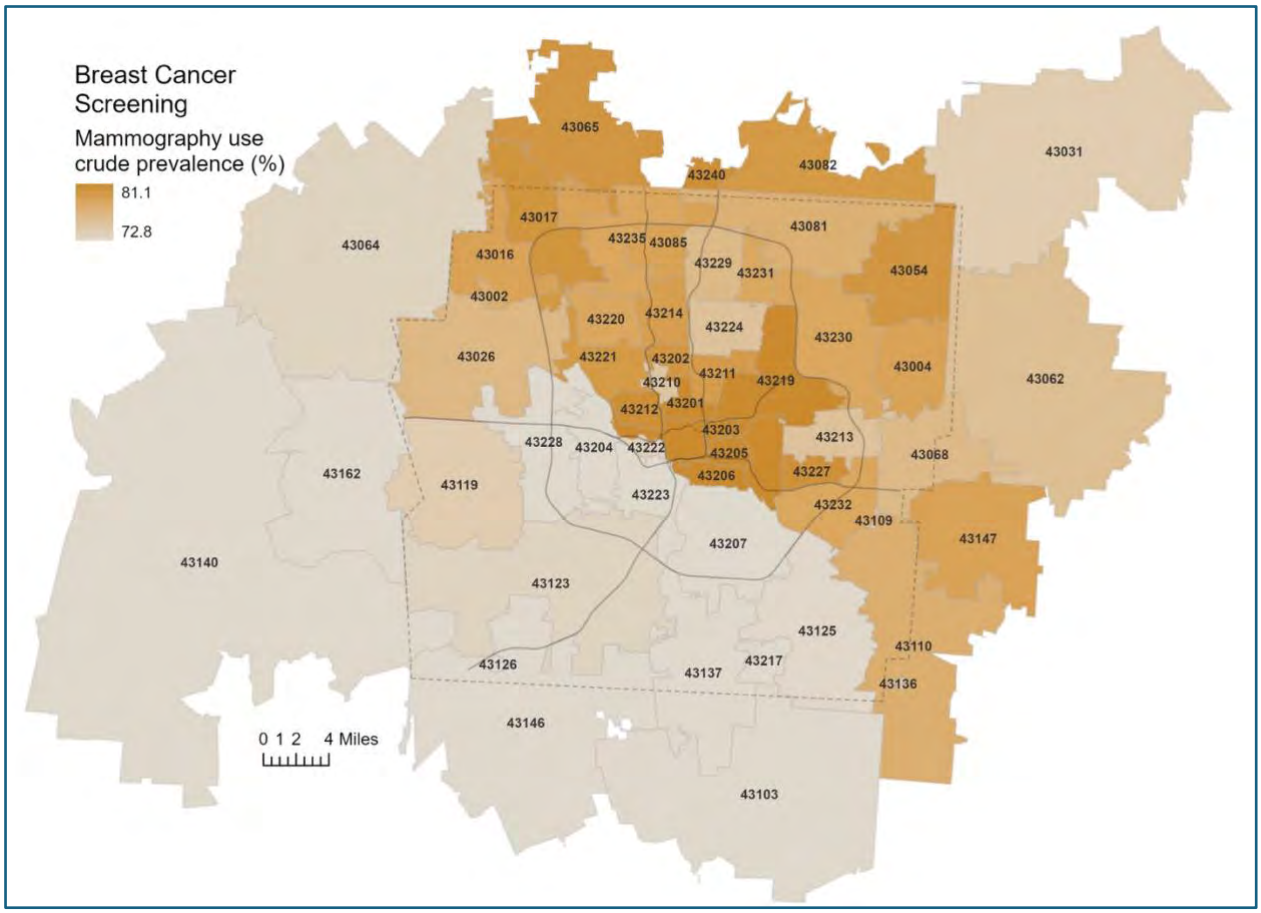
HP2030 objective for Breast Cancer Screening: Not met

Healthy People Objective:	Most recent Franklin County data (HM2025)
80.3%	**69.7%**

Colorectal cancer screening rates are lowest in Franklin County's north-central zip codes (e.g., 43211, 43224), western zip codes (e.g., 43222, 43223, 43204, 43228), and some southern zip codes (e.g., 43207, 43217).



Breast cancer screening rates are lower in nearly all of Franklin County's southern and southwestern zip codes.



Additional Information & References

To assess the prevalence of this health behavior, *HealthMap2025* obtained recent data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS), which completes structured survey interviews with residents via telephone.[5] For colorectal cancer screening, survey respondents were asked if they had ever received either a colonoscopy or sigmoidoscopy, and how long it had been since their last colonoscopy. Survey respondents aged 45-75 and who had received a colonoscopy within the last 10 years were considered up to date. For breast cancer screening, women were asked whether they had received a mammogram, and how long it had been since their last mammogram. Survey respondents aged 40+ and who had received a mammogram in the last 2 years were considered up to date.

In 2021, the United States Preventative Services Task Force (USPSTF) recommended changing the screening age for colorectal cancer from 50-75 to 45-75. Because the HM2022

indicator reflected a narrower age range, it would be misleading to compare that estimate to the one for HM2025, which reflects a wider age range.[2]

Over the last 10 years, breast cancer screening recommendations for individuals aged 40-50 have changed multiple times. Previously, the USPSTF recommended that women aged 50-75 receive mammograms every 2 years and that women aged 40-49 receive mammograms based on their personal health history and status.[1] This was updated in 2024 to recommend mammograms every 2 years for all women aged 40+, and the data for HM2022 and for HM2025 reflect that recent recommendation. These guidelines are also intended for generally healthy adults with no prior cancer history or family cancer history. There are separate guidelines for those at higher risk due to their individual medical and family history, which may involve screening earlier or more frequently.

To enable comparisons by demographic subgroups (e.g., age, sex, race), Columbus Public Health staff analyzed BRFSS data using the most recent year or two available (typically 2021 & 2022). Due to small sample sizes, only white (non-Hispanic) and black (non-Hispanic) residents of Franklin County could be compared to one another.

To map the prevalence of these indicators at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the CDC's PLACES[6] resource, which uses BRFSS data (2021 or 2022), Census Bureau data (either the 2020 decennial census or 2022 annual population estimates), and American Community Survey data (2018-2022 estimates).

[1] US Preventive Services Task Force. Screening for Breast Cancer: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2024;331(22):1918–1930. doi:10.1001/jama.2024.5534

[2] US Preventive Services Task Force. Screening for Colorectal Cancer: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2021;325(19):1965–1977. doi:10.1001/jama.2021.6238

[3] Healthy People 2030 objective C-07, U.S. Department of Health and Human Services

[4] Healthy People 2030 objective C-05, U.S. Department of Health and Human Services.

[5] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data, 2022 (HM2025), 2018 (HM2022), 2016 (HM2019)

[6] Centers for Disease Control and Prevention, PLACES: Local Data for Better Health. (n.d.) https://www.cdc.gov/places/index.html

Alcohol Use

Excessive alcohol use – which includes binge drinking – can lead to several chronic diseases and other serious health problems, including heart disease, liver disease, stroke, mental health problems, and alcohol use disorders, among others. Excessive alcohol use has been associated with 178,000 deaths in the United States each year.[1]

17.8% of Franklin County adults reported **binge drinking**.

≈ Similar to HM2022 (18.5%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
18-64 more likely	None identified	White more likely	Observed (see map)

Community Voices

Members of the community perceive alcohol to be too easy to access in their communities. They see its broad acceptance as a socializing activity to be a barrier to healthier consumption.

> *"There's a liquor store in every corner. You don't have to go far to find liquor or beer or cheap alcohol."*
>
> *"Even our events truly are centered around alcohol. We have wine and arts, tequila and tacos…There's this conception of family and hometown, and all I see personally is people walking around with their kids in strollers and getting drunk."*
>
> *"It feels like no matter what you're doing with your friends, there's people drinking. And I know if I'm ever like, 'Oh, I'm just like, not gonna drink tonight.' Like, people will start asking me if I'm pregnant…the pressure is so intense and ridiculous."*

Community members also believe that overconsumption of alcohol stems from using it as a coping method for stress.

> *"Life is so stressful, people just drink. I definitely think that a lot of us are functionally alcoholics. And I'm speaking for 20 to 30 [year-olds].".*
>
> *"People overindulge. Some people drink because they can't cope with things that are going on, it's a comfort thing to them. I see a lot of people who come back from the military and just can't cope. And that's a coping skill. It's not a healthy coping skill, but it's a coping skill a lot of people use."*

> *"I know that this affects people of all financial statuses, situations. I met somebody who I look up to a lot, and [asked] a question about how he manages stress, and he said he was really good at managing stress, but in the times of his life where he really had a lot of stress at work and stuff, he just leaned really heavily on the alcohol. And I think that a lot of people don't realize that they are coping with whatever is going on in their life. It's like the easiest way to numb it."*

COVID-19 is perceived to have resulted in an increase of alcohol overconsumption at home.

> *"I think especially with in the house drinking, people used to be a little more responsible. So they were going out, maybe having a drink or two. Once COVID came, bars closed. It went to, I'm gonna go to the liquor store and grab me a pint or a fifth. So now you're sitting at home and instead of having one or two that you would usually have at happy hour, you're drinking a whole bottle."*

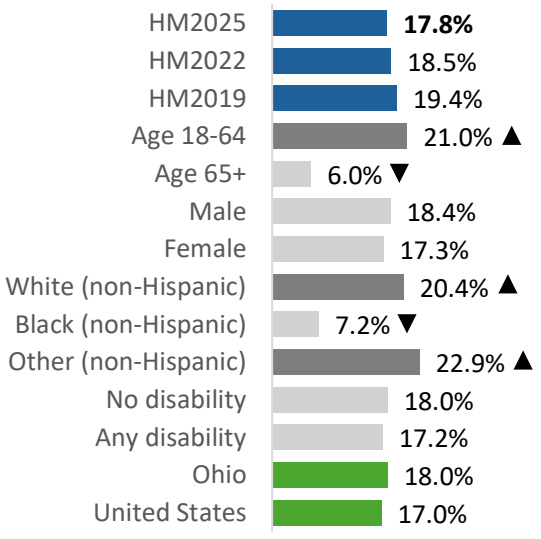
The negative effects of overconsuming alcohol mentioned by community members included worsened mental health and violence in the community.

> *"So I think people don't know the consequences yet of the type of drinking we're doing now. I was one of those weekend people with the fifth, but I stopped. And before I stopped, I started experiencing depression, anxiety, and not being able to focus and no motivation. All that changed, my life changed dramatically just from cutting that weekend use."*
>
> *"No good can come from too much alcohol. And you can see all the violence downtown when places are closing. People lose all sense of reason."*

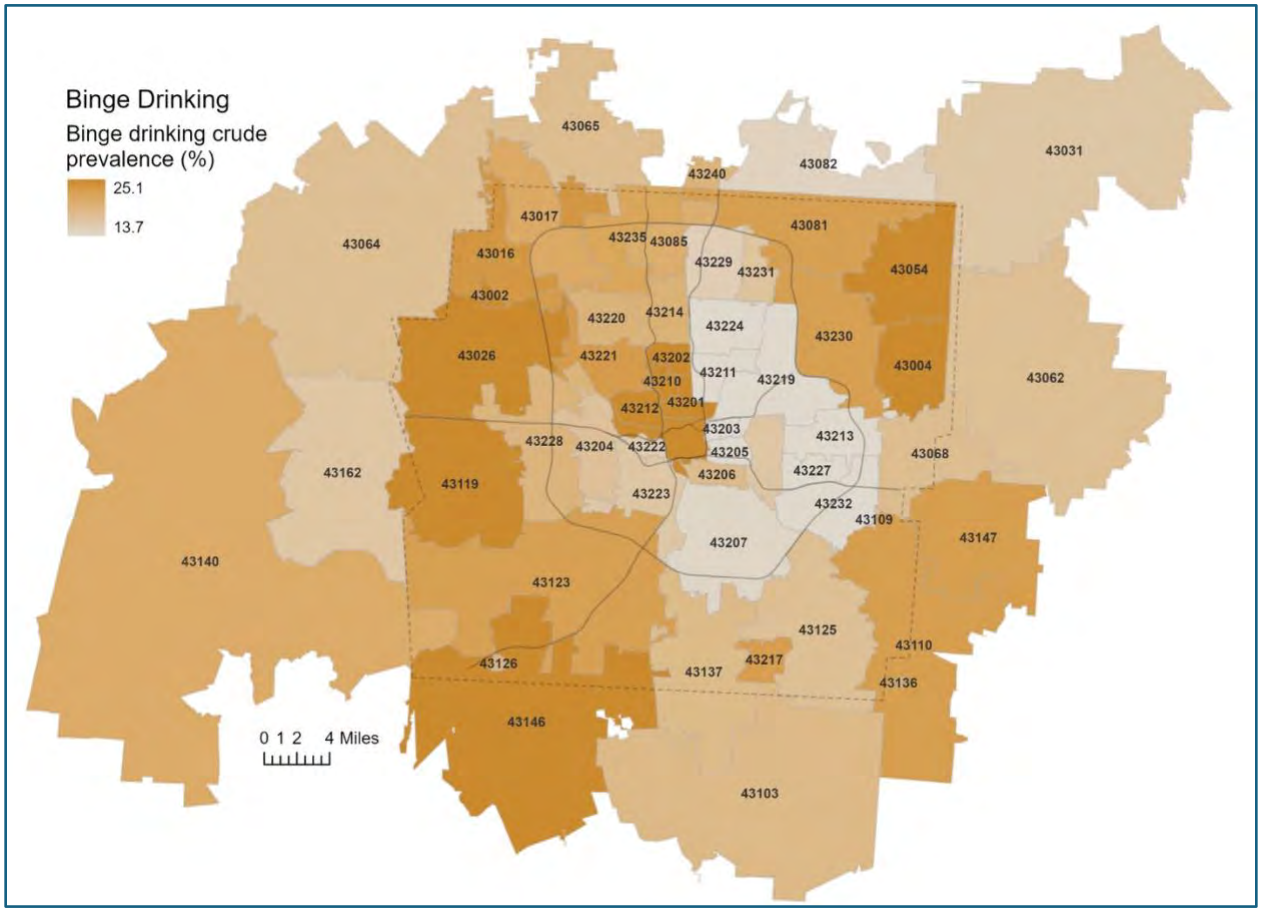
The prevalence of self-reported binge drinking has decreased slightly over time as compared to previous *HealthMaps*.

People aged 18-64 are more likely than those aged 65+ to report binge drinking, as are those who identify as white (non-Hispanic).

Binge Drinking Prevalence



Binge drinking prevalence is higher in Franklin County's far western zip codes, in the zip codes that span the Grandview, Upper Arlington, OSU, and Clintonville areas, and in the county's far northeastern zip codes.



Additional Information & References

To assess the prevalence of this health behavior, *HealthMap2025* obtained recent data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS), which completes structured survey interviews with residents via telephone.[2] For men, binge drinking is defined as having five or more drinks on one occasion in the past 30 days; for women, binge drinking is defined as having four or more drinks on one occasion in the past 30 days.

To enable comparisons by demographic subgroups (e.g., age, sex, race), Columbus Public Health staff analyzed BRFSS data using the most recent year or two available (typically 2021 & 2022). To map the prevalence of this indicator at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the CDC's PLACES[3] resource, which uses BRFSS data (2021 or 2022), Census Bureau data (either the 2020 decennial census or 2022 annual population estimates), and American Community Survey data (2018-2022 estimates).

Data Gap: Because the BRFSS uses telephone interviewing methods to collect this information, it is likely that these statistics *underestimate* the amount of binge drinking occurring in the community. This is because some people might wish to be viewed favorably by the person interviewing them, and therefore not accurately report the full extent to which they engage in a socially unacceptable behavior (e.g., a social desirability bias).

Data Gap: The Community Health Needs Assessment Steering Committee requested recent data about the rates of binge drinking, cigarette use, and e-cigarette use among Franklin County's youth (e.g., those between the ages of 11 and 17). Unfortunately, Ohio's Youth Risk Behavior Survey does not calculate statistical estimates at the county level.

[1] Centers for Disease Control and Prevention, *What is Excessive Drinking?* https://www.cdc.gov/drinklessbeyourbest/excessivedrinking.html

[2] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data, 2022 (HM2025), 2019 (HM2022), 2016 (HM2019),

[3] Centers for Disease Control and Prevention, PLACES: Local Data for Better Health. (n.d.) https://www.cdc.gov/places/index.html

Tobacco Use

Cigarette use is one of the highest contributors to mortality, disease, disability, and overall health status worldwide and in the United States.[1] Aside from the approximately 480,000 smoking-attributable deaths in smokers every year, there are also approximately 41,000 deaths from secondhand smoke exposure. Although decades of intervention have successfully decreased cigarette smoking rates, there is still progress to be made.

Originally marketed as a smoking cessation tool with fewer risks than traditional cigarettes, e-cigarettes increased in popularity over the past 10-15 years, especially among youth and young adults. Early evidence already suggests that there may be significant long and short term risks to e-cigarette use, particularly for the respiratory system.[2]

15.2% of Franklin County adults reported currently **smoking cigarettes**.

Down from HM2022 (22.7%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
18-64 more likely	Male more likely	Other races (non-Hispanic) more likely	Observed (see map)

9.1% of Franklin County adults reported currently **using e-cigarettes**.

Up from HM2022 (6.8%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
18-64 more likely	Female more likely	Other races (non-Hispanic) more likely	Observed (see map)

Community Voices

Community members worry less about traditional cigarette use in their communities, and more about e-cigarette use, which they perceive as overwhelmingly common among ex-smokers and people who have never smoked. They are highly concerned about misconceptions surrounding the healthiness of vaping.

> *"Some people are trying to go to vaping to quit smoking, but it's having the exact opposite effect. They're more addicted to it. They are using it more often. They're having to go to higher nicotine levels. It's doing the exact opposite."*

> *"I see a lot of people giving up tobacco think that the e-cigarettes are going to are safer. That to me is the big problem. They really aren't. But people really have that belief that, well, I don't really smoke."*
>
> *"And a lot of people who weren't smoking in any capacity, over time, have gotten hooked on vapes because it's like, you have a drink, you're at a party, and this isn't a cigarette. This thing tastes like candy, and you smell the cloud of it. And you're like, this is harmless. This is vapor."*
>
> *"That's really troubling to somebody my age to see young people vaping, when so much information has not come out or been made available. The oils and how that goes into your lungs and stuff. That really concerns me for young people."*

Ease of access, misconceptions about the safety of vaping, and its use as a coping mechanism for stress and anxiety contribute to the pervasiveness of vaping amount the county's youth.

> *"I used to do substance use prevention in middle schools, and that was a big thing…so many kids knew about vapes and have them. Not even be able to make it through class without needing a vape. Like, going to the bathroom and taking a vape."*
>
> *"For my daughter, she never, we never smoked or drank or anything growing up. And then when she went to college 2 hours away, she ended up starting smoking. And she said it calms her nerves."*

While encouraging residents and businesses to follow laws around vape sales and spreading accurate information about the health risks is necessary to decrease this behavior, efforts must also contend with how appealing vapes are compared to traditional cigarettes, and the difficulty of regulating the industry.

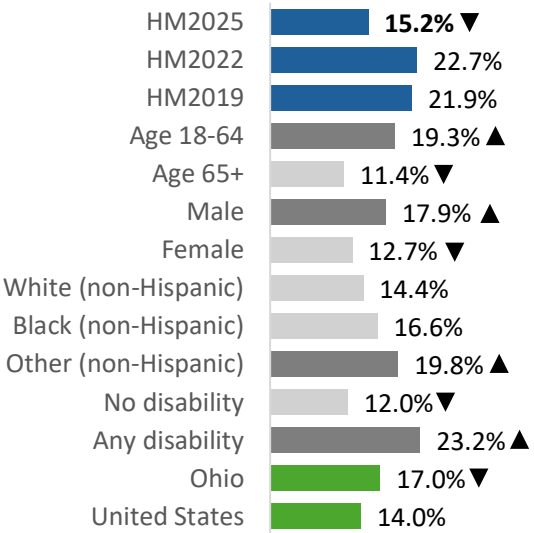
> *"It's the taste, you know, they don't feel as bad. It doesn't taste like a regular cigarette."*
>
> *"There's no social drawback of just vaping a mango kiwi."*
>
> *"I think the oversight is the piece that's slow. Technology is moving fast. The amount of nicotine that you're getting, the size of the e-cigarettes…the vaping and the nicotine is moving faster than the government can say, 'Hey, let's regulate this. Hey, let's put a study on this, or let's try to stop this.'"*
>
> *"They banned that brand. But then there's so many other brands. And the reason why they banned that brand is because you had a lot of people, like, getting stuff wrong with their esophagus…but it's like, why would you ban the brand and then there's 20 other brands? People still have access."*

Some community members perceive attempts to curb smoking and vaping as futile, ineffective solutions that impose unreasonable burdens.

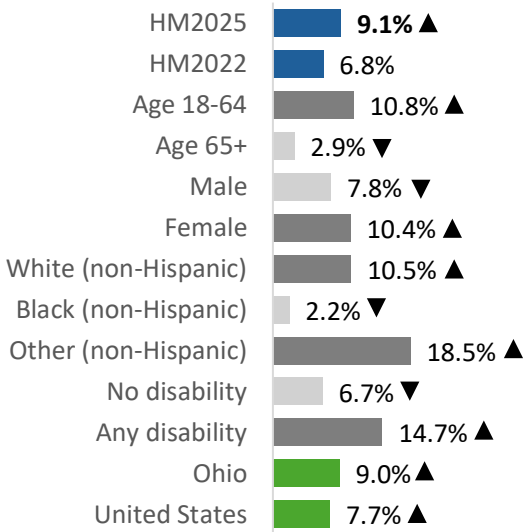
> *"It makes me so mad that our legislators are trying to deal with these issues by banning certain things or by dealing with the symptoms or the superficial. Like, they're gonna ban menthol cigarettes, but you're not really dealing with tobacco use. You're not taking on the big tobacco companies. You're not doing anything except making it harder for me to get a new pack…And you're not stopping anything. You're just putting more stress and making it harder on communities that are already vulnerable, already at risk, already stressed out…"*
>
> *"My community just made everything nonsmoking. You can't smoke in your house. You can't smoke out on the premises anywhere. And I'm like, you're paying almost $2,000 to live in these so-called luxury apartments, and you telling me I can't smoke a cigarette, that just blows my mind."*

As shown below, current cigarette use has dropped significantly since *HealthMap2022*. However, although the Franklin County adult smoking rate is lower than that for Ohio, it is still above the US average. Furthermore, e-cigarette use among Franklin County adults has increased since *HealthMap2022*.

Cigarette Smoking



E-Cigarette Use



The demographic patterns are stark: individuals with an other (non-Hispanic) racial background use e-cigarettes as often as cigarettes. Additionally, males are more likely than females to smoke cigarettes, while females are more likely than males to use e-cigarettes. Black (non-Hispanic) individuals were distinctly unlikely to use e-cigarettes, which is an

interesting trend given that cigarette use among black (non-Hispanic) adults was higher than the average. As expected, e-cigarette use among older adults was very low.

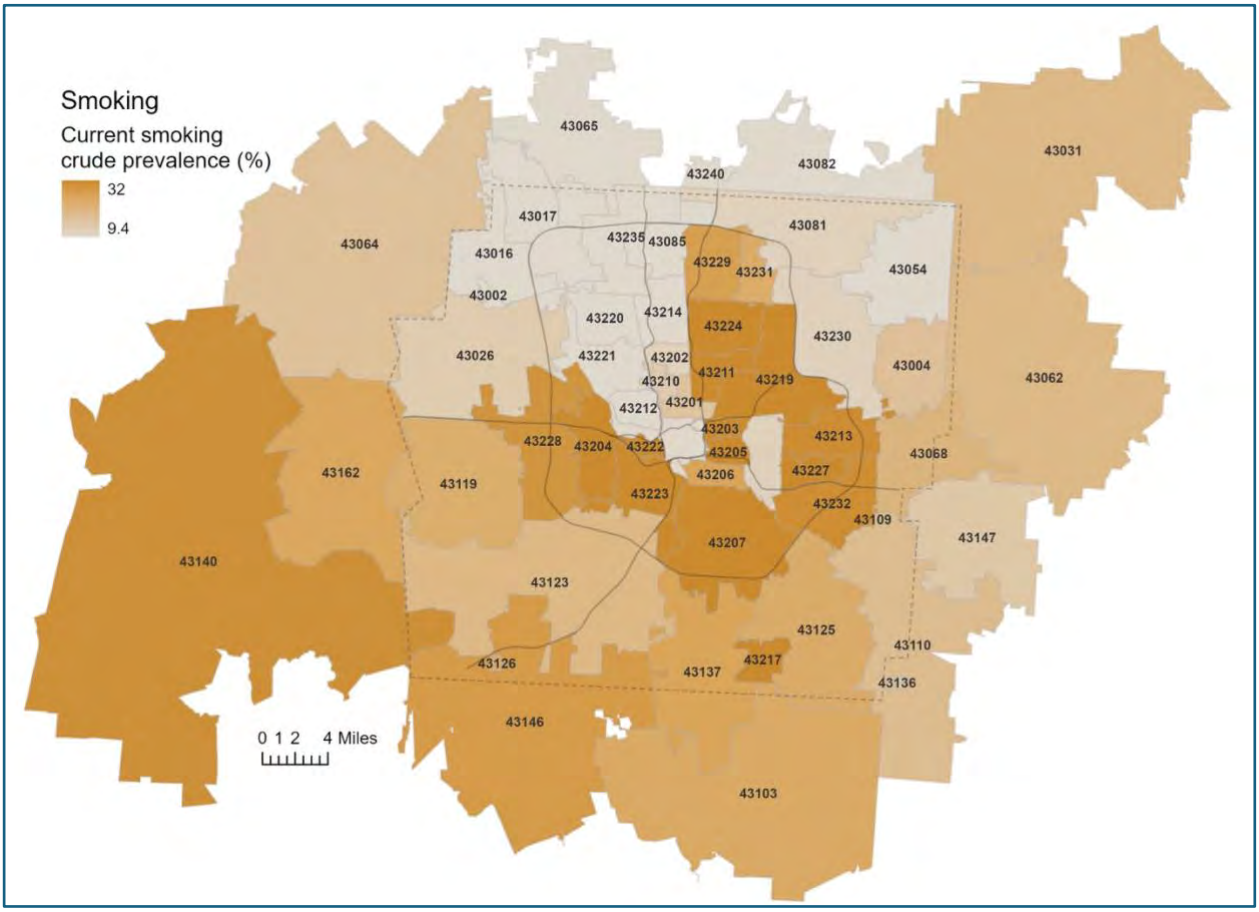
Healthy People 2030

While Franklin County does not meet the Healthy People 2030 standard, there has been significant improvement from HM2022, which estimated that 22.7% of Franklin County adults were current smokers.[3] Unfortunately, there is no HP2030 goal for e-cigarette use among adults.

HP2030 objective for Adults Currently Smoking Cigarettes: Not met (but improving)

Healthy People Objective:	Most recent Franklin County data (HM2025)
6.1%	**15.2%**

Smoking prevalence is higher in most Franklin County zip codes that are within I-270, except for those zip codes in the northwestern quadrant. Prevalence rates are also higher in many of the county's southern zip codes.



Additional Information & References

To assess the prevalence of this health behavior, *HealthMap2025* obtained recent data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS), which completes structured survey interviews with residents via telephone.[4] To assess cigarette use, adults were asked whether they smoke cigarettes every day, some days, or not at all. To assess e-cigarette use, adults were asked whether they have never used e-cigarettes, use every day, use some days, or used them in the past but not now. Participants were classified as current users if they used the product some days or every day.

Note that the question on e-cigarette use changed slightly in BRFSS' 2022 version of the survey questionnaire. In 2021, the question read "Do you now use e-cigarettes or other electronic vaping products every day, some days or not at all?" and in 2022 became "Would you say you have never used e-cigarettes or other electronic vaping products in your entire life or now use them every day, use them some days, or used them in the past but do not currently use them at all?" Both questions result in the same group being categorized as current users (every day or some days), however the new question allows further clarification of "never users" compared to "past users".[4] Still, considering there was a change in question wording, readers should be cautious when drawing conclusions about changes over time.

It is also important to note that multiple cities in Franklin County (e.g., Columbus, Bexley, Dublin, Grandview Heights) instituted a ban on the sale of all flavored nicotine products as of January 1, 2024. This measure has faced several legal challenges, and it is unclear whether it will withstand scrutiny from higher courts.[5] There is not yet data to discern whether this measure has or will have any effect on tobacco use in Franklin County, but this will be a critical issue in future *HealthMap* assessments.

To enable comparisons by demographic subgroups (e.g., age, sex, race), Columbus Public Health staff analyzed BRFSS data using the most recent year or two available (typically 2021 & 2022). To map the prevalence of these indicators at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the CDC's PLACES[6] resource, which uses BRFSS data (2021 or 2022), Census Bureau data (either the 2020 decennial census or 2022 annual population estimates), and American Community Survey data (2018-2022 estimates).

[1] National Center for Chronic Disease Prevention and Health Promotion (US) Office on Smoking and Health. (2014). *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General*. Centers for Disease Control and Prevention (US).

[2] Marques, P., Piqueras, L., & Sanz, M. J. (2021). An updated overview of e-cigarette impact on human health. *Respiratory research*, *22*(1), 151. https://doi.org/10.1186/s12931-021-01737-5

[3] Healthy People 2030 objective TU-02, U.S. Department of Health and Human Services

[4] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data, 2022 (HM2025), 2019 (HM2022), 2016 (HM2019)

[5] Shipkowski, Bruce. (2024, May 20). *Judge rules Ohio law that keeps cities from banning flavored tobacco is unconstitutional*. Associated Press. https://apnews.com/article/ohio-tobacco-regulations-local-vaping-bans-41396258b60c26798ec128e85851dfac

[6] Centers for Disease Control and Prevention, PLACES: Local Data for Better Health. (n.d.) https://www.cdc.gov/places/index.html

Weight Status

Weight is an important health indicator for mortality, chronic health conditions, and quality of life. Individuals at a higher weight are at greater risk for conditions such as cancer, heart disease, and diabetes. In 2015, high body mass index (BMI) contributed to 7.1% of deaths and 4.9% of disability-adjusted life years globally.[1]

29% of Franklin County adults reported **being overweight**.

≈ Similar to HM2022 (30.6%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
65+ more likely	Male more likely	White more likely	Observed (see map)

37% of Franklin County adults reported **being obese**.

≈ Similar to HM2022 (35.7%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
None observed	Female more likely	Black more likely	Observed (see map)

Community Voices

Community members noted that weight status contributes to many other physical health issues, and that achieving a healthier weight status becomes even more difficult due to the compounded issues.

> *"I think that obesity led to issues in my knees. So now I have arthritis in my knees. They would always say, if you lose some of that weight, it'll take less off of your knees and your ankles and that kind of thing…Diabetes and blood pressure can also lead to swelling and inflammation. But to [lose weight], you got to have the ability to. Like, I would never go anywhere because I would be out of breath in ten minutes. I couldn't walk up that hill, so I wasn't going there."*

Community members cited difficulty achieving adequate physical activity as a primary contributor to overweight status. Contributors to inadequate physical activity mentioned included the lack of affordable places to exercise, work schedules, work environments, and a culture that prioritizes cars, among others.

"Health wise, weight gain and things like that, there's not many other things except for expensive gyms to go to. I get off late at night. I'm not gonna go walk around at 10:00 at night and get my exercise."

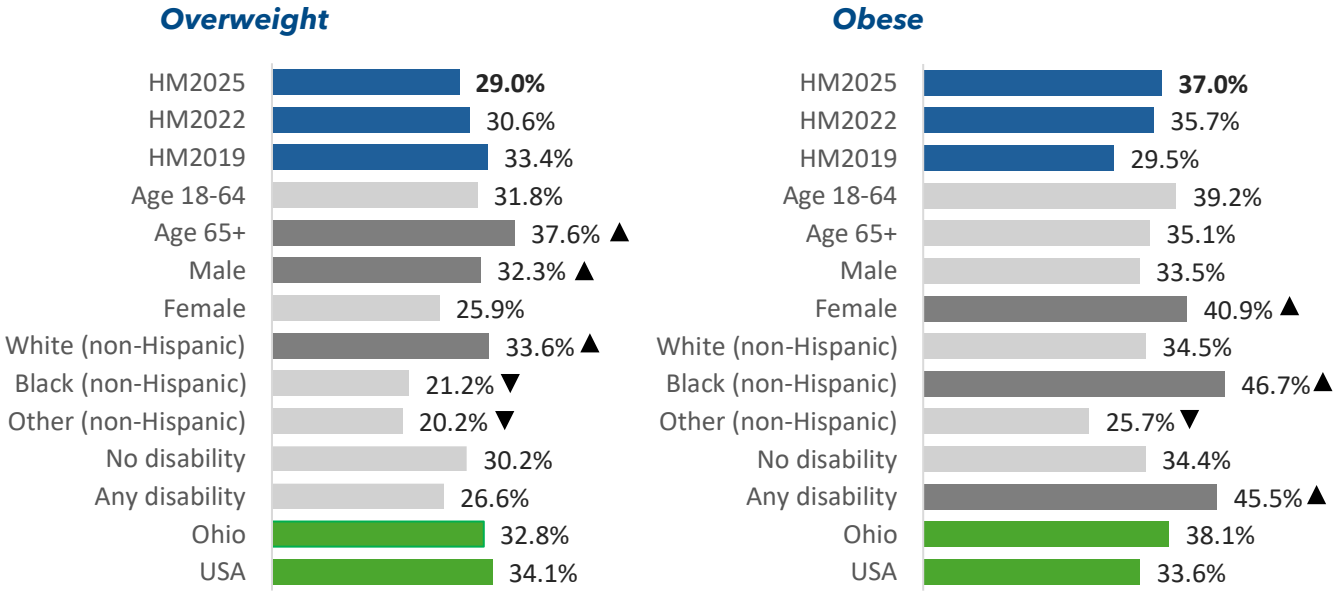
"My neighborhood stays quiet. There's a lot of kids, but I think most of the time they're either on their phones or in the house, playing video games…so it's creating a lazier, more unhealthier child that's [creating a cycle]…they'll have kids, and they just see their parents doing nothing."

"I work in an office environment…. [A lot of us are] sitting all day and possibly not getting the exercise or the movement that we might need…we have little stand up desks, but we're not moving around all day. We're literally just sitting there."

"Our country, our nation is gearing towards driving to get to places. Bikes are actually fading away. We barely see people biking around. Walking is not safe anymore. So people barely walk and stuff. So I think that lack of mobility is causing the obesity and overweight."

"The cost, yeah, Silver Sneakers is free. But then you get into knowing that our high schools uses that pool for their swimming…if you want a lap lane, you have to now reserve it. So it's like you have the initiative to go do something, but you kind of get detoured."

In Franklin County, black (non-Hispanic) individuals are more likely to be obese than overweight, indicating that there may be unmet needs for intervention for this population. Women are also more likely to be obese than overweight compared to men. Hispanic individuals were excluded from this analysis due to low sample size.



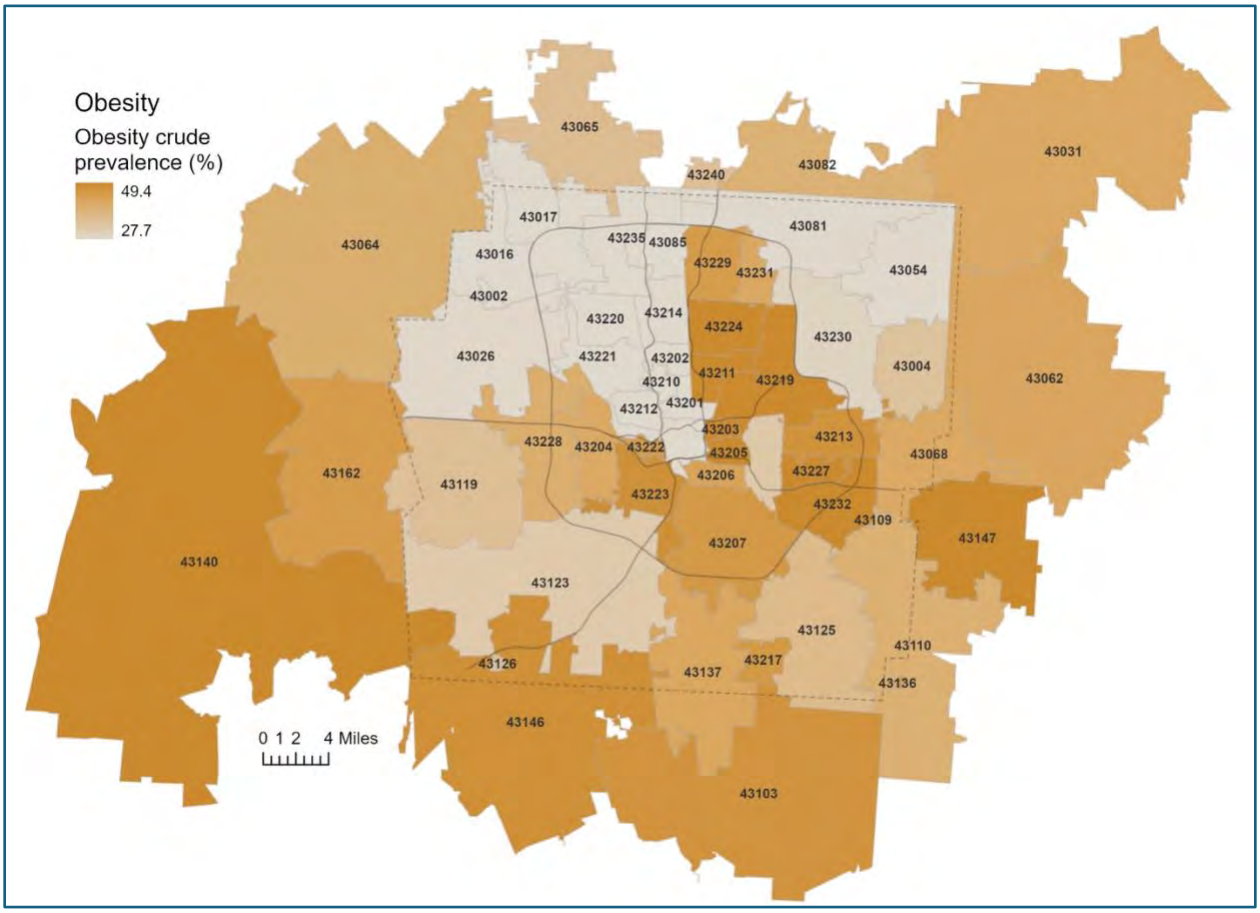
Healthy People 2030

Healthy People 2030 uses data from the National Health and Nutrition Examination Survey, which estimated that 38.6% of US adults were obese from 2013-2016. The BRFSS data used in HM2025 has a more conservative US estimate of 33.6% from 2021-2022. On either measure, the rate of obesity is rising locally and nationwide. There is no Healthy People 2030 goal for overweight status.

HP2030 objective for Obesity: Not met

Healthy People Objective:	Most recent Franklin County data (HM2025)
36%	**37%**

Obesity prevalence is higher in many Franklin County zip codes that are within I-270, except for those zip codes in the northwestern quadrant and the far northeastern areas. Prevalence rates are also higher in some of the county's southern zip codes.



Additional Information & References

To assess the prevalence of this health status, *HealthMap2025* obtained recent data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS), which completes structured survey interviews with residents via telephone.[3] A body mass index (BMI) of less than 18.5 is considered underweight, 18.5-24.9 is considered normal, 25-29.9 is considered overweight, and 30+ is considered obese.[4]

Although BMI is a commonly used measure of overweight/obesity status, it has been criticized as an outdated and discriminatory marker of health. This measure was developed in the 1800s and based primarily on male bodies, which are not the standard for all humans. Because BMI is a ratio of height to weight, the measure cannot differentiate between lean (muscle) mass and fat mass. Therefore, an elite athlete may be classified as overweight or obese despite being very fit and healthy. However, there are no other standardized measures of body composition that are as widely known and used.[5]

To enable comparisons by demographic subgroups (e.g., age, sex, race), Columbus Public Health staff analyzed BRFSS data using the most recent year or two available (typically 2021 & 2022). To map the prevalence of this indicator at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the CDC's PLACES[6] resource, which uses BRFSS data (2021 or 2022), Census Bureau data (either the 2020 decennial census or 2022 annual population estimates), and American Community Survey data (2018-2022 estimates).

Data Gap: The Community Health Needs Assessment Steering Committee requested recent data about the proportion of adult residents who meet physical activity guidelines. Unfortunately, the BRFSS stopped measuring this metric in 2019.

[1] GBD 2015 Obesity Collaborators, Afshin, A., Forouzanfar, M. H., Reitsma, M. B., Sur, P., Estep, K., Lee, A., Marczak, L., Mokdad, A. H., Moradi-Lakeh, M., Naghavi, M., Salama, J. S., Vos, T., Abate, K. H., Abbafati, C., Ahmed, M. B., Al-Aly, Z., Alkerwi, A., Al-Raddadi, R., Amare, A. T., … Murray, C. J. L. (2017). Health Effects of Overweight and Obesity in 195 Countries over 25 Years. *The New England journal of medicine*, *377*(1), 13–27. https://doi.org/10.1056/NEJMoa1614362

[2] Healthy People 2030 objective NWS-03, U.S. Department of Health and Human Services.

[3] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data, 2022 (HM2025), 2019 (HM2022), 2016 (HM2019)

[4] Weir, C. B., & Jan, A. (2023). BMI Classification Percentile And Cut Off Points. In *StatPearls*. StatPearls Publishing.

[5] Nuttall F. Q. (2015). Body Mass Index: Obesity, BMI, and Health: A Critical Review. *Nutrition today*, *50*(3), 117–128. https://doi.org/10.1097/NT.0000000000000092

[6] Centers for Disease Control and Prevention, PLACES: Local Data for Better Health. (n.d.) https://www.cdc.gov/places/index.html

MATERNAL AND INFANT HEALTH

Pre-pregnancy And Pregnancy Health

The health of pregnant individuals before and during their pregnancy is a significant opportunity for meaningful intervention. Pregnant individuals with medical comorbidities are at significantly increased risk for complications for both parent and child, including severe morbidity such as placental abruption, eclampsia, and neonatal intensive care unit (NICU) admission.[1]

43.7% of women who had a live birth had a **chronic health condition**.

≈ Similar to HM2022 (42.8%)

Disparities by selected social determinants of health: *White more likely*

44.9% of women who had a live birth were not taking **vitamins** before pregnancy.

≈ Similar to HM2022 (48.8%)

Disparities by selected social determinants of health: *Hispanic, Black more likely*

18.4% of women who had a live birth had pre-pregnancy **depression**.

≈ Similar to HM2022 (17.7%)

Disparities by selected social determinants of health: *White more likely*

6.1% of women who had a live birth had pre-pregnancy **hypertension**.

↑ Up from HM2022 (5.4%)

Disparities by selected social determinants of health: *Black more likely*

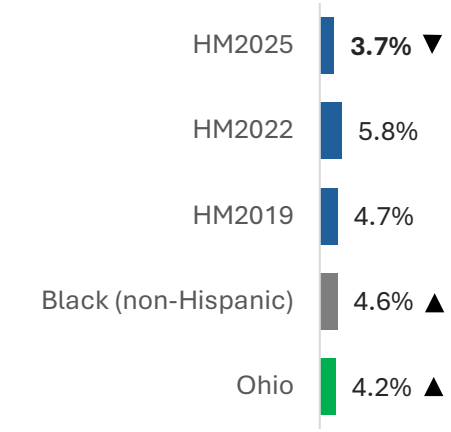
24.9% of live births were from **unintended pregnancies**.

≈ Similar to HM2022 (23.9%)

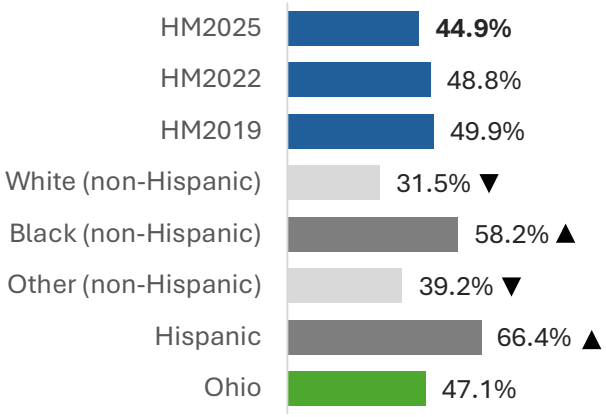
Disparities by selected social determinants of health: *Black, Hispanic more likely*

Although pre-pregnancy diabetes has decreased in recent years, black (non-Hispanic) residents are at increased risk for that health condition. Both black (non-Hispanic) and Hispanic residents were more likely to report not taking vitamins prior to pregnancy, as compared to white (non-Hispanic) residents or individuals who have an other (non-Hispanic) racial background.

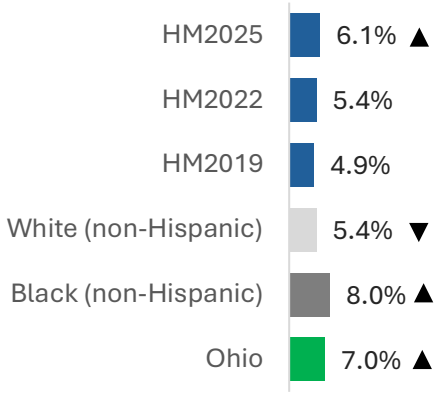
Pre-pregnancy Diabetes



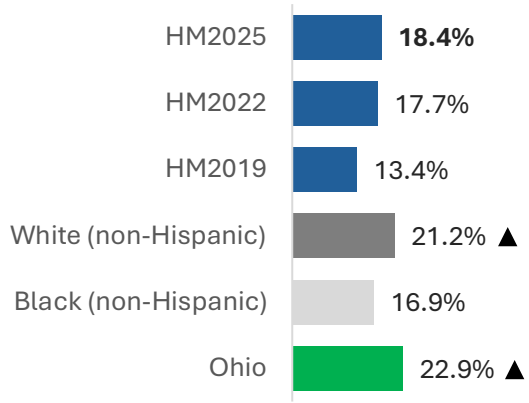
No Vitamins Pre-pregnancy



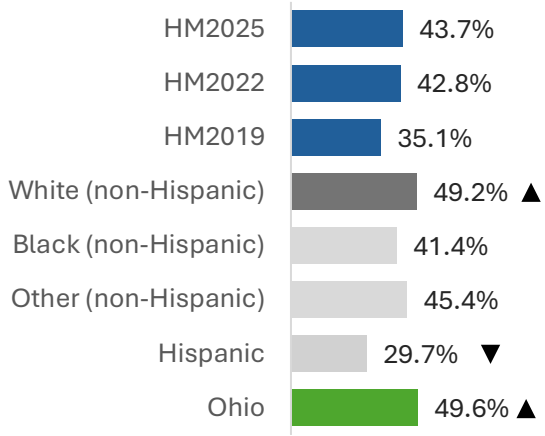
Pre-pregnancy Hypertension



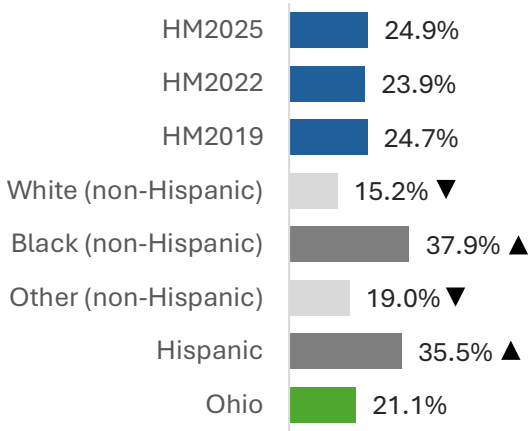
Pre-pregnancy Depression



Prenatal Chronic Conditions



Unintended Pregnancy



Additional Information & References

Data for this section were sourced from the Ohio Pregnancy Assessment Survey (OPAS), which asks questions of women who had a live birth.[2] Pre-conception vitamin usage was defined as taking multivitamins, prenatal vitamins, or other folic acid vitamins in the month before conception. Pre-pregnancy diabetes was defined as type 1 or 2 diabetes in the past 3 months before conception. Similarly, pre-pregnancy hypertension and depression were measured in the 3 months before conception. Prenatal chronic health conditions were defined as one or more conditions of anxiety, depression, gestational diabetes, or pregnancy-onset hypertension. Finally, unintended pregnancy was defined as either wanting to be pregnant later or not wanting to be pregnant at all prior to conception.

Readers might notice that pre-pregnancy overweight and obesity status was reported in *HealthMap2022* but not in *HealthMap2025*. This is because these data are no longer publicly reported by OPAS. This may be due in part to the increasing normalization of pregnancy at a higher BMI.

Data Gap: Future HealthMaps should consider obtaining data about pregnancy-related / maternal mortality.

[1] Tanner, M. S., Malhotra, A., Davey, M. A., Wallace, E. M., Mol, B. W., & Palmer, K. R. (2022). Maternal and neonatal complications in women with medical comorbidities and preeclampsia. *Pregnancy hypertension*, *27*, 62–68. https://doi.org/10.1016/j.preghy.2021.12.006

[2] Ohio Department of Health. *Ohio Pregnancy Assessment Survey* [Interactive Dashboard]. Retrieved from https://grcapps.osu.edu/app/opas, 2022 (HM2025), 2019 (HM2022), 2016 (HM2019)

Prenatal Racial Bias

Health disparities by race have been increasingly highlighted as a contributor to the maternal-child health crisis in the United States.[1] One proposed mechanism for why certain groups experience greater risks is bias or discrimination in healthcare. This may result in patients receiving substandard medical care or avoiding prenatal care altogether.[1]

9.9% of **pregnant individuals** reported **experiencing racial bias** from a healthcare provider.

Up from HM2022 (6.4%)

Disparities by selected social determinants of health: *Black, Hispanic more likely*

Community Voices

Community members spoke about the issue of maternal mortality, and how inadequate treatment by health care professionals contributes to higher rates for black mothers.

> *"The maternal death rates. If you're white middle class, your average chance of survival [in pregnancy and childbirth] is much greater than ours. I think it's like twice. The difference is pretty high. And that's just egregious. We have needs, we have the ability, we're just not putting the resources in."*
>
> *"Moms are going into hospitals and they're not believing in their pain. My aunt's friend went into the hospital, and she had her baby. She kept telling there was something wrong, and they left her for 4 hours…She passed away. She had an aneurysm. And she has been telling them all this time…the migraine, the headache she was having, it was so bad. They just told her, 'It's from the epidural.' And that's probably true…I'm pretty sure she would have been a great advocate for herself, but she was just in so much pain, she couldn't do it."*

Community members also gave other specific examples of how they have seen racial bias within the health care system, including health care professionals not listening to their wishes for labor and delivery, inadequate treatment of health issues resulting from pregnancy, and unfair assumptions that young black women are sexually promiscuous.

> *"I just had a baby eight months ago. And if it wasn't for the doula putting a birth plan and being an advocate for me, things could have went left several times during the delivery process. So you just think that not everyone has access to someone who can advocate for you in that process. They were trying to push a lot of stuff. I was very much like, I don't want any medication unless medically necessary…They'll go out the room and have those*

> *conversations, come back and try to still push it. And so it was frustrating at times…"*
>
> *"I had gallstones for the whole time I was pregnant. Found out that they were gallstones after I had my son. And then I'm still complaining of pain. It's like up to a year and a half later, maybe two years, and I was in the hospital four or five times. Then guess what? I had pancreatitis, because they never cleaned out my bioduct from the gallstones when I was 16. They never listened to me. And I really do think it's because I'm half black, half Hispanic."*
>
> *"The first time I had sex, I got pregnant, and I had my exam at the hospital. The first thing that they did was check me for STD's and ask me, how many people have I been with, and I have had other friends say, 'that's never happened to us.' I just wonder if the same thing would have happened if I had walked in white."*

Community members suspect that they experience racial bias in the health care system due to historical myths that black women feel less pain, as well as assumptions by health care professionals that their health issues are due to inherent genetic differences.

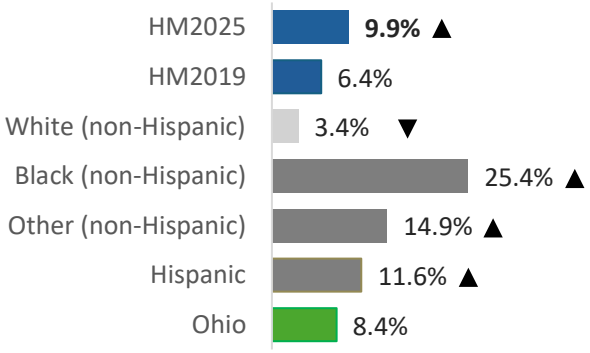
> *"It's obviously not true, but for the longest time in doula training, when you read the books, they were told that black women can accept more pain than a woman that's not black."*
>
> *"I've gone to a doctor and I've actually had them say, 'With you being an African American female, this is probably hereditary, you're probably having diabetes or it's high blood pressure' or something…they're making that assumption without doing the testing. They didn't afford me the opportunity to be tested…'It's probably just this. I don't think you have anything to worry about.' When I tell you I've heard that so many times, and then it develops into something."*

Lastly, a black community member highlighted how the historical treatment of people of color by the health care system and their preclusion from knowledge about their health still impacts the ability of healthcare to be equitable today:

> *"Knowledge is power. I mean, you can advocate better for yourself and for others when you know better. And I think it can be a class issue, it could be a socioeconomic issue. But if we consider racial discrimination or any of those factors…Even if I have access today, the reality is that two, three, four generations ago, it was withheld. Or even if my ancestors had the knowledge, they couldn't do anything with it because they were barred from being able to do so…We're behind. We have to try to play catch up as it pertains to a lot of things that can speak to our physical health, our mental health."*

As would be expected, experiences of racial bias are most common among racial and ethnic minorities. This was particularly prominent for black (non-Hispanic) patients, even compared to other racially minoritized groups. Concerningly, these experiences increased since the last *HealthMap*.

Prenatal Racial Bias Prevalence



Additional Information & References

To assess the experience of racial bias in prenatal care, data from the Ohio Pregnancy Assessment Survey (OPAS) were used.[2] Participants were asked "During your most recent pregnancy, did you experience discrimination or were you made to feel inferior while getting any type of health or medical care because of the things listed below", where one of the options was "My race, ethnicity, or culture". This measure is only reported periodically, with the most recent publicly available data collected in 2020.

[1] ACOG Committee Statement No. 10: Racial and Ethnic Inequities in Obstetrics and Gynecology. (2024). *Obstetrics and gynecology*, *144*(3), e62–e74. https://doi.org/10.1097/AOG.0000000000005678

[2] Ohio Department of Health. *Ohio Pregnancy Assessment Survey* [Interactive Dashboard]. Retrieved from https://grcapps.osu.edu/app/opas, 2020 (HM2025), 2016 (HM2019)

Maternal Healthcare

Pre-pregnancy healthcare visits offer expectant mothers and their doctors an opportunity to discuss healthy diet choices, folic acid supplementation, and other interventions that help to build the foundation for a healthy pregnancy.[1] Postpartum visits allow mothers who recently delivered a baby to be screened for postpartum depression, to have their overall health examined, and to discuss possible pregnancy complications such as gestational diabetes.[2]

72.3% of pregnant individuals had a **healthcare visit** in the year before their pregnancy.

≈ Similar to HM2022 (67.6%)

Disparities by selected social determinants of health: *Hispanic less likely*

90.2% of postpartum individuals had a **postpartum healthcare visit**.

≈ Similar to HM2022 (93.2%)

Disparities by selected social determinants of health: *Hispanic less likely*

Community Voices

Community members are aware that pregnant and postpartum individuals may not seek out health care when they should. They also drew attention to how specific health issues like preeclampsia and postpartum depression can worsen if not addressed by a health care professional.

> *"I hear that they don't get the prenatal [checks], they don't see the doctor like they should."*
>
> *"Postpartum preeclampsia, not knowing that they even have it until after they have the baby and then they're home for like a few days and then they're nearly about to die. But it wasn't caught during pregnancy."*
>
> *"I know I was almost psychotic after I had my child many years ago, and they're all safely grown now. But it was bad. I mean, I literally shudder when I think of the thoughts that would go through your mind. You had no control. And there was just nothing. There was no resources. If you go tell your doctor that, they're going to lock you up, take your kid away. I don't want to lose my child. But there was no help."*

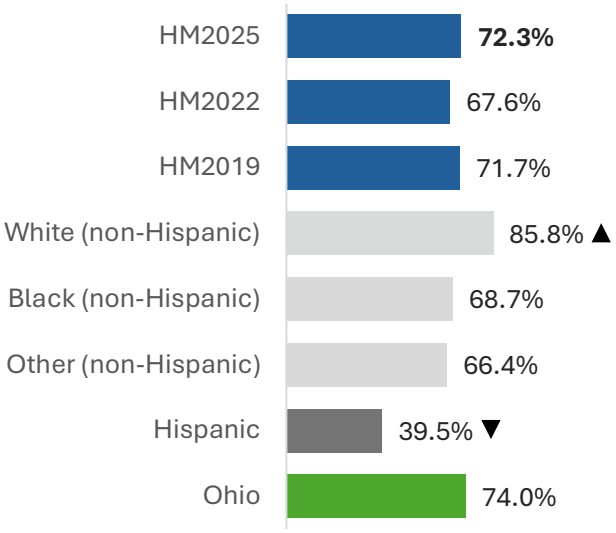
Community members mentioned that one of the reasons pregnant individuals don't seek health care is out of fear they will not receive adequate care. These fears appear to be especially prevalent in black communities.

"A lot of us were scared of doctors because of situations in the past. We really don't trust doctors. It's hard to even find one that we can really bond with…so many black women are dying during childbirth because they're not getting adequate care. They say we were better off back when we caught them ourselves than going to the hospital."

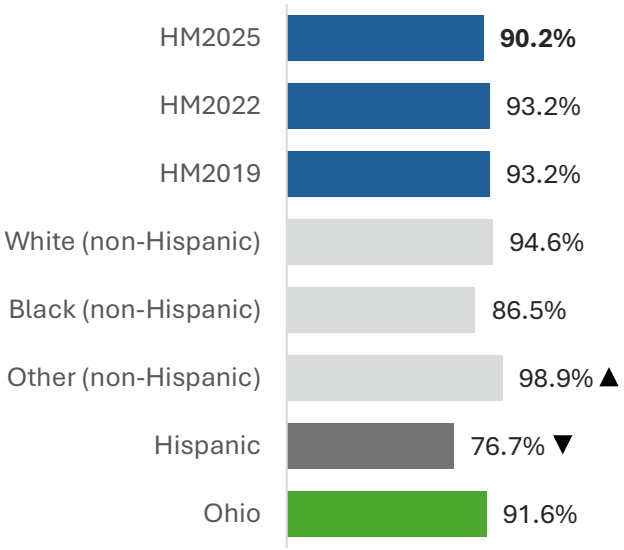
"There's just a lot of stories that you hear out here, where mostly black women are telling horror stories of how they're just not getting the proper care."

Pre-pregnancy healthcare visits were higher among white (non-Hispanic) individuals than all other racial groups and were particularly low among Hispanic individuals. Postpartum healthcare visits are high for all groups but are similarly lowest for Hispanic individuals. This could indicate a cultural or language barrier that can be further addressed.

Pre-pregnancy Healthcare visit



Postpartum Healthcare Visit



Additional Information & References

To assess the healthcare visit status of Franklin County mothers with a recent live birth, *HealthMap2025* used data from the Ohio Pregnancy Assessment System (OPAS).[3] Pre-pregnancy healthcare visits were defined as any visit with a healthcare professional in the 12 months prior to conception. Postpartum healthcare visits were defined as a checkup for the postpartum individual that occurs around 4-6 weeks after delivery.

[1] Berghella, V., Buchanan, E., Pereira, L., & Baxter, J. K. (2010). Preconception care. *Obstetrical & gynecological survey*, *65*(2), 119–131. https://doi.org/10.1097/OGX.0b013e3181d0c358

[2] ACOG Committee Opinion No. 736: Optimizing Postpartum Care. (2018). *Obstetrics and gynecology*, *131*(5), e140–e150. https://doi.org/10.1097/AOG.0000000000002633

[3] Ohio Department of Health. (2022). *Ohio Pregnancy Assessment Survey* [Interactive Dashboard]. Retrieved from https://grcapps.osu.edu/app/opas, 2022 (HM2025), 2019 (HM2022), 2016 (HM2019)

Infant Health and Adolescent Pregnancy

Infant health and mortality is a global concern, even in high-income countries such as the United States. Worldwide, the leading cause of death among those under age 5 is preterm birth, with the third cause of death being intrapartum-related events.[1] Adolescent pregnancy, along with increasing the risk for adverse infant outcomes, is also associated with serious physical and social consequences for the mother.[2]

7.4 infants died per 1,000 live births.	≈ Similar to HM2022 (6.9)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Unavailable	N/A	Black more likely	Observed (see map)

9.4% of infants were **born with a low birthweight**.	≈ Similar to HM2022 (9.5%)
10.6% of infants were **born prematurely**.	≈ Similar to HM2022 (10.9%)
12.1 infants had **neonatal abstinence syndrome** per 1,000 live births.	≈ Similar to HM2022 (11.4)
The **teen birth rate** was **15.2** per 1000 adolescent females.	↓ Down from HM2022 (17.2)

Community Voices

Community members are concerned that the county's youth are unable to access reproductive health care like birth control or abortion. They emphasized the importance of options and choices for teens who become pregnant. Abstinence-only education is not sufficient in their minds to reduce the issue of teen pregnancy.

"What concerns me now is there is not the access to care for young women that there used to be when I was that age. I can remember in high school, driving down to campus to go to Planned Parenthood with friends so that they could get on the pill or do whatever…We always knew in the back of our mind that if something came up, there were options."

"So as far as options, I think that if my mom would have had those options back then, I probably wouldn't be here, but it was an option, and it was a choice. She just did not have that. And there was not even birth control, birth control was not an option for her. From what she told me, it's because she was taught abstinence [only]."

"In high school, they have to take health. The kids consider it a joke. But if the kids think it's a joke, whether it's a valid program or not, then they're not getting anything from it. You're a freshman and you are getting a pregnancy test. And it happens all the time, but I think that means that what we're teaching them, it's not enough."

Community members also think that perceptions that gynecologists should only be seen once a person becomes sexually active are contributing to youth not having enough knowledge or access when it comes to reproductive health.

"A lot of the OBs, they don't even want to see the kids until they're 21. I called her because my daughter had extremely heavy bleeding several days, I wanted to get her on something that could help reduce that. And she's like, 'Well, we don't normally see them until they're 21.' If the health providers in that world are even saying this isn't really the age that we start to see them at, then you reduce the number of places that you can get help."

"One of my friends said to her daughter, 'Now that you've got a boyfriend, we should go to the gynecologist.' And I was standing right there, 'No, no. You go to the gynecologist because you're a woman and you take care of yourself. The boyfriend has nothing to do with this.' And I don't know if that is the message that they're getting."

A lack of education about sex and reproductive health can ultimately result in young parents being unequipped to adequately care for children.

"Young moms don't have the knowledge that they need. Years ago, they would have classes so when you got pregnant, you had a class that taught you the things that you needed, just the stuff you would need to know. Now they have these kids having babies and they don't know anything…they don't have a formula for the baby. Like, she was feeding the baby actual 2% milk because she didn't have any formula. She didn't know she needed the formula. She didn't have a means to get the formula, and her and the baby is just out. They didn't have Pampers."

Relatedly, families' unwillingness to broach the subject of sex and reproduction with their children may prevent youth from accessing birth control when it could be helpful for them.

> *"They don't teach them about their bodies. We have 8, 9-year-old girls who have started their periods, and their parents don't tell them. I remember a little girl, when she was eight, she said, 'I need a pad.' I'm not thinking like a sanitary pad. I'm thinking she was talking about paper… Some of the parents are talking to them, but a lot of them, they're not teaching. And the boys too, they're not teaching them about puberty, how their body's changing, how it's normal to feel what you're feeling."*
>
> *"My family was very closed [off], 'don't talk [about it]'. I don't think we ever even talked about sex, honestly. And when I got to college, the doctor was recommending for my migraines the Depo shot, which is a birth control. And I didn't want to have to tell my parents I needed birth control because I didn't think they would believe me that it wasn't about sex. And so I went to Planned Parenthood, and I used the money I earned working in school, and I got the Depo for $65 every three months."*

The infant health indicators have not changed significantly in recent years; not only does infant mortality remain relatively high, and is especially high among black (non-Hispanic) babies. Franklin County's neonatal abstinence syndrome (NAS) rate is slightly higher than that for Ohio.

Infant Mortality Rate

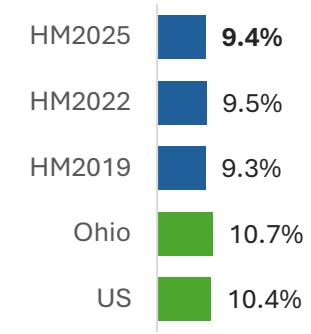
	Rate per 1,000 babies born
HM2025	**7.4**
HM2022	**6.9**
HM2019	**8.7**
White (non-Hispanic)	3.7 ▼
Black (non-Hispanic)	12.6 ▲
Hispanic	7.8
Ohio	**7.1**
US	**5.6**

Neonatal Abstinence Syndrome

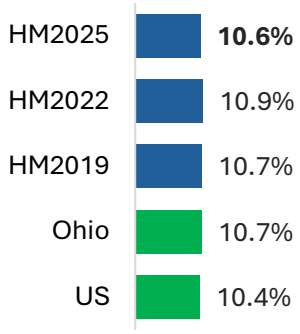
	Rate per 1,000 babies born
HM2025	**12.1**
HM2022	**11.4**
HM2019	**12.3**
Ohio	**10.1** ▼

Although Franklin County is similar to Ohio and the United States with regard to low birthweight and preterm birth rates, the teen birth rate has significantly declined across all geographies.

Low Birthweight



Preterm Birth



Teen Birth Rate

Rate per 1,000 girls age 15-19	
HM2025	**15.2** ▼
HM2022	**17.2**
HM2019	**23.4**
Ohio	**15.4** ▼
US	**13.6** ▼

Healthy People 2030

There is still progress to be made on infant mortality[3] and preterm births[4] in order to achieve the Healthy People 2030 goals. However, the adolescent pregnancy goal[5] has been exceeded and is currently less than half the target rate for that objective.

HP2030 objective for Infant Mortality: Not met

Healthy People Objective:
5.0 per 1000 live births

Most recent Franklin County data (HM2025)
7.4

HP2030 objective for Preterm Births: Not met

Healthy People Objective:
9.4%

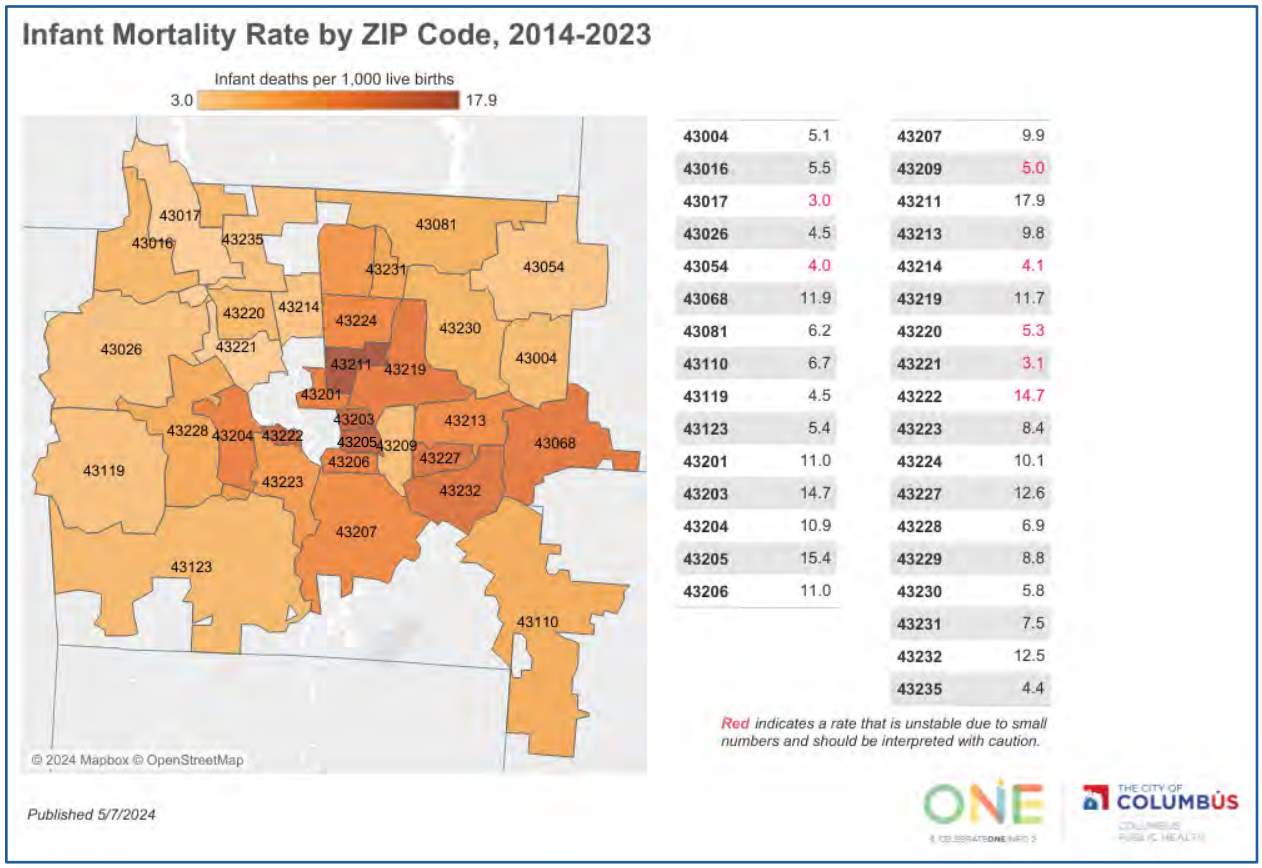
Most recent Franklin County data (HM2025)
10.6%

HP2030 objective for Adolescent Pregnancy: Met

Healthy People Objective:
31.4 per 1000 females aged 15-19

Most recent Franklin County data (HM2025)
15.2

The map below is a screenshot of the infant mortality rate across Franklin County's zip codes from 2014-2023, as mapped by Celebrate One and Columbus Public Health. The zip codes with the highest infant mortality rates are 43211, 43205, 43203, and 43222.[6] Readers who are interested in learning more about this topic are encouraged to visit Celebrate One and Columbus Public Health's interactive map, which can be accessed by **clicking here**.



Additional Information & References

Infant mortality refers to deaths that occur before someone is 1 year of age. Low birthweight is defined as less than 2500 grams (i.e., ~5.5 pounds) and preterm births are births that occur before 37 weeks gestation. NAS hospitalization rates were calculated from the number of reported NAS hospitalizations divided by the number of births in the same year. Adolescent fertility rates were defined as the birth rate of adolescent females aged 15-19 per 1000 in the same age range.

Adolescent pregnancy is challenging to measure both because there is no standard age when an individual becomes fertile and because abortions and miscarriages may be underreported. The most typical age range for reporting adolescent pregnancy and birth is

15-19; although pregnancies can and do occur under 15 years old, they constitute a very small number and are not frequently reported.

Franklin County infant mortality data were sourced from the City of Columbus' Infant Mortality Report for 2023, which in turn obtained data from Ohio Department of Health's Bureau of Vital Statistics about all births in which the mother was a resident of Franklin County.[7] Ohio and US infant mortality were sourced from the National Center for Health Statistics for 2022.[8] Low birthweight and preterm delivery for Franklin County and Ohio were sourced through the DataOhio Birth tool for 2023, while US statistics were again pulled from the National Center for Health Statistics for 2022.[9,10] Neonatal abstinence syndrome data were pulled from the Ohio Department of Health Violence and Injury Prevention division for 2022, 2020, and 2017.[11-14] Finally, adolescent pregnancy rates were sourced from the Centers for Disease Control and Prevention's WONDER database.[15]

[1] Perin, J., Mulick, A., Yeung, D., Villavicencio, F., Lopez, G., Strong, K. L., Prieto-Merino, D., Cousens, S., Black, R. E., & Liu, L. (2022). Global, regional, and national causes of under-5 mortality in 2000-19: an updated systematic analysis with implications for the Sustainable Development Goals. *The Lancet. Child & adolescent health*, *6*(2), 106–115.

[2] Maheshwari, M. V., Khalid, N., Patel, P. D., Alghareeb, R., & Hussain, A. (2022). Maternal and Neonatal Outcomes of Adolescent Pregnancy: A Narrative Review. *Cureus*, *14*(6), e25921. https://doi.org/10.7759/cureus.25921

[3] Healthy People 2030 objective MICH-02, U.S. Department of Health and Human Services

[4] Healthy People 2030 objective MICH-07, U.S. Department of Health and Human Services

[5] Healthy People 2030 objective FP-03, U.S. Department of Health and Human Services

[6] Celebrate One and Columbus Public Health (2023). Infant Mortality Report. https://public.tableau.com/app/profile/columbus/viz/InfantMortalityReport/P1Home

[7] City of Columbus. (2023). *Infant Mortality Report Franklin County, Ohio* [Interactive Dashboard]. Retrieved in 2024 from https://public.tableau.com/app/profile/columbus/viz/InfantMortalityReport/P1Home

[8] Ely DM, Driscoll AK. Infant mortality in the United States: Provisional data from the 2022 period linked birth/infant death file. National Center for Health Statistics. Vital Statistics Rapid Release; no 33. Hyattsville, MD: National Center for Health Statistics. 2023. DOI: https://doi.org/10.15620/cdc:133699

[9] DataOhio. (2023). *Birth* [Interactive Dashboard]. Ohio Department of Health, Bureau of Vital Statistics. Retrieved in 2024 from https://data.ohio.gov/wps/portal/gov/data/view/ohio_births

[10] Osterman MJK, Hamilton BE, Martin JA, Driscoll AK, Valenzuela CP. Births: Final data for 2022. National Vital Statistics Reports; vol 73, no 2. Hyattsville, MD: National Center for Health Statistics. 2024. DOI: https://dx.doi.org/10.15620/cdc:145588.

[11] Violence and Injury Prevention Section, Ohio Department of Health. (n.d.). *2022 Ohio Neonatal Abstinence Syndrome County Report*. https://odh.ohio.gov/wps/wcm/connect/gov/c9ba2f12-7d0a-4c4d-a7fd-ac9df2841c4a/Ohio+NAS+Data+by+County%2C+2018-2022.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_79GCH8013HMOA06A2E16IV2082-c9ba2f12-7d0a-4c4d-a7fd-ac9df2841c4a-oHsSMQB

[12] Violence and Injury Prevention Section, Ohio Department of Health. (n.d.). *2020 Ohio Neonatal Abstinence Syndrome County Report*. https://odh.ohio.gov/wps/wcm/connect/gov/7105d74d-7647-4dd6-83f9-9cbd0bba0d1c/Ohio+NAS+Data+by+County%2C+2016-2020.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-7105d74d-7647-4dd6-83f9-9cbd0bba0d1c-nNqG8oP

[13] Violence and Injury Prevention Section, Ohio Department of Health. (n.d.). *2017 Ohio Neonatal Abstinence Syndrome County Report*. https://odh.ohio.gov/wps/wcm/connect/gov/4cad708c-ba99-4b8b-b425-01cfef119c5d/2017+NAS+County+Table+12.3.2018.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-4cad708c-ba99-4b8b-b425-01cfef119c5d-oNFlFoC

[14] Violence and Injury Prevention Section, Ohio Department of Health. (n.d.). *2022 Ohio Neonatal Abstinence Syndrome Report*. https://odh.ohio.gov/wps/wcm/connect/gov/bb7407ed-f681-4ec0-b73e-572ffe05bb31/2022+NAS+Hospital+Discharge+Data+Summary+Table.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-bb7407ed-f681-4ec0-b73e-572ffe05bb31-oHsSFwF

[15] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER Online Database. Data are from the Natality Records 2016-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/natality-expanded-current.html

Celebrate One and Columbus Public Health's interactive map can be accessed at https://public.tableau.com/app/profile/columbus/viz/InfantMortalityReport/P1Home.

INFECTIOUS DISEASES

Common Infectious Diseases

Infectious diseases are among the leading causes of death worldwide, even in high income countries.[1] COVID-19, which emerged in 2019, has become the most commonly reported infectious disease, one that has long-term and severe health effects (including serious illness and/or death), especially among vulnerable members of the population. Community members continue to be at risk for COVID-19, and preventing the spread of this and other diseases continues to be a public health concern in Franklin County.

The most commonly reported **infectious diseases** for both adults and children were **COVID-19, Chlamydia,** and **Gonorrhea**

New metrics for HM2025

The most commonly reported infectious disease was COVID-19 for both adults and children/adolescents, followed by several sexually transmitted diseases and foodborne pathogens. Pertussis is a vaccine preventable disease, so the ongoing infection rate underscores the importance of continuing vaccination efforts. Interventions regarding sexually transmitted and foodborne illnesses continue to be important as well.

Adults (18+)

Disease	Rate per 1,000
COVID-19	**28.37**
Chlamydia	**9.16**
Gonorrhea	**3.99**
Syphilis (Primary and Secondary)	0.56
Campylobacter	0.27
Salmonella	0.15
Streptococcal disease, group a invasive (IGAS)	0.14
Streptococcus pneumoniae, invasive disease (ISP)	0.14
Legionella	0.08
Ecoli	0.08

Children (0-17)

Disease	Rate per 1,000
COVID-19	**14.45**
Chlamydia	**3.50**
Gonorrhea	**1.00**
Campylobacter	0.24
Giardia	0.19
Salmonella	0.17
Pertussis	0.13
Shigella	0.12
Ecoli	0.11
Lyme Disease	0.09

In *HealthMap2022*, infectious diseases were measured for the total population (instead for separately for adults and for children), resulting in a rate of 7.86 per 1,000 for chlamydia and 3.78 per 1,000 for gonorrhea. By recalculating these infectious diseases for the total

population in *HealthMap2025*, the rate of chlamydia is observed to be similar (7.84 per 1,000) while the rate of gonorrhea has decreased (3.30 per 1,000).

Additional Information & References

Using data from the Ohio Disease Reporting System, Columbus Public Health's Office of Epidemiology provided the total number of infectious disease cases in 2023 for each of the top 10 reported diseases among adults and children (separately). Case numbers were then converted into crude rates based on the age-specific population of Franklin County, using 2023 population estimates provided by Ohio's Department of Public Safety.[2]

The data in this report are based on counts of infectious diseases that were reported to the Ohio Department of Health. Some illnesses, such as influenza, are not reportable unless there is a severe outbreak, novel infectious, or severe morbidity or mortality. Other diseases may not be reported if the individual is asymptomatic or manages symptoms at home without medical intervention. Influenza was excluded from these data, as the counts would only include hospitalizations or mortality and would be a misleading presentation of influenza rates.

Data Gap: Readers might be surprised to learn about the prevalence of sexually transmitted infections among youth aged 0-17. One possible data source that could potentially add context to this finding is the High School Youth Risk Behavior Survey (YRBS). Although 2023 YRBS data for Ohio were not available in time for inclusion in this report, they are now available online at https://youthsurveys.ohio.gov/reports-and-insights/yrbs-yts-reports. Those data could be analyzed to determine if there have been changes in the percentage of high school youth who reported ever having sexual intercourse, current sexual activity, or condom use.

[1] World Health Organization. (2024). *The Top 10 Causes of Death.* https://www.who.int/news-room/fact-sheets/detail/the-top-10-causes-of-death

[2] Ohio Division of Emergency Medical Services, Ohio Department of Public Safety. (2024). Personal communication.

Human Immunodeficiency Virus (HIV)

Human Immunodeficiency Virus (HIV) was first identified in 1981, exponentially rising to over 130,000 cases annually by 1984 in the United States before being controlled by greater surveillance and treatment.[1] Rapid advancements in prophylactic and antiretroviral therapies have both decreased transmission rates and extended the expected lifespan of HIV infected individuals to be close to non-HIV infected individuals.[2]

There were **14.8 new HIV diagnoses** per 100,000 Franklin County residents.

≈ Similar to HM2022 (16.3)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Unavailable	Male more likely	Black more likely	Unavailable

Although Franklin County's overall HIV incidence rate has not changed significantly in recent years, it remains higher than the rates for Ohio and the United States.

Within Franklin County, there are vast disparities by both race and sex: individuals who do not have a white racial background and males are much more likely to have been diagnosed with HIV.

HIV Incidence	**Rate per 100,000**
HM2025	**14.8**
HM2022	**16.3**
White	6.7 ▼
Black/African American	34.5 ▲
Multi-Race	20.7 ▲
Hispanic	24.8 ▲
Male	22.6 ▲
Female	7.3 ▼
Ohio	**7.4**
US	**13.3**

Healthy People 2030

The Healthy People 2030 goal for HIV is a total of 3000 new infections per year nationally, which is equivalent to a rate of 0.9 per 100,000 population.[3] Franklin County (indeed, the United States as a whole) still has much progress that needs to be made toward this objective.

HP2030 objective for New HIV Infection: Not met

Healthy People Objective:	Most recent Franklin County data (HM2025)
0.9	**14.8**

Additional Information & References

To assess HIV incidence in Franklin County and Ohio, *HealthMap2025* sourced data about new infections from the Ohio Department of Health HIV/AIDS Surveillance Program for 2022 and 2019.[4,5] For the United States rates, data were obtained from the Centers for Disease Control and Prevention HIV Surveillance Report for the same years.[6]

Data Gap: Future *HealthMaps* should explore the possibility of calculating HIV incidence within each Franklin County zip code (or other sub-county geography).

[1] Bosh, K. A., Hall, H. I., Eastham, L., Daskalakis, D. C., & Mermin, J. H. (2021). Estimated Annual Number of HIV Infections — United States, 1981-2019. *MMWR. Morbidity and mortality weekly report*, *70*(22), 801–806. https://doi.org/10.15585/mmwr.mm7022a1

[2] Samji, H., Cescon, A., Hogg, R. S., Modur, S. P., Althoff, K. N., Buchacz, K., Burchell, A. N., Cohen, M., Gebo, K. A., Gill, M. J., Justice, A., Kirk, G., Klein, M. B., Korthuis, P. T., Martin, J., Napravnik, S., Rourke, S. B., Sterling, T. R., Silverberg, M. J., Deeks, S., … North American AIDS Cohort Collaboration on Research and Design (NA-ACCORD) of IeDEA (2013). Closing the gap: increases in life expectancy among treated HIV-positive individuals in the United States and Canada. *PloS one*, *8*(12), e81355. https://doi.org/10.1371/journal.pone.0081355

[3] Healthy People 2030 objective HIV-01, U.S. Department of Health and Human Services

[4] HIV Surveillance Program, Ohio Department of Health. (2023). *New Diagnoses of HIV Infection Reported in Franklin County*. https://odh.ohio.gov/wps/wcm/connect/gov/cac882ed-d27b-42ff-9d14-2e60a4c7e366/Franklin2022.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_79GCH8013HMOA06A2E16IV2082-cac882ed-d27b-42ff-9d14-2e60a4c7e366-oFCnYED

[5] HIV Surveillance Program, Ohio Department of Health. (2023). *New Diagnoses of HIV Infection Reported in Ohio*. https://odh.ohio.gov/wps/wcm/connect/gov/6ceaf279-cee6-4254-b899-386b585f0e5a/Ohio2022.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_79GCH8013HMOA06A2E16IV2082-6ceaf279-cee6-4254-b899-386b585f0e5a-oFCmzk1

[6] Centers for Disease Control and Prevention. (2024). *Diagnoses, deaths, and prevalence of HIV in the United States and 6 territories and freely associated states, 2022*. http://www.cdc.gov/hiv-data/nhss/hiv-diagnoses-deaths-prevalence.html

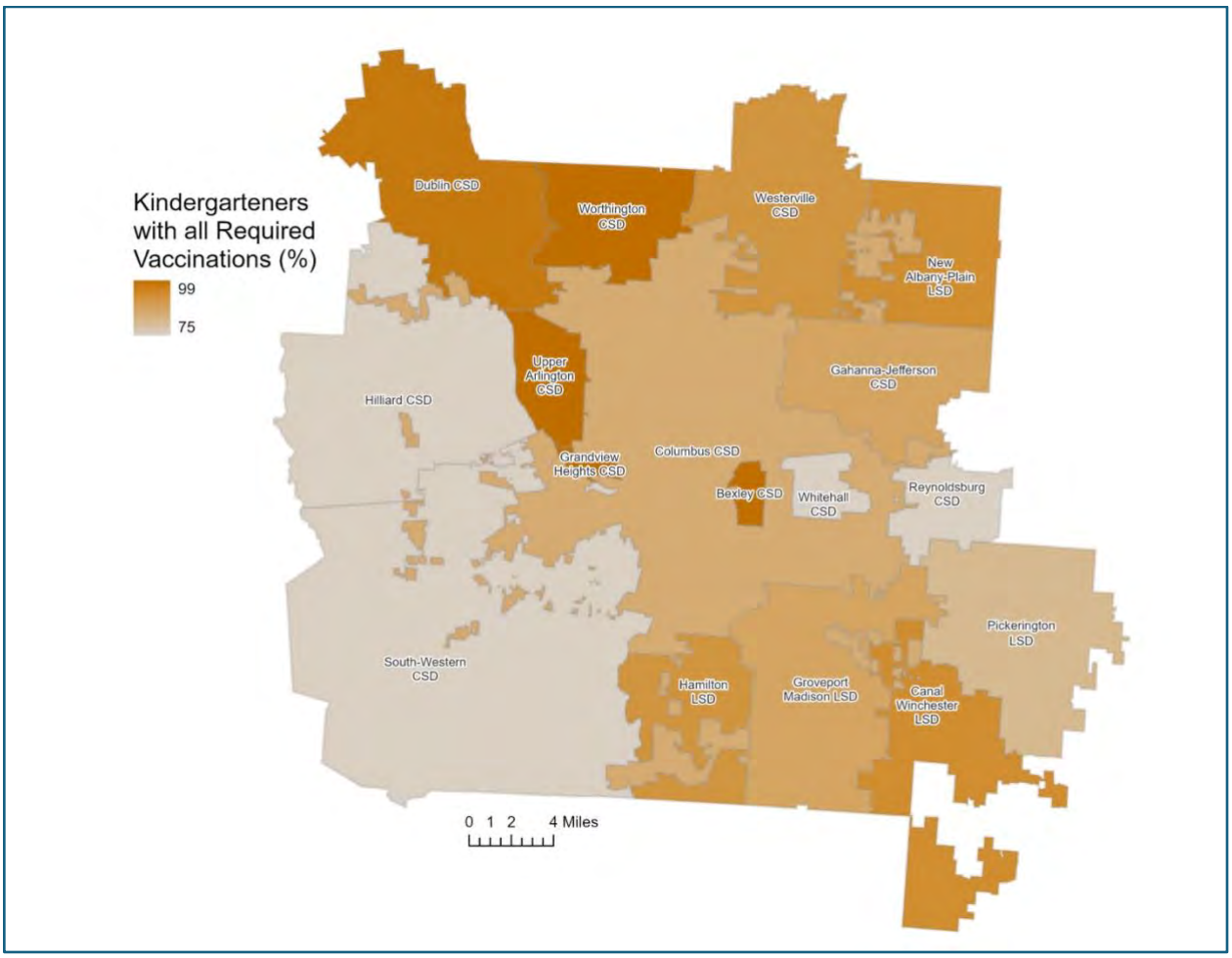
Kindergarten Vaccinations

Vaccinations are one of the most powerful, lifesaving health innovations of the 20th century. Globally, an estimated 154 million lives have been saved in the past 50 years due to vaccination, 146 million of which were children younger than 5.[1]

86.6% of Franklin County kindergarteners received all required **vaccines**.

New metric for HM2025

The Grandview Heights, Upper Arlington, Bexley, Worthington, and Dublin school districts reported that ≥95% of their kindergarteners entered school with all required vaccinations complete. The Columbus, Pickerington, Reynoldsburg, Hilliard, South-Western, and Whitehall school districts reported that ≤89% of their kindergarteners entered school with all required vaccinations complete.



Additional Information & References

The required vaccinations for a kindergarten student in Ohio includes 4+ doses of Diphtheria, Tetanus, and Pertussis (DTaP); 3+ doses of Hepatitis B; 2 doses of Measles, Mumps, and Rubella (MMR); 3+ doses of Polio; and 2 doses of Varicella.[2] More doses than the minimum may be required depending on the age of the child and when the child received their vaccines.

For this metric, Columbus Public Health's Office of Epidemiology requested data from Ohio Department of Health's Immunization Program. These data are a composite measure of kindergarteners in Franklin County public and private schools who had received all required vaccines for the 2022-2023 school year. Columbus Public Health staff then aggregated the data to calculate an estimate for each school district. Franklin County Public Health staff then mapped the prevalence of this indicator across the various school districts.

[1] Shattock, A. J., Johnson, H. C., Sim, S. Y., Carter, A., Lambach, P., Hutubessy, R. C. W., Thompson, K. M., Badizadegan, K., Lambert, B., Ferrari, M. J., Jit, M., Fu, H., Silal, S. P., Hounsell, R. A., White, R. G., Mosser, J. F., Gaythorpe, K. A. M., Trotter, C. L., Lindstrand, A., O'Brien, K. L., … Bar-Zeev, N. (2024). Contribution of vaccination to improved survival and health: modelling 50 years of the Expanded Programme on Immunization. *Lancet (London, England)*, *403*(10441), 2307–2316. https://doi.org/10.1016/S0140-6736(24)00850-X

[2] Vanderhoff, B. (2023). *In Re: Approved Means of Immunization Pursuant to Sections 3701.13 and 3313.671 of the Ohio Revised Code Director's Journal Entry*. Ohio Department of Health. https://odh.ohio.gov/wps/wcm/connect/gov/8e6d4c5d-7b45-4a0a-80cb-a1d8d00f4073/%28JE%29+%28131628%29+10-23-23+Directors-Journal-School-Requirements+10.16.2023+CERTIF.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_79GCH8013HMOA06A2E16IV2082-8e6d4c5d-7b45-4a0a-80cb-a1d8d00f4073-oJII3Hj

HEALTH CARE ACCESS

Emergency Department Utilization

Emergency department (ED) volume is an important metric for allocating appropriate resources and preventing overcrowding.[1] Frequent use of the emergency department is more common among women, patients with Medicare/Medicaid, black, and those who abuse prescriptions drugs.[2] Many patients report visiting the emergency department multiple times for the same condition, indicating that there may be a gap in either inpatient or follow-up care that drives frequent ED visits.[2]

There were **470.6 total emergency department visits** per 1,000 residents.	≈ Similar to HM2022 (511.3)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Older more likely	Female more likely	Black more likely	Observed (see maps)

There were **410.5 treated-and-released emergency department visits** per 1,000 residents.	≈ Similar to HM2022 (449.7)
There were **60.2 hospital admissions from an emergency department** per 1,000 residents.	≈ Similar to HM2022 (61.6)

Community Voices

Community members spoke about how difficulties finding providers who accept their insurance and long waitlists for appointments can lead individuals to use the emergency room for issues that could have been treated more affordably elsewhere. Additionally, many community members may not know about Federally Qualified Health Centers where they can get more affordable care if they are uninsured.

> *"So [the insurance companies] give you a list of who will take you. Well, then when you call them, they don't want to take you. Then I looked at [medical center] for what they offered, and they don't do it during the summer and then they're backed up forever. So I actually made a complaint to my insurance company and I said, 'I have this benefit, but no one will take me.' So they refer me to online counseling. So that finally came through. Don't know how long it's going to last, but I can see where, especially young people who need someone immediately, they end up in the hospital so*

> *many times."*
> *"There is availability for access to healthcare for people that do not have insurance that is affordable. I just think that it's not advertised enough. I know that it's not advertised enough. I went eleven years with no health care until I found out about FQHCs. I could have been going, because I was that person that only went to the emergency room when it was absolutely necessary. People don't know that they're available and they can help with 340b access to medications and PAPs through pharmaceutical companies. They're just not advertised enough."*

Community members also pointed out that a general lack of education about the medical system can lead individuals to use the ER for minor issues, and that more education is needed to ensure people seek the appropriate level of care for their health issues.

> *"I remember I sprained my ankle and I made the mistake of going to the emergency room at [medical center]. I think I got billed $4,000 and that's with health insurance."*
>
> *"I couldn't get insurance because I was working and it was so expensive. I was working two jobs and I would go to the ER all the time. Now every year when I get my taxes, I have to pay the emergency room for all this stuff that I was doing when I was 18, 19, 20, and I didn't know anything about the medical system. I just know I'm sick and I need to go to the doctor. So I just don't think they educate people enough and they aren't helping people enough with the medical assistance."*

The overall rates of total emergency department visits, treated and released visits, and admissions to the hospital from the emergency department have not significantly changed in Franklin County or Ohio since HM2022 (see tables on this page and the next page).

Children had a lower rate of all visit types, whereas older adults had higher rates of total ED visits and ED visits that resulted in hospital admission. Additionally, black (non-Hispanic) individuals had higher rates for all visit types, whereas white (non-Hispanic) individuals had lower rates of total ED visits and treated/released ED visits.

Lastly, males had lower rates of total ED visits and treated/released ED visits whereas females had higher rates for those types of visits.

Total ED Visits

	Rate per 1,000
HM2025	**470.6**
HM2022	**511.3**
HM2019	**608.8**
Age 0-17	299.1 ▼
Age 18-64	499.1
Age 65+	630.9 ▲
White (non-Hispanic)	371.4 ▼
Black (non-Hispanic)	683.9 ▲
Other (non-Hispanic)	541.5
Hispanic	464.2
Male	410.8 ▼
Female	528.2 ▲
Ohio	**492.3**

Treated and Released ED visits

	Rate per 1,000
HM2025	**410.5**
HM2022	**449.7**
HM2019	**546.3**
Age 0-17	280.4▼
Age 18-64	450.9
Age 65+	443.6
White (non-Hispanic)	312.1▼
Black (non-Hispanic)	609.2▲
Other (non-Hispanic)	492.9▲
Hispanic	430.0
Male	352.3▼
Female	466.5▲
Ohio	**423.4**

Hospital Admissions from ED Visits

	Rate per 1,000
HM2025	**60.2**
HM2022	**61.6**
HM2019	**62.4**
Age 0-17	18.8▼
Age 18-64	48.2▼
Age 65+	187.3▲
White (non-Hispanic)	59.3
Black (non-Hispanic)	74.7▲
Other (non-Hispanic)	48.6▼
Hispanic	34.2▼
Male	58.6
Female	61.7
Ohio	**69.0**

The rate of minor severity (level 1) visits to the emergency department has increased among Franklin County residents while the rate of high severity (level 4) visits has decreased since HM2022. Elsewhere in Ohio, the rates of both low-moderate (level 2) and moderate severity (level 3) visits have decreased since HM2022.

Severity of ED Visits (per 1,000 patients treated)

	HM2025	HM2022	HM2019	Ohio
Level 1 (minor severity)	**10.0▲**	**8.0**	**10.1**	**7.1**
Level 2 (low to moderate severity)	**52.8**	**51.7**	**50.2**	**30.5▼**
Level 3 (moderate severity)	**161.3**	**162.0**	**149.9**	**140.5▼**
Level 4 (high severity, urgent evaluation required)	**142.7▼**	**134.9**	**121.1**	**136.2**
Level 5 (high severity, immediate threat to life or function)	**94.1▼**	**92.2**	**77.3**	**109.0**

The diagnoses associated with emergency department use are an important indicator of healthcare access in the community. For example, many concerns treated in the emergency department might have been treated by a primary care provider, but oftentimes patients report being unable to access that first line of treatment in a timely manner. Demographic

variables such as low socioeconomic status are also associated with non-urgent use of the emergency department.[3,4]

Overall, the leading cause of visits to an emergency department that resulted in patients being treated-and-released was acute upper respiratory infection (unspecified), which is a catch-all term for a nose/throat infection that does not have a known cause. This was followed by two different types of chest pain and COVID-19. The rates of these diagnoses among Franklin County residents who visited EDs were similar to Ohioans who visited EDs.

Top Diagnoses Among Those Who Were Treated & Released By An Emergency Department (Total Population; rate per 1,000)

	HM2025	HM2022	Ohio
1st	Nose/throat infection (acute upper respiratory infection; unspecified): 10.3▼	Nose/throat infection (acute upper respiratory infection; unspecified): 12.0	Other chest pain: 11.0
2nd	Other chest pain: 9.9	Chest pain (unspecified): 10.9	Nose/throat infection (acute upper respiratory infection; unspecified): 9.4
3rd	Chest pain (unspecified): 6.6▼	Other chest pain: 9.8	Chest pain (unspecified): 7.1
4th	COVID-19: 6.5	Headache: 8.7	COVID-19: 6.6
5th	Headache (unspecified): 5.7	Abdominal pain (unspecified): 8.1	Urinary tract infection: 6.0

Among youth, the leading cause of treated-and-released visits to an emergency department was also upper respiratory infections (unspecified), followed by other infectious diseases.

Top Diagnoses Among Those Who Were Treated & Released By An Emergency Department (Ages 0-17; rate per 1,000)

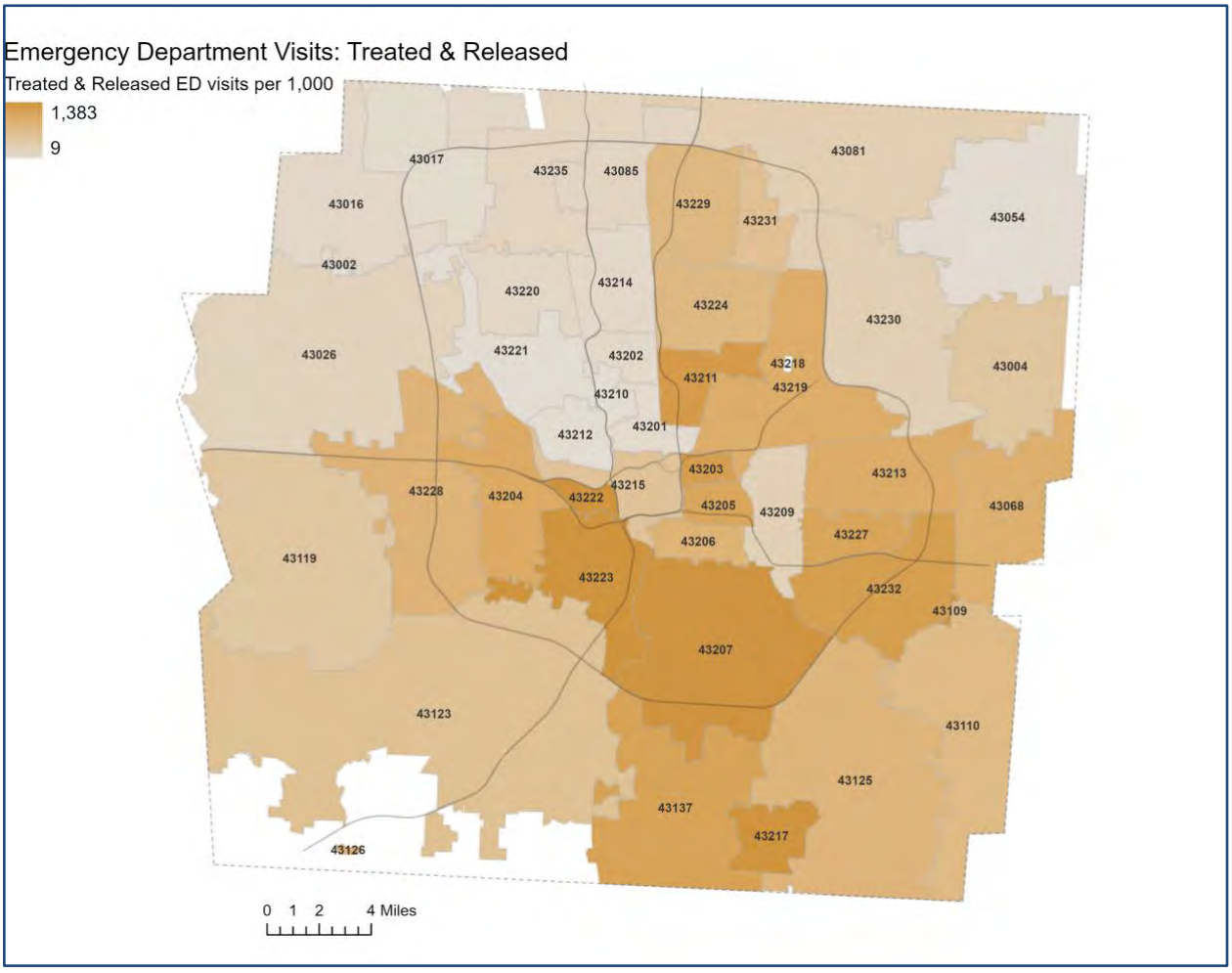
	HM2025	HM2022	Ohio
1st	Nose/throat infection (acute upper respiratory infection; unspecified): 19.1▼	Nose/throat infection (acute upper respiratory infection; unspecified): 24.7	Nose/throat infection (acute upper respiratory infection; unspecified): 21.7
2nd	Strep throat (streptococcal pharyngitis): 12.3	Fever (unspecified): 8.9	Strep throat (streptococcal pharyngitis): 11.7
3rd	Viral infection (unspecified): 8.9	Viral infection (unspecified): 8.9	Viral infection (unspecified): 9.0
4th	Vomiting (unspecified): 4.9▼	Vomiting (unspecified): 6.9	Fever (unspecified): 7.6
5th	Upper airway infection causing breathing difficulty (acute obstructive laryngitis; croup): 4.7	Influenza: 6.2	Injury to the head (unspecified): 6.6

Among older adults, the leading cause of treated-and-released visits to an emergency department was chest pain followed by urinary tract infection.

Top Diagnoses Among Those Who Were Treated & Released By An Emergency Department (Ages 65+; rate per 1,000)

	HM2025	Ohio
1st	Other chest pain: 11.9	Other chest pain: 13.1
2nd	Urinary tract infection: 11.2	Urinary tract infection: 12.3
3rd	COVID-19: 9.9	COVID-19: 10.7
4th	Chest pain (unspecified): 9.3	Chest pain (unspecified): 9.1
5th	Vertigo/light headedness (dizziness and giddiness): 9.1	Vertigo/light headedness (dizziness and giddiness): 8.9

As shown below, the rate of emergency department visits that led to patients being treated and released was highest in southern zip codes (43207, 43217, 43137), west-central zip codes (43222, 43223), and 43211.



Overall, the leading cause of visits to an emergency department that resulted in patients being admitted into a hospital was sepsis and hypertensive heart and chronic kidney disease (with heart failure) or chronic kidney disease, followed by hypertensive heart disease (with heart failure) and kidney failure. The rates of these diagnoses among Franklin County residents who visited EDs were similar to Ohioans who visited EDs.

Top Diagnoses Among Those Who Were Admitted Into A Hospital From An Emergency Department (Total Population; rate per 1,000)

	HM2025	HM2022	Ohio
1st	Sepsis (unspecified organism): 4.4▼	Sepsis (unspecified organism): 5.6	Sepsis (unspecified organism): 4.7
2nd	Hypertensive heart & chronic kidney disease with heart failure or chronic kidney disease (unspecified): 1.6▼	Hypertensive heart & chronic kidney disease with heart failure or chronic kidney disease (unspecified): 2.0	Hypertensive heart & chronic kidney disease with heart failure or chronic kidney disease (unspecified): 1.9
3rd	Hypertensive heart disease with heart failure: 1.4▼	Hypertensive heart disease with heart failure: 1.7	Hypertensive heart disease with heart failure: 1.7
4th	Acute kidney failure (unspecified): 1.2▼	Acute kidney failure (unspecified): 1.4	Acute kidney failure (unspecified): 1.5
5th	COPD (with acute exacerbation): 0.9	Heart attack (NSTEMI): 1.3	Pneumonia (unspecified organism): 1.4

Among youth, two of the top 5 leading causes of visits to an emergency department that resulted in a hospital admission were related to lung infections, and two of the other top 5 leading causes were related to major depression.

Top Diagnoses Among Those Who Were Admitted Into A Hospital From An Emergency Department (Ages 0-17; rate per 1,000)

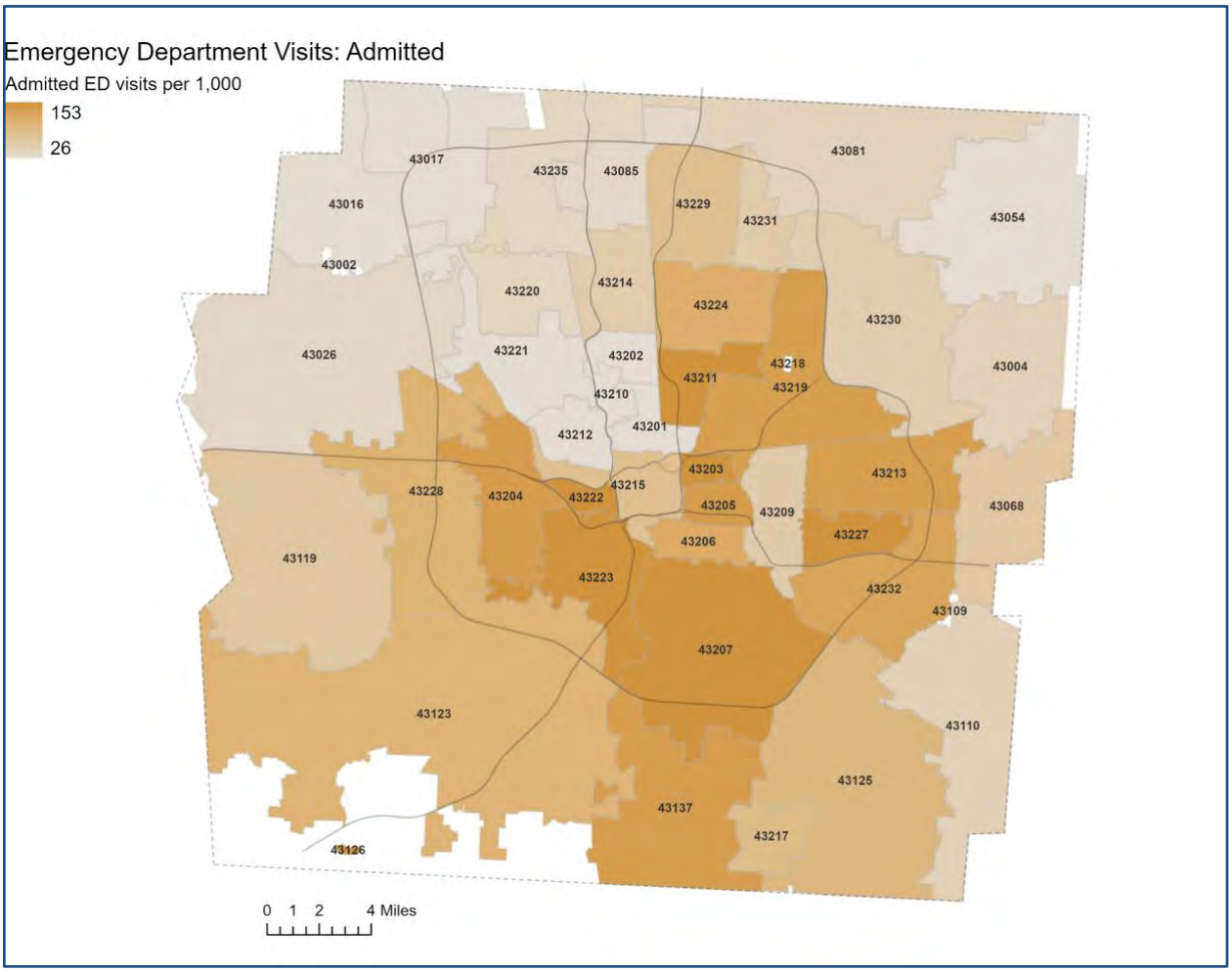
	HM2025	HM2022	Ohio
1st	Lung infection (acute bronchiolitis; RSV): 1.6	Lung infection (acute bronchiolitis; RSV): 1.5	Lung infection (acute bronchiolitis; RSV): 0.6
2nd	Recurrent major depression (without psychosis): 0.5	Dehydration: 1.4	Dehydration: 0.5
3rd	Lung infection (bronchiolitis; specified organism): 0.5▼	Lung infection (acute bronchiolitis;unspecified): 1.1	Recurrent major depression (without psychosis): 0.3
4th	Major depression (single episode): 0.4	Lung infection (bronchiolitis; specified organism): 1.0	Lung infection (acute bronchiolitis; unspecified):0.3
5th	Type 1 diabetic ketoacidosis (without coma): 0.4▼	Type 1 diabetic ketoacidosis (without coma): 0.7	Disruptive mood dysregulation: 0.3

Among older adults, the leading cause of visits to an emergency department that resulted in a hospital admission was sepsis, followed by hypertensive heart and chronic kidney disease, hypertensive heart disease (with heart failure), and kidney failure.

Top Diagnoses Among Those Who Were Admitted Into A Hospital From An Emergency Department (Ages 65+; rate per 1,000)

	HM2025	Ohio
1st	Sepsis (unspecified organism): 20.6▲	Sepsis (unspecified organism): 15.7
2nd	Hypertensive heart & chronic kidney disease with heart failure or chronic kidney disease (unspecified): 10.8▲	Hypertensive heart & chronic kidney disease with heart failure or chronic kidney disease (unspecified): 8.9
3rd	Hypertensive heart disease with heart failure: 7.8▲	Hypertensive heart disease with heart failure: 6.6
4th	Acute kidney failure (unspecified): 6.4	Acute kidney failure (unspecified): 6.1
5th	Heart attack (NSTEMI): 5.3	COVID-19: 5.2

As shown below, the rate of emergency department visits that led to patients being admitted to a hospital was highest in southern zip codes (43207, 43137), west-central zip codes (43222, 43223), 43203, and 43211.



Additional Information & References

Readers who are interested in learning more about this topic should also read the *HealthMap2025* section that focuses on individuals with disabilities (see page 65).

To measure emergency department utilization, *HealthMap2025* requested data from the Ohio Hospital Association for calendar year 2023.[5] Franklin County residents who visited any Ohio hospital's emergency department are counted in these data. The raw data from each category was divided by the total population for the appropriate year and geographic region, and then converted into a rate per 1,000. For sample size reasons, the "other (non-Hispanic)" racial category includes all racial/ethnic groups other than black (non-Hispanic), white (non-Hispanic), and Hispanic. Franklin County Public Health staff then mapped these data for each zip code in Franklin County.

The Ohio Hospital Association also provided data for the most frequent diagnoses (i.e., the primary ICD-10 codes) among Franklin County and Ohio residents who either (1) were treated and released from an emergency department (i.e., without being admitted to the hospital) in 2023 or (2) were admitted to a hospital from an emergency department in 2023.[5] The raw numbers that were provided were converted into crude rates for the appropriate geographic and age group.

Data Gap: The Community Health Needs Assessment Steering Committee requested recent data about patients who went to emergency departments for the same underlying health need(s) on multiple occasions over some duration of time (i.e., "emergency department readmissions"). Unfortunately, that type of data is unavailable.

[1] Kenny, J. F., Chang, B. C., & Hemmert, K. C. (2020). Factors Affecting Emergency Department Crowding. *Emergency medicine clinics of North America*, *38*(3), 573–587. https://doi.org/10.1016/j.emc.2020.04.001

[2] Behr, J. G., & Diaz, R. (2016). Emergency Department Frequent Utilization for Non-Emergent Presentments: Results from a Regional Urban Trauma Center Study. *PloS one*, *11*(1), e0147116. https://doi.org/10.1371/journal.pone.0147116

[3] Unwin, M., Kinsman, L., & Rigby, S. (2016). Why are we waiting? Patients' perspectives for accessing emergency department services with non-urgent complaints. *International emergency nursing*, *29*, 3–8. https://doi.org/10.1016/j.ienj.2016.09.003

[4] Montoro-Pérez, N., Richart-Martínez, M., & Montejano-Lozoya, R. (2023). Factors associated with the inappropriate use of the pediatric emergency department. A systematic review. *Journal of pediatric nursing*, *69*, 38–46. https://doi.org/10.1016/j.pedn.2022.12.027

[5] Ohio Hospital Association. (2023). *Ohio Hospital Association* [Dataset].

Dental Care Access

Oral health, which includes the mouth, teeth, and other maxillofacial elements, allows people to eat, breathe, and speak, granting it an important role in individuals' physical, mental, social, and economic well-being.[1,2] Poor oral health has been associated with a variety of health conditions, including cardiovascular disease, pregnancy and birth complications, and pneumonia.[3] Therefore, equitable access to dental care is critical to ensure optimal health.[4]

3.3% of children age 3-18 **needed dental care but could not secure it**.	↓ Down from HM2022 (3.9%)
12.8% of adults age 19-64 **needed dental care but could not secure it**.	↓ Down from HM2022 (16.1%)

Community Voices

Community members identified how fear and embarrassment can influence residents to avoid seeking dental care. Alternatively, people may not place a high priority on visiting a dentist if they have not experienced any teeth "problems."

> *"People are worried, if this goes wrong, my teeth are going to be gone."*
>
> *"To get dentures, you get an appointment, and they'll say you have to go get them pulled. Then come back here. Who wants to go eight weeks without teeth?…it needs to be more convenient."*
>
> *"I think another thing is embarrassment. So if you haven't gone to the dentist in a long time, it might feel sort of just scary to go into the dentist after a while because of fear of judgment from healthcare practitioners."*
>
> *"The fear of like not being treated well, being stigmatized, being seen as a drug addict, being seen as like we'll do all these procedures, we'll take out all your teeth, but we're not going to give you any pain medication because you struggle with addiction…"*
>
> *"I was one of those people that had good teeth anytime I went for cleaning. There were never any issues, so I held off for a really long time. And then I was finally like I need to go. And I got my first cavity…I was scared to go back again because you gotta get it fixed, right. And it's actually considered dental surgery…So I was really worried about pain. And then also this really weird thing, if I have easy teeth for such a long time, why do I need to go?"*

Dental care costs also play a large role in residents' willingness to see a dentist or orthodontist, whether they have insurance or not.

"But those [insurance] costs are not covering anything for the kids. The kids need braces. They're only covering $2,000 for the braces. But the average cost of braces was starting at $5,000."

"Even if you have insurance, it's outrageous. It really is. Like, if you need to have an implant, you might as well count on $5,000, and that's with insurance, though. They're just not covered."

"My husband just recently cracked a tooth about a month ago, and we don't have dental because he unfortunately lost his position where he was at. He went to a local dentist here. They told him what they could do, and then they started adding on different things and a health plan. 'This is what you can do, a yearly plan.' He goes, 'Wait a minute. Am I buying a condo, and I don't know about it?' That's exactly what he felt like. He left, and we went back to where I grew up in Galloway. They're working with us for him, just for a payment plan. Just for a broken molar, it's $3,000 to fix when you don't have any insurance."

"So for the past four years, I've been trying to get my mouth fixed affordably, which is impossible because I have no insurance. I don't have Medicaid anymore either, because I don't qualify. I can't afford the insurance either. I go to different places to check, and they want for one root canal, one crown; it was over $3,000…There could be a lot of work done in regard to affordability, dental care, especially for the self-pay."

"They want you to take that credit, that CareCredit, and the interest rates on those are outrageous. If you can't afford it to begin with, and you're saying you need to pay $3,000 back in two years. That's not going to happen. So you just don't do it at all, and you live with the pain."

Finding a dentist that will accept their insurance and being able to schedule appointments that do not conflict with work schedules are additional barriers to dental care.

"And then it's finding a dentist that will accept you. It's hard to find a dentist that will accept your insurance or if you don't have insurance, and it's just hard to find one and keep one."

"And the insurance changes whether you can stay with your dentist. I was with my dentist for almost 30 years, and then all of a sudden, they don't accept your insurance anymore. You already have a relationship, a rapport with them, and then you got to start all over again."

"Scheduling, too. It's hard to get into a dentist around a time that works for you, especially when you're working. A lot of places aren't open after five. I don't want to go on my lunch break because they always have me sitting there forever. And, after that, 'Oh, well, we can do your cleaning today but you have to schedule another appointment and miss work, use PTO to get your teeth pulled.'"

Franklin County residents also think there needs to be expanded emergency dental services in the community.

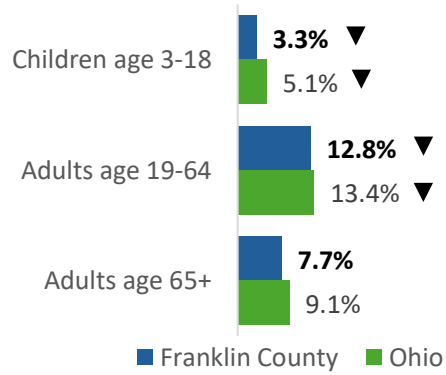
"[medical center] has emergency dental, but they only take the first ten people…So it's one of these, there is an emergency dental clinic, but again, if you're not right there when it first opens…"

"I don't understand why we've never had better emergency services for a dental situation. Because my mom had that and she had to run to a different one every Saturday. Now my particular dentist is pretty good. You call him at 7:00 in the morning and end up going, but it's not guaranteed the way Urgent Care is. "

"You go out with your friends and you get a tooth knocked out. Your dentist probably isn't going to answer either on a Friday or Saturday…where do you go?"

From HM2022 to HM2025, fewer children age 3-18 and adults age 19-64 needed dental care but could not secure it.

Needed Dental Care But Could Not Secure It



Additional Information & References

Data for this indicator were obtained from the Ohio Medicaid Assessment Survey.[5]

[1] World Health Organization. (n.d.) Oral health. https://www.who.int/health-topics/oral-health#tab=tab_1
[2] Peres MA, Macpherson LMD, Weyant RJ et al. Oral diseases: a global public health challenge. *The Lancet*. 2019;394(10194):249–60.
[3] Mayo Clinic. (n.d.) Oral health: A window to your overall health. https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475
[4] Hannan CJ, Ricks TL, Espinoza L, Weintraub JA. Addressing Oral Health Inequities, Access to Care, Knowledge, and Behaviors. Prev Chronic Dis 2021;18:210060. DOI: http://dx.doi.org/10.5888/pcd18.210060
[5] The Ohio Medicaid Assessment Survey Dashboard. https://grcapps.osu.edu/app/omas, 2021 (HM2025), 2019 (HM2022)

INJURY AND DEATH

Mental and Social Health

Mental and social health are increasingly recognized as both direct and indirect contributors to overall health. Experiencing violence or being exposed to violence in the home has long-term physical and mental health impacts.[1,2] In addition to the direct impact on an individual's mortality, suicide also has rippling negative effects among other community members, from family members to peers to first responders.[3]

13.8 per 100,000 residents died by **suicide**.

↑ Up from HM2022 (10.8)

26.4% of Franklin County residents reported feeling **lonely**.

New metric for HM2025

Disparities by selected social determinants of health

Age:	Sex:	Race/Ethnicity:	Geography:
None observed	Recently pregnant females more likely	Unavailable	Unavailable

23.7% of Franklin County adults reported ever having **depression**.

≈ Similar to HM2022 (23.1%)

Disparities by selected social determinants of health

Age:	Sex:	Race/Ethnicity:	Geography:
18-64 more likely	Female more likely	White more likely	Observed (see map)

14.7 per 100,000 residents died from **100% alcohol-attributable causes**.

↑ Up from HM2022 (12.9)

Disparities by selected social determinants of health

Age:	Sex:	Race/Ethnicity:	Geography:
60+ more likely	Male more likely	White more likely	Unavailable

5,729 children were victims of **child abuse**.

↓ Down from HM2022 (7,240)

5,495 residents were victims of **domestic violence**.

↓ Down from HM2022 (7,471)

Unfortunately, hospitalizations due to self-harm and deaths from suicide have both increased in Franklin County since the last *HealthMap*.

Self-Harm and Suicide

	Self-harm hospitalization (rate per 100,000)	Suicide death (rate per 100,000)
HM2025	7.6 ▲	13.8 ▲
HM2022	6.8	10.8
HM2019	4.9	12.5
Ohio	-	15.2
US	-	14.8

Healthy People 2030

Unfortunately, the suicide rate in Franklin County has risen above the Healthy People 2030 objective in recent years. Further research and interventions should examine what has caused this change.

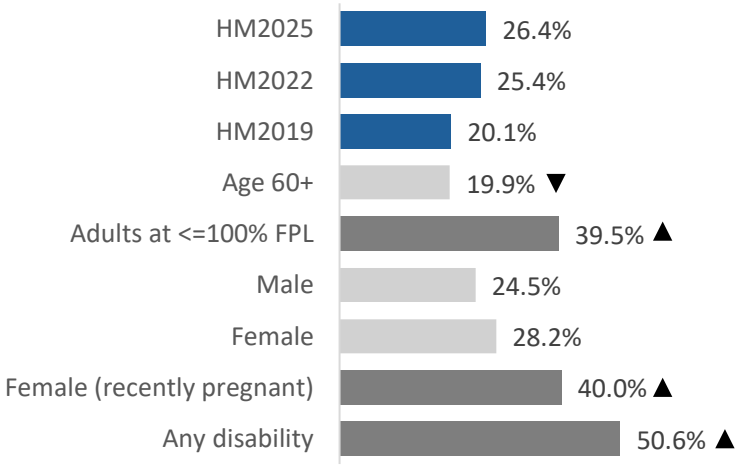
HP2030 objective for Suicide Deaths: Not met

Healthy People Objective:	Most recent Franklin County data (HM2025)
12.8	**13.8**

In 2023, the United States Surgeon General issued an advisory notice that warned Americans about an emerging public health crisis: the epidemic of loneliness, isolation, and lack of connection.[4]

Unfortunately, over a quarter of Franklin County adult (ages 19+) report feeling isolated from others (i.e., lonely). Those individuals who have a household income that places them at or under the 100% federal poverty level, recently pregnant females, and individuals with disabilities are most likely to report feeling lonely.

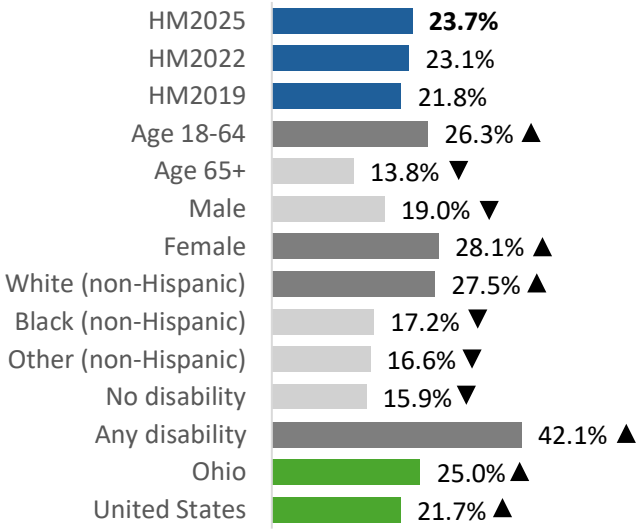
Loneliness

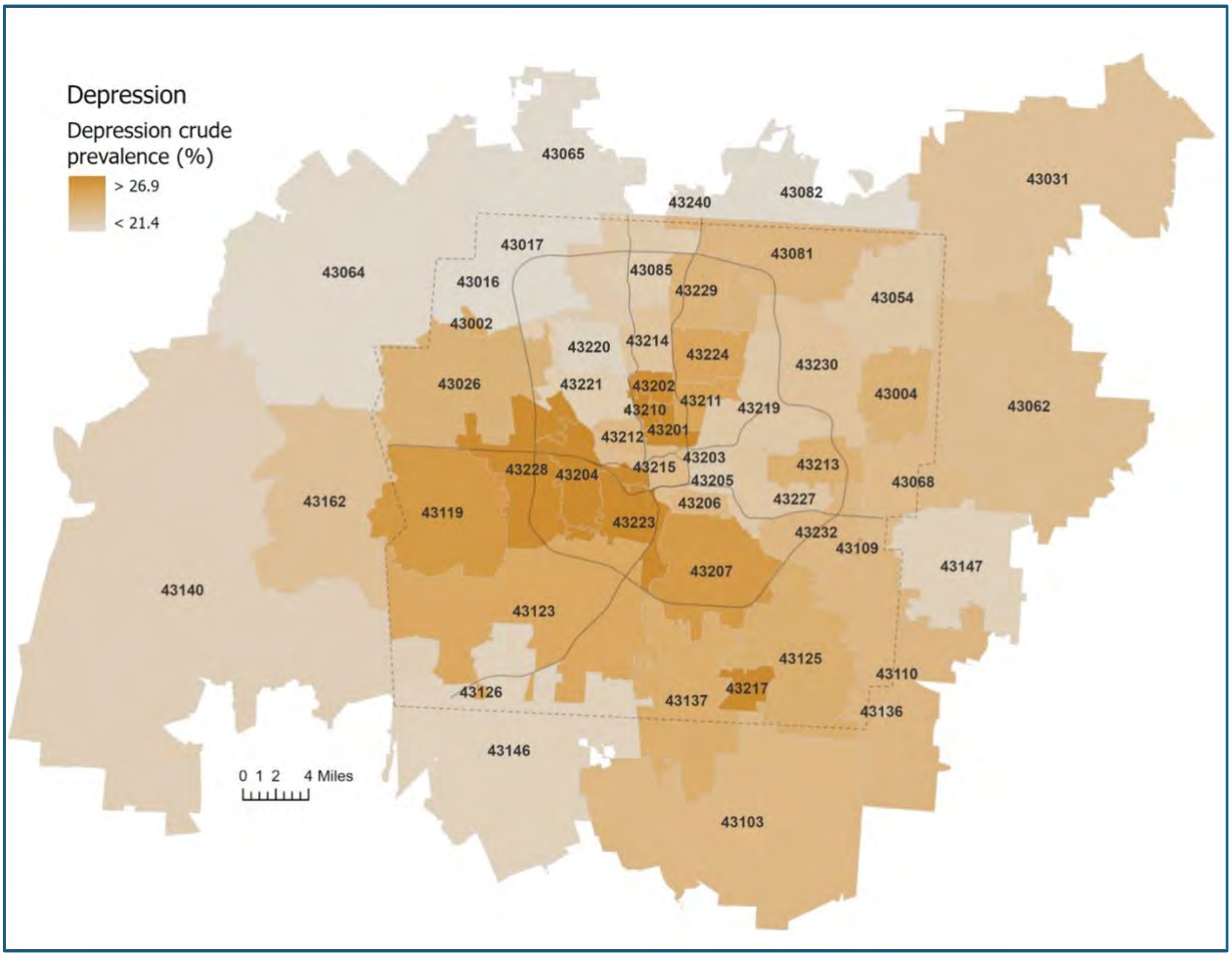


Females, white (non-Hispanic) individuals, adults under the age of 65, and individuals with a disability are more likely than other groups to report ever being told by a healthcare professional that they have a depressive disorder (e.g., depression).

Depression prevalence is higher in Franklin County's western and north-central zip codes.

Depression





Community Voices: Depression

Community members perceive that anyone can be vulnerable to depression, and that economic hardships contribute to depression in their community. They believe depression is hard to address because it is not easy to always tell when someone is suffering. Although residents say mental health issues seem to be losing some of the stigma they once held, depressed individuals are still met with perceptions that they just need to "get over it."

"The best-looking person is on the edge. [Mental health], it's so fragile and it has to be taken way more seriously. That commercial that says there's no way he's depressed, he's young, you know, those type of stigmas, it's terrible. And that's why we see a lot of people out on the street or a lot of people doing what they're doing because their mental health issues have not been addressed or they've been temporarily addressed."

"I see it with my job that I totally despise…does it affect my mental health? Absolutely. Can I pay the mortgage this month? Can I buy food this week? It's just a lot…I have a lot of breaking points."

"Mental health is something that you don't see a lot as well. It could be a neighbor that you think is okay, but they may get evicted or, you know, their property taxes went up too high and can't afford it. So those aren't physical things, you may not even be able to see [even with] neighbors that you probably thought you were close to."

"There's a lot of people who say 'mental health is so important to us and we're working on it.' But then if you do have some kind of issue with depression, there's still this like, 'Okay, well, I guess you better get over it.' You still have to keep going. And you're just kind of hopeless."

Meanwhile, community members also said that stigma around depression can prevent people from getting help they need. For example, it may still be perceived negatively to be medicated for depression, and generational attitudes around depression may prevent helpful conversations around mental health from happening.

"I could say in my community, I believe that it was always, 'don't get put on that medicine.' It was a bad thing if you got medicated. So some people have been diagnosed, but they're not being treated because they don't want to be on that medication."

"I have tried to talk with a lot of older people [in my community]…They have been through traumas, like they've been through wars, running from people and fleeing to a new country. That's a lot of trauma. But they don't agree that it's trauma. And I don't know how to tell [them] because I have not been in that place. I just came with them. And when I tried to tell them that, 'You

> *got to talk about this, so it gets out of your head.' They just don't want to talk about it."*
>
> *"Depression is big…And it's all ages. I live with my grandma. She doesn't believe in depression, and I'm sure she's been depressed for most of her life. But back in the day it was more like, you just gotta push through it and fight through it. You gotta be strong. 'Everybody's depressed.'"*
>
> *"The kids, they can't talk about mental health problems with their parents because the parents will think that it's a disease and that's not good. So they will try to do substances, which just goes down the wrong path. And the parents can't take control of the kids, and the kids are now alone in their [mind], and it's hard."*

Alcohol use disorder frequently co-occurs with other mental health disorders. Compared to the last *HealthMap*, Franklin County residents whose deaths were 100% alcohol-attributable have increased and are particularly high among males, white (non-Hispanic) individuals, and the elderly.

Alcohol Attributable Deaths

	Rate per 100,000
HM2025	**14.7** ▲
HM2022	**12.9**
HM2019	**9.1**
Age 20-59	13.6
Age 60+	38.1 ▲
White (non-Hispanic)	18.4 ▲
Black (non-Hispanic)	11.9
Male	21.4 ▼
Female	8.2 ▲
Ohio	**14.1** ▼
US	**14.4**

The number of child abuse victims and abuse reports have declined across all geographic groups; the number of domestic violence reports has remained stable while the number of domestic violence victims in Franklin County has dropped dramatically. A unique victim is only counted once but could be associated with multiple reports of violence in a year.

Family Violence

	Child maltreatment (unique victims)	Child maltreatment (substantiated reports)	Domestic violence (unique victims)	Domestic violence (substantiated reports)
HM2025	**5,729 ▼**	**16,784 ▼**	**5,495 ▼**	**3,505**
HM2022	**7,240**	**19,801**	**7,471**	**3,636**
HM2019	**6,243**	**18,060**	**11,224**	**3,157**
Ohio	**22,439 ▼**	**17,037 ▼**	**58,822 ▲**	**31,142 ▼**
US	**558,899 ▼**	**553,479 ▼**	**598,490 ▲**	**1,370,440 ▲**

Additional Information & References

Relatedly, who are interested in learning more about this topic are encouraged to read the Franklin County Suicide Prevention Coalition's 2023 Report, which can be accessed by **clicking here**. Additionally, readers who are interested in learning more about this topic should also read the *HealthMap2025* sections that focus on alcohol use (see page 81), overdose deaths (see page 163), and individuals with disabilities and their mental health experiences (see page 133).

For HealthMap2025, data on suicides and alcohol-attributable deaths were collected from the CDC WONDER database for 2023, 2020, and 2017, and self-harm hospitalizations were provided by the Ohio Department of Public Safety, which accessed the Trauma Acute Care Registry (TACR) system for 2022 and 2019.[5-7] Loneliness statistics were provided by Franklin County Public Health, which accessed the Ohio Medicaid Assessment Survey for 2023.

To assess the prevalence of depression, *HealthMap2025* obtained recent data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS), which completes structured survey interviews with residents via telephone.[8] In most cases, survey respondents were asked if a doctor, nurse, or other health professional ever told them that they had a specific chronic health condition (i.e., a depressive disorder). To enable comparisons by demographic subgroups (e.g., age, sex, race), Columbus Public Health staff analyzed BRFSS data using the most recent year or two available (typically 2021 & 2022). To map the prevalence of these indicators at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the CDC's PLACES[9] resource, which uses BRFSS data (2021 or 2022), Census Bureau data (either the 2020 decennial census or 2022 annual population estimates), and American Community Survey data (2018-2022 estimates).

Alcohol-attributable deaths were defined using the National Center for Health Statistics definition, which includes immediate deaths such as overdose as well as long-term chronic conditions such as alcoholic fatty liver.[5]

In both categories of violence, a "report" refers to a single instance where abuse or neglect was alleged to authorities. These reports are then investigated, and charges or action may be taken if there is enough evidence. A unique victim is counted only once in a calendar year, but they may be the subject of multiple reports if they experienced multiple acts of violence. Child maltreatment victims and reports were included if the abuse or neglect was classified as either "substantiated" or "indicated" in 2022, 2019, and 2016. Franklin County statistics were provided by the Ohio Department of Job and Family Services.[10] Statistics about child maltreatment from the United States and Ohio were sourced from the US Department of Health and Human Services annual Child Maltreatment report.[11]

Domestic violence statistics included all victim/perpetrator relationships, including married couples, life partners, and other eligible categories. Ohio and Franklin County statistics were sourced from an Ohio Bureau of Criminal Investigation report, where statistics were reported from all police agencies.[12,13] Reports were included if a charge was filed, and the included years were 2023, 2020, and 2017. For the United States, data were sourced from the Bureau of Justice Statistics for 2022.[14]

- Data Gap: The child maltreatment and domestic violence statistics reviewed here likely *underestimate* the full extent of those issues in the population, due to underreporting. Future HealthMaps should attempt to obtain different/more accurate data.
- Data Gap: The Community Health Needs Assessment Steering Committee requested recent data about the mental health of Franklin County's youth (e.g., those between the ages of 11 and 17). Unfortunately, Ohio's Youth Risk Behavior Survey does not calculate statistical estimates at the county level.
- Data Gap: The Community Health Needs Assessment Steering Committee requested recent data about resiliency. Unfortunately, this construct has not been measured quantitatively at the county level.
- Data Gap: Future *HealthMaps* should explore the possibility of calculating the percentage of adults who recently had an alcohol attributable death within each Franklin County zip code (or other sub-county geography).

[1] Potter, L. C., Morris, R., Hegarty, K., García-Moreno, C., & Feder, G. (2021). Categories and health impacts of intimate partner violence in the World Health Organization multi-country study on women's health and domestic violence. *International journal of epidemiology*, *50*(2), 652–662. https://doi.org/10.1093/ije/dyaa220

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[4] U.S. Department of Health and Human Services. (2023). Our epidemic of loneliness and isolation. https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf

[5] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database. Data are from the final Multiple Cause of Death Files, 2018-2022, and from provisional data for years 2023-2024, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. http://wonder.cdc.gov/mcd-icd10-provisional.html

[6] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999-2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999-2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

[7] Ohio Division of Emergency Medical Services, Ohio Department of Public Safety. (2024). *Trauma Acute Care Agency* [Dataset].

[8] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data, 2022 (HM2025), 2019 (HM2022), 2015 (HM2019)

[9] Centers for Disease Control and Prevention, PLACES: Local Data for Better Health. (n.d.). https://www.cdc.gov/places/index.html

[10] Ohio Department of Job and Family Services, Ohio Department of Health. (2024). *Foster Care and Adult Protective Services* [Dataset].

[11] U.S. Department of Health & Human Services, A. for C., Families, Y., Administration on Children, & Families, C. B. (2023). Child Maltreatment 2022. https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2022.pdf

[12] Ohio Bureau of Criminal Investigation. (2024). *Victims of Domestic Violence by County and Agency*.

[13] Ohio Bureau of Criminal Investigation. (2024). *Domestic Violence Incidents by County and Agency*.

[14] Thompson, A., & Tapp, S. N. (2023). *Criminal Victimization, 2022*. Bureau of Justice Statistics, US Department of Justice. https://bjs.ojp.gov/document/cv22.pdf

Franklin County Suicide Prevention Coalition's 2023 Report can be accessed at https://franklincountyspc.org/wp-content/uploads/2024/04/2023-Franklin-County-Suicide-Report-Updated-4.22.24.pdf.

Mortality

With advances in medicine, technology, and sanitation, life expectancy at birth (i.e., the average number of years that a person can expect to live) has risen substantially over the last century.[1] However, significant disparities in life expectancy at birth and in mortality rates exist by sex, race, and geography, among others.[2]

The **life expectancy** at birth was **75.9 years** in Franklin County.

Down from HM2022 (77.1)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
n/a	Unavailable	None observed	Observed (see map)

The **mortality rate** (all causes) was **891.5 per 100,000 residents** in Franklin County.

New metric for HM2025

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Older adults highest	None observed	Black higher	Observed (see map)

As shown on the next page, Franklin County residents' life expectancy has decreased slightly since the last *HealthMap* and is similar to residents throughout Ohio and the United States. Asian and Hispanic individuals have a higher life expectancy than Franklin County overall, whereas black (non-Hispanic) individuals have the lowest life expectancy.

The next page also displays a table that presents data regarding the all-cause mortality rate (age-adjusted) among Franklin County residents. As expected, the mortality rate is lower among children and much higher among older adults. Black (non-Hispanic) individuals in Franklin County have an all-cause mortality rate that is substantially higher than the county as a whole; Asian (non-Hispanic) individuals have a mortality rate that is substantially lower than the county as a whole.

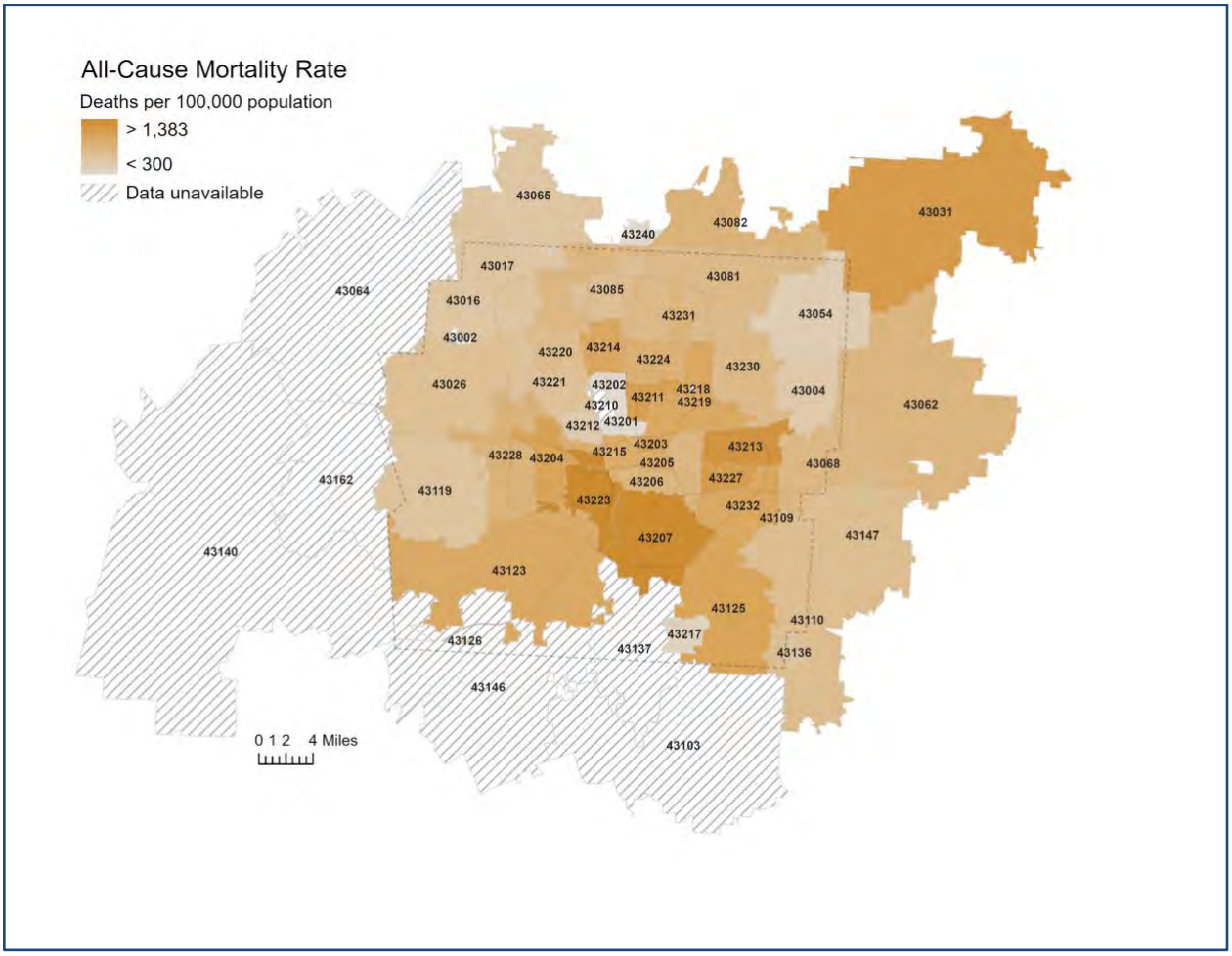
Life Expectancy at Birth

	Years
HM2025	**75.9**
HM2022	**77.1**
White (non-Hispanic)	76.6
Black (non-Hispanic)	72.9
Asian (non-Hispanic)	84.9 ▲
Hispanic	84.7 ▲
Ohio	**74.5**
US	**77.5**

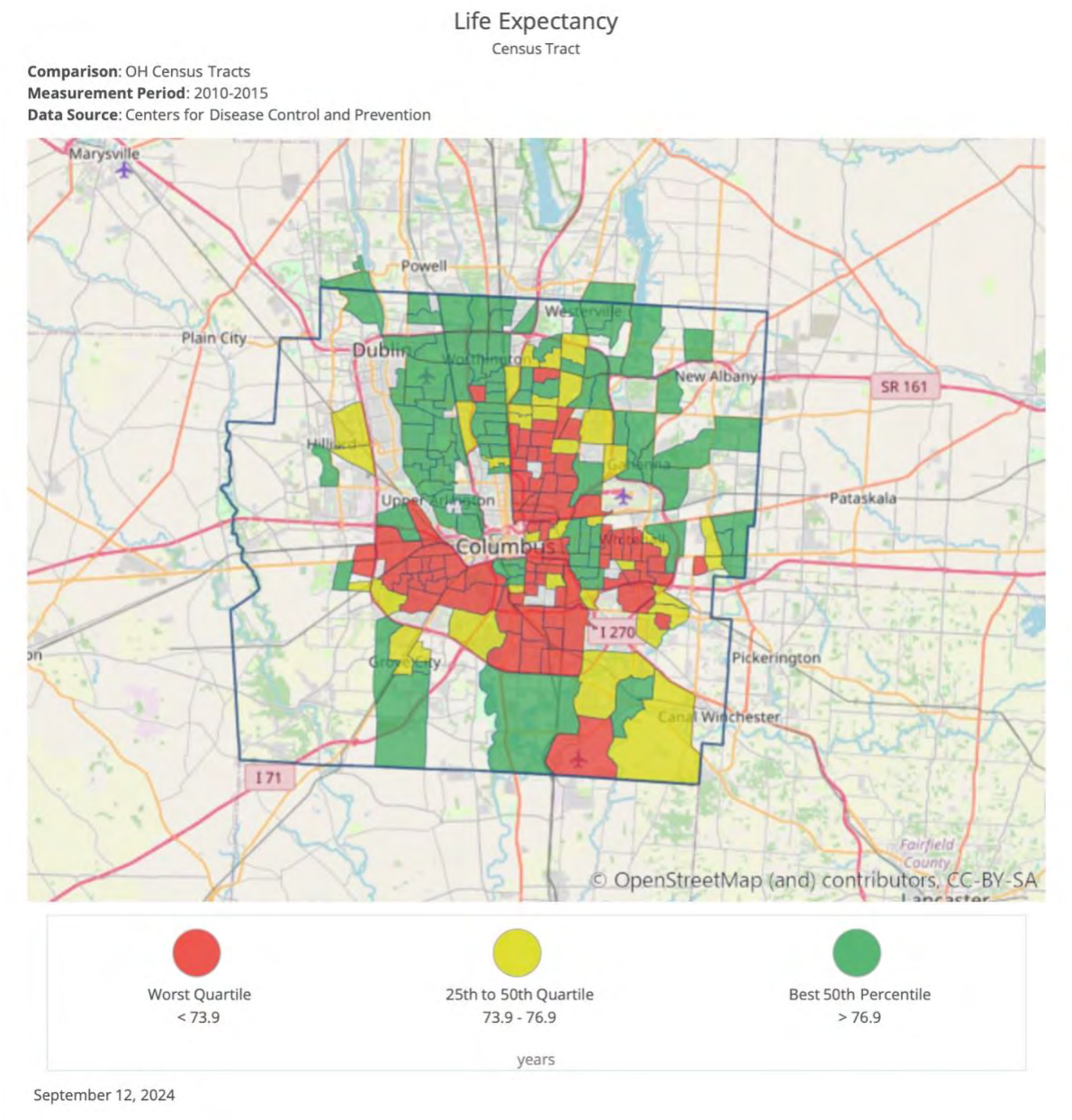
All-Cause Mortality Rate

	Age-adjusted rate per 100,000	
HM2025	**891.5**	
Ages 1-19	30.8	▼
Age 65+	4,969.0	▲
White (non-Hispanic)	880.8	
Black (non-Hispanic)	1,031.6	▲
Asian (non-Hispanic)	471.7	▼
Hispanic	486.6	▼
Male	1,067.6	▲
Female	750.3	▼
Ohio	**849.1**	▼
US	**753.3**	

The map below shows the all-cause mortality rate (crude) for those Franklin County zip codes that have data available for mapping. The all-cause mortality rate is highest in 43223 (Franklinton area), 43207 (southern Franklin County), and 43213 (Whitehall area).



The map below is a screenshot of residents' life expectancy across Franklin County's census tracts during the period from 2010-2015 (the most recent data available), as mapped by Franklin County CARES.[3] The census tracts with the lowest quartiles of life expectancy (e.g., less than 73.9 years) are concentrated in the Franklinton, Hilltop, South Side, Linden, and Whitehall areas of Franklin County. Readers who are interested in learning more about this topic are encouraged to visit Franklin County CARES' interactive map, which can be accessed by **clicking here**.



Additional Information & References

To report life expectancy in Franklin County, *HeathMap2025* referenced County Health Rankings reports from 2024 (data 2019-2021) and 2020 (data 2016-2018).[4] For Ohio and the

United States, we used data from the Centers for Disease Control and Prevention Mortality Reports in 2021 and 2022, respectively.[5,6] Note that the methodology for the County Health rankings has changed in recent years to reflect updated race categories.

The age-adjusted mortality rate for Franklin County was obtained from the National Institute on Minority Health and Health Disparities for the 2018-2022 period.[7] The mortality rates for Ohio and for the US relied on provisional data obtained from the CDC WONDER system for 2023.[8,9] Franklin County Public Health staff mapped the all-cause mortality rate for each zip code in Franklin County that had those data.

[1] Kinsella K. G. (1992). Changes in life expectancy 1900-1990. *The American journal of clinical nutrition*, *55*(6 Suppl), 1196S–1202S. https://doi.org/10.1093/ajcn/55.6.1196S

[2] Woolf, S. H., & Schoomaker, H. (2019). Life Expectancy and Mortality Rates in the United States, 1959-2017. *JAMA*, *322*(20), 1996–2016. https://doi.org/10.1001/jama.2019.16932

[3] Franklin County CARES. (n.d.) Life Expectancy (2010-2015). https://www.franklincocares.org/indicators/index/view?indicatorId=8195&localeTypeId=4&comparisonId=6807

[4] Population Health Institute, University of Wisconsin. (2023) County Health Rankings [Interactive Tool]. Retrieved in 2024 from https://www.countyhealthrankings.org/health-data/health-outcomes/length-of-life/life-expectancy?year=2024

[5] Kochanek, K. D., Murphy, S. L., Xu, J., & Arias, E. (2024). Mortality in the United States, 2022. NCHS data brief, (492), 1–8. https://www.cdc.gov/nchs/data/databriefs/db492.pdf

[6] Arias, E., Xu, J., Tejada-Vera, B., & Bastian, B. (2024). U.S. State Life Tables, 2021. National vital statistics reports : from the Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, 73(7), 1–18. https://www.cdc.gov/nchs/data/nvsr/nvsr73/nvsr73-07.pdf

[7] HDPulse: An Ecosystem of Minority Health and Health Disparities Resources. National Institute on Minority Health and Health Disparities. Data are from 2018-2022. Available from https://hdpulse.nimhd.nih.gov

[8] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database. Data are from the final Multiple Cause of Death Files, 2018-2022, and from provisional data for years 2023-2024, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. http://wonder.cdc.gov/mcd-icd10-provisional.html

[9] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999-2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999-2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

Franklin County CARES' interactive map can be accessed at https://www.franklincocares.org/indicators/index/view?indicatorId=8195&localeTypeId=4&comparisonId=6807.

Leading Causes of Death

Leading causes of death are an important metric for population health. These data can assist in identifying the impact of emerging health concerns such as COVID-19, provide an ecologic view of the outcomes of exposures such as environmental toxins, and illustrate health disparities by age and race.

The leading cause of death among those aged 0-17 was a **perinatal health condition** (**21.5** per 100,000).	↑ Up from HM2022 (19.2)
The leading cause of death among those aged 18-59 was an **accident** (**94.8** per 100,000).	↓ Down from HM2022 (114)
The leading cause of death among those aged 60+ was **heart disease** (**689.7** per 100,000).	↓ Down from HM2022 (743.1)

The leading causes of death among Franklin County children have remained consistent over time, with the most frequent cause of death being perinatal conditions, a label that includes deaths that occur after preterm births, birth complications, or birth defects, among others. Other leading causes of death for assault children include accidents, congenital conditions, and assault. Note: although the top two causes of death for black children were also perinatal conditions and accidents, those occurred at much higher rates (30.8 and 24.9, respectively) than the population averages reported below.

Leading Causes of Death – Children (age 0-17; rate per 100,000)

	HM2025	HM2022	Ohio	US
1st	Perinatal conditions: 21.5	Perinatal conditions: 19.2	Perinatal conditions: 18	Perinatal conditions: 13.7
2nd	Accidents: 9.8	Congenital Conditions: 10.9	Accidents: 10	Accidents: 8.5
3rd	Congenital conditions: 8.5	Assault: 8.3	Congenital conditions: 6.9	Congenital conditions: 6.8
4th	Assault: 5.5	Accidents: 7.6	Assault: 4.4	Assault: 3.1
5th			Cancer (malignant neoplasms): 2.5	Intentional self-harm: 2.2

	HM2025	HM2022	Ohio	US
6th			Intentional self-harm: 2.4	Cancer (malignant neoplasms): 2.2
7th			Heart diseases: 1.4	Heart diseases: 1.0
8th			Influenza & pneumonia: 0.9	Influenza & pneumonia: 0.6
9th				Sepsis (septicemia): 0.5
10th				Cerebrovascular diseases: 0.4

The leading cause of death among Franklin County adults aged 18-59 was accidents, followed by heart diseases, cancer, suicide, and assault.

Leading Causes of Death – Adults (age 18-59; rate per 100,000)

	HM2025	HM2022	Ohio	US
1st	Accidents: 94.8	Accidents: 113.98	Accidents: 82.7	Accidents: 67.4
2nd	Heart diseases: 40.6	Heart diseases: 51.03	Cancer (malignant neoplasms): 55.3	Cancer (malignant neoplasms): 47.3
3rd	Cancer (malignant neoplasms): 39.1	Cancer (malignant neoplasms): 46.5	Diseases of heart: 49.0	Diseases of heart: 42.2
4th	Intentional self-harm: 17.4	Assault: 20.21	Intentional self-harm: 19.3	Intentional self-harm: 18.0
5th	Assault: 16.7	COVID-19 : 14.77	Chronic liver disease and cirrhosis: 12.4	Chronic liver disease and cirrhosis: 12.2
6th	Chronic liver disease & cirrhosis: 9.4	Intentional self-harm: 13.86	Diabetes mellitus: 11.2	Diabetes mellitus: 9.4
7th	Diabetes mellitus: 8.6	Chronic liver disease & cirrhosis: 10.88	Assault: 10.6	Assault: 9.8
8th	Cerebrovascular diseases: 5.5	Diabetes mellitus: 8.55	Cerebrovascular diseases: 7.1	Cerebrovascular diseases: 7.2
9th	Chronic lower respiratory diseases: 5.2	Chronic lower respiratory diseases: 8.03	Chronic lower respiratory diseases: 6.2	Chronic lower respiratory diseases: 4.6
10th	Sepsis (septicemia): 4.7	Cerebrovascular diseases: 7.38	Sepsis (septicemia): 4.7	Nephritis, nephrotic syndrome & nephrosis: 3.4

Black (non-Hispanic) individuals between the ages of 20 and 59 were more likely than white (non-Hispanic) individuals to die due to many of these leading causes; this was especially the case for accidents, heart diseases, and diabetes.

Leading Causes of Death by Race – Adults (age 20-59; rate per 100,000)

	White (non-Hispanic)	Black (non-Hispanic)	Hispanic
1st	Accidents: 94	Accidents: 134.4	Accidents: 122.8
2nd	Cancer (malignant neoplasms): 46.8	Heart diseases: 68.7	
3rd	Heart diseases: 40.1	Assault: 47.1	
4th	Intentional self-harm: 18.5	Cancer (malignant neoplasms): 39.6	
5th	Chronic liver disease & cirrhosis: 12.5	Intentional self-harm: 16.9	
6th	Diabetes mellitus: 7.6	Diabetes mellitus: 15.7	
7th	Chronic lower respiratory diseases (includes COPD, asthma, others): 6.2	Cerebrovascular diseases: 12.2	
8th	Assault: 5.8		

The leading cause of death among Franklin County adults age 60+ was heart diseases, followed by cancer, cerebrovascular disease, accidents, chronic lower respiratory disease, and Alzheimer's disease.

Leading Causes of Death – Older Adults (age 60+; rate per 100,000)

	HM2025	HM2022	Ohio	US
1st	Heart diseases: 689.7	Heart diseases: 772.2	Heart diseases: 849.6	Heart diseases: 764.4
2nd	Cancer (malignant neoplasms): 673.4	Cancer (malignant neoplasms): 627.9	Cancer (malignant neoplasms): 721.2	Cancer (malignant neoplasms): 666.3
3rd	Cerebrovascular diseases: 212.1	COVID-19: 372.7	Cerebrovascular diseases: 226.4	Cerebrovascular diseases: 189.1
4th	Accidents: 185.7	Cerebrovascular diseases: 187.2	Chronic lower respiratory diseases (includes COPD, asthma, others):203.5	Chronic lower respiratory diseases (includes COPD, asthma, others):173.2
5th	Chronic lower respiratory diseases (includes COPD, asthma, others):171.3	Chronic lower respiratory diseases (includes COPD, asthma, others):177.0	Alzheimer's disease: 163.8	Alzheimer's disease: 143.9

	HM2025	HM2022	Ohio	US
6th	Alzheimer's disease: 135.0	Alzheimer's disease: 157.2	Accidents: 128.4	Accidents: 111.5
7th	Diabetes mellitus: 77.1	Accidents: 126.0	Diabetes mellitus: 113.5	Diabetes mellitus: 98.8
8th	Nephritis, nephrotic syndrome & nephrosis: 64.7	Diabetes mellitus: 104.1	Nephritis, nephrotic syndrome & nephrosis: 70.8	Nephritis, nephrotic syndrome & nephrosis: 62.1
9th	Sepsis (septicemia): 52.7	Influenza & pneumonia: 57.5	COVID-19: 68.7	COVID-19: 58.9
10th	Parkinson's disease: 51.5	Nephritis, nephrotic syndrome & nephrosis: 57.1	Sepsis (septicemia): 56.4	Parkinson's disease: 50.5

The leading causes of death for black and white residents age 60 and over are relatively similar to another. However, Asian residents were significantly less likely to die of heart disease or cancer.

Leading Causes of Death by Race – Older Adults (age 60+; rate per 100,000)

	White (non-Hispanic)	Black (non-Hispanic)	Asian
1st	Heart diseases: 743.1	Cancer (malignant neoplasms): 732.1	Heart diseases: 308.4
2nd	Cancer (malignant neoplasms): 710.8	Heart diseases: 695.8	Cancer (malignant neoplasms): 275.4
3rd	Cerebrovascular diseases: 211.4	Cerebrovascular diseases: 258.3	
4th	Accidents: 195	Accidents: 209.2	
5th	Chronic lower respiratory diseases (includes COPD, asthma, others): 193.9	Chronic lower respiratory diseases (includes COPD, asthma, others): 145.1	
6th	Alzheimer's disease: 156.6	Diabetes mellitus: 119.5	
7th	Diabetes mellitus: 71.2	Nephritis, nephrotic syndrome and nephrosis: 119.5	
8th	Parkinson's disease: 63.5	Alzheimer's disease: 91.8	
9th	Nephritis, nephrotic syndrome & nephrosis: 55.3	Sepsis (septicemia): 72.6	
10th	Nutritional deficiencies: 53.1	Essential hypertension & hypertensive renal disease: 51.2	

Additional Information & References

To measure leading causes of death in Franklin County, raw numbers of the leading causes of death were obtained from the Ohio Department of Health Mortality tool,[1] which were then

converted into crude rates using the age and year appropriate population. Among children, the numbers for certain causes of death were particularly small. Therefore, only those causes of death that had at least 15 observations were included; that is the reason why only 4 leading causes of death are included in the table titled, "Leading Causes of Death – Children (age 0-17; rate per 100,000)."

In Ohio and the United States, the crude rates of leading causes of death are from the Centers for Disease Control WONDER database.[2]

For the overall leading causes of death, we defined children as age 0-17, adults as age 18-59, and older adults as age 60+. However, due to the age categories reported by the U.S. Census Bureau, it was not possible to obtain rates by race using the same age categories. Therefore, the age categories for leading causes of death by race were defined as 0-19, 20-59, and 60+.

[1] DataOhio. (2023). *Mortality* [Interactive Dashboard]. Ohio Department of Health, Bureau of Vital Statistics. Retrieved in 2024 from https://data.ohio.gov/wps/portal/gov/data/view/mortality

[2] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database. Data are from the final Multiple Cause of Death Files, 2018-2022, and from provisional data for years 2023-2024, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. http://wonder.cdc.gov/mcd-icd10-provisional.html

Traumatic Injury

A traumatic injury is a severe physical injury that occurs suddenly and requires hospital admission. Examples of such injuries include musculoskeletal injuries, visceral injuries, nerve injuries, soft tissue damage, spinal injuries, and limb loss, all of which might be caused by a variety of blunt, penetrating, or other mechanisms.[1,2] Major traumatic injuries like these are one of the leading causes of death in children and adults under the age of 40, both nationally and here in Franklin County (see page 145).

57% of residents who were hospitalized due to trauma **experienced a fall**.

≈ Similar to HM2022 (53.7%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Older adults more likely (falls)	Male more likely (firearms, being struck, being cut/pierced)	Black more likely (firearms)	Observed (see maps)

Among those Franklin County residents who were hospitalized due to bodily trauma, the most common type of trauma was a fall. The next most common types of trauma hospitalizations were accidents involving an occupant of a motor vehicle and being struck (either by something or against something).

Leading Causes of Trauma Hospitalizations

	HM2025	**HM2022**	**HM2019**
1st	Fall: 56.6%	Falls: 53.7%	Falls: 48.5%
2nd	Motor vehicle accident (occupant): 12.2%	Motor vehicle accident (occupant): 12.7%	Motor vehicle accident (occupant): 15.5%
3rd	Struck by or against: 7.9%▼	Struck by or against: 9.6%	Struck by or against: 9.2%
4th	Firearm: 5.1%▲	Firearm: 4%	Firearm: 5.5%
5th	Cut or Pierce: 2.6%	Cut or Pierce: 2.6%	Cut or Pierce: 2.6%

As shown below, fall injuries that lead to hospitalization occur more frequently among older adults (age 65+), whereas most other types of injuries that lead to hospitalization occur among adults aged 18-64.

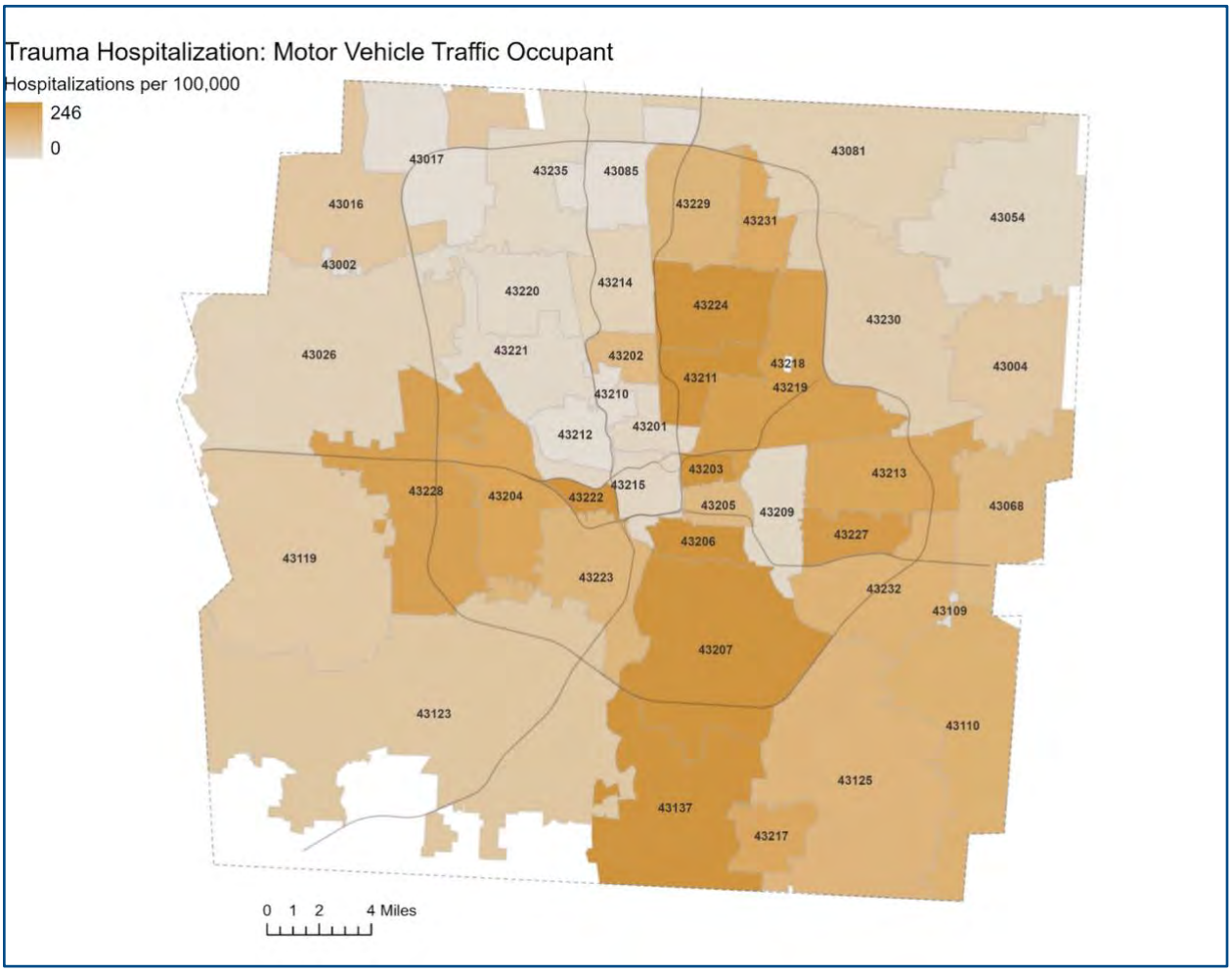
Injuries due to firearms, being struck (by or against something), or cutting/piercing that lead to hospitalization all occur more frequently among males than females. Injuries due to firearms that lead to hospitalization occur more frequently among black individuals.

Leading Causes of Trauma Hospitalizations (by Key Demographics)

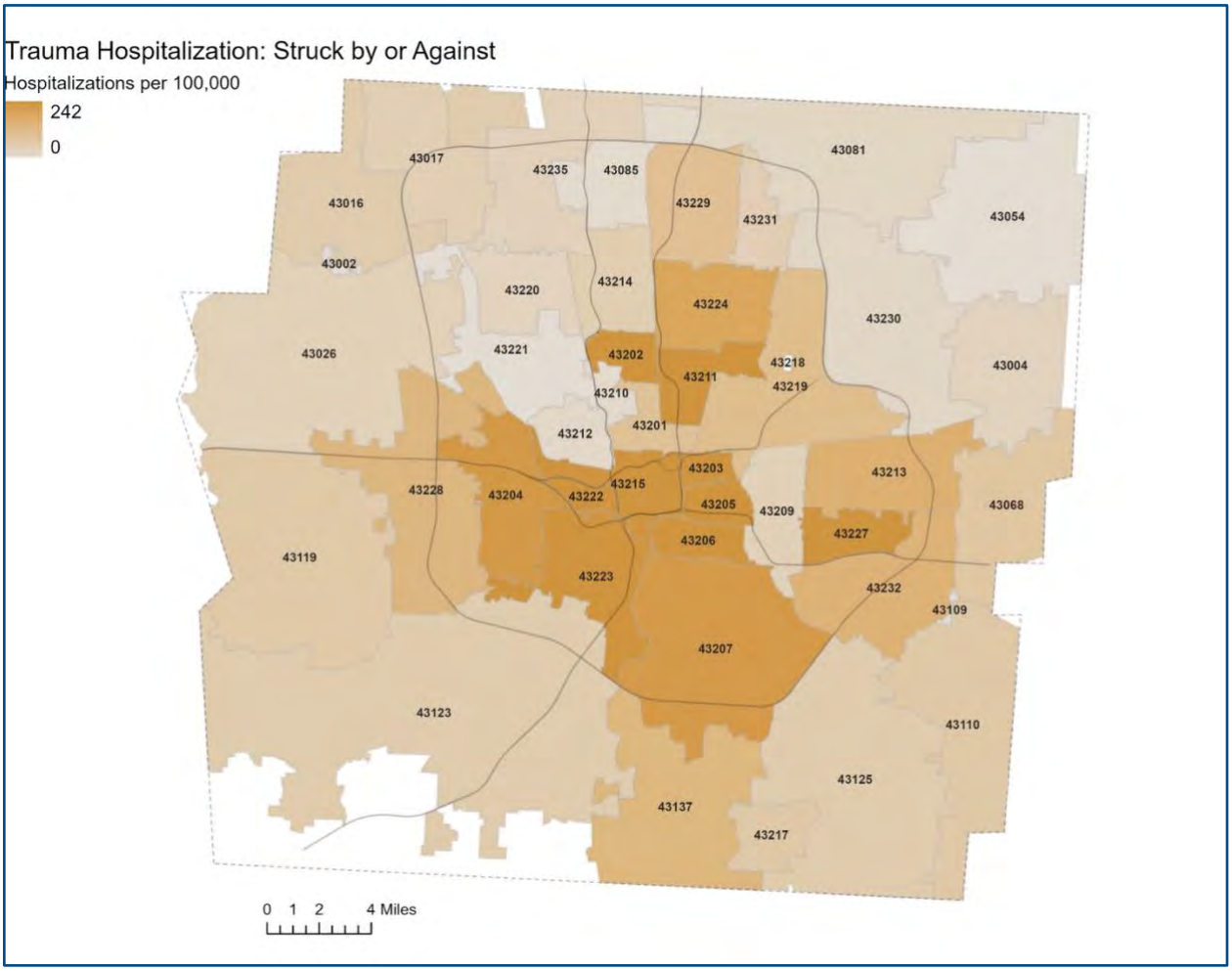
	Fall	Motor vehicle (occupant)	Struck by or against	Firearm	Cut or pierce	All others
Total	**5,766**	**1,245**	**805**	**521**	**266**	**1,577**
	56.6%	**12.2%**	**7.9%**	**5.1%**	**2.6%**	**15.5%**
Age						
0-17 Years	6.9%	7.4%	12.4%	14.8%	10.2%	
18-64 Years	30.8%	***75.8%***	***81.1%***	***83.5%***	***83.1%***	
65+ years	***62.4%***	16.8%	6.5%	1.3%	6.8%	
Gender						
Female	54.7%	48.8%	23.6%	14.0%	21.1%	
Male	44.8%	51.0%	***76.0%***	***85.8%***	***79.0%***	
Race						
American Indian	0.1%	0.1%	0.1%	0.2%	-	
Asian	2.2%	2.3%	1.4%	0.8%	2.3%	
Black/African American	14.9%	35.3%	42.6%	***74.7%***	44.7%	
Native Hawaiian, Other	0.1%	0.2%	0.1%	0.2%	0.8%	
Unknown	5.3%	9.6%	8.9%	5.8%	13.5%	
White	***77.4%***	52.6%	46.8%	18.4%	38.7%	

The rate of trauma hospitalizations due to falls seems to be relatively evenly distributed throughout Franklin County; that said, rates for that type of injury tend to be lower in northwestern zip codes, western zip codes, and far northeastern zip codes.

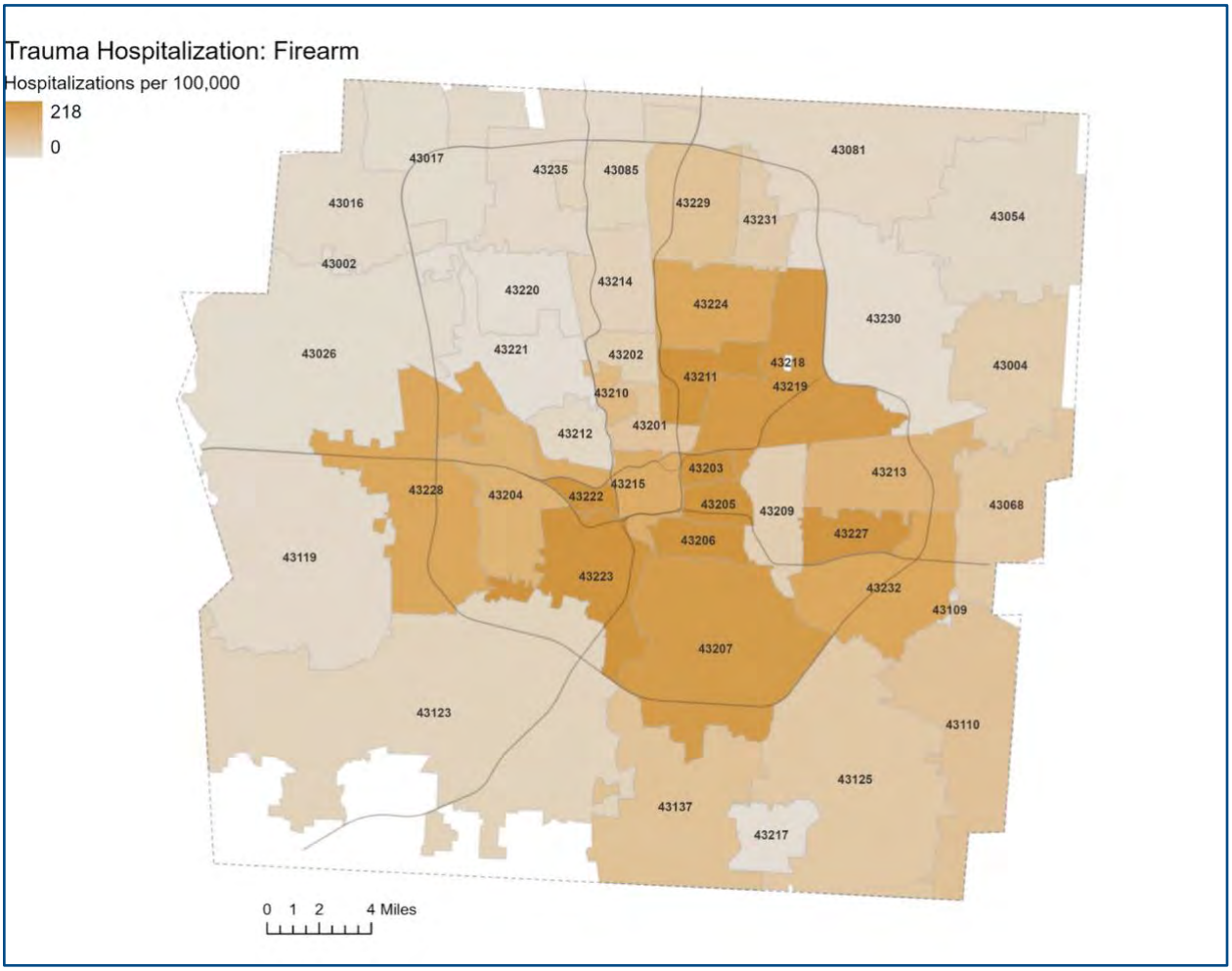
The rate of trauma hospitalizations involving an occupant of a motor vehicle that was in an accident is greater in north-central zip codes (43211, 43224), west-central zip codes (43222, 43204, 43228), and southern zip codes (43206, 43207).



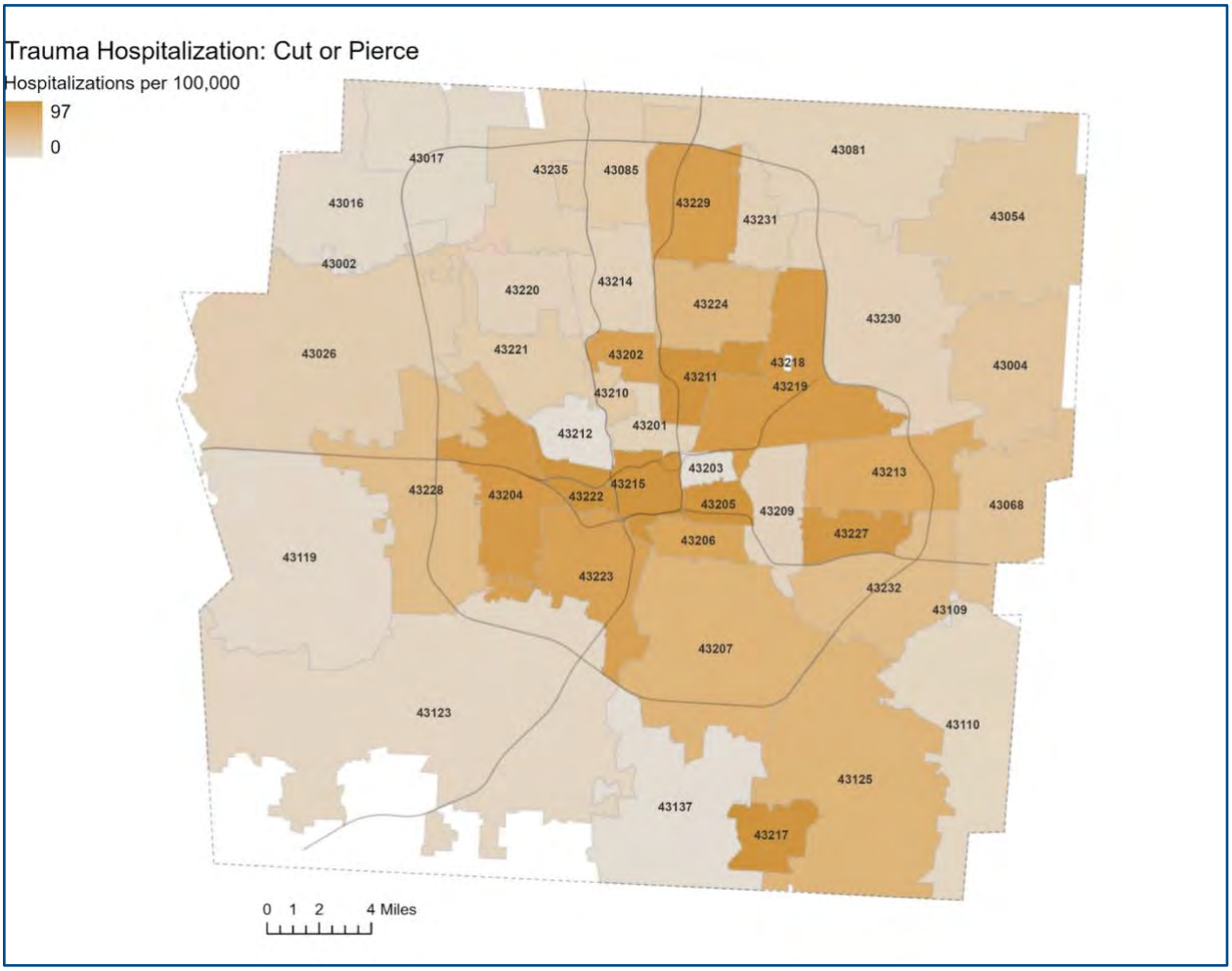
The rate of trauma hospitalizations due to being struck by or against something is greater in north-central zip codes (43202, 43211), central zip codes (43203, 43208, 43215, 43222, 43204, 43223), southern zip codes (43206, 43207), and the Whitehall area (43227).



The rate of trauma hospitalizations due to firearms is greater in north-central zip codes (43211, 43218, 43219), east-central zip codes (43203, 43205), west-central zip codes (43222, 43223), southern zip codes (43206, 43207), and the Whitehall area (43227).



The rate of trauma hospitalizations due to being cut or pierced is greater in north-central zip codes (43211, 43202, 43218, 43219), east-central zip codes (43215, 43205), west-central zip codes (43222, 43204), and the Whitehall area (43227).



Additional Information & References

Trauma-related hospitalization data were provided by the Ohio Department of Public Safety, which accessed the Trauma Acute Care Registry (TACR) system for 2022, 2019, and 2016.[3]

Franklin County Public Health staff then mapped these data for each zip code in Franklin County.

[1] Rehabilitation after traumatic injury. London: National Institute for Health and Care Excellence (NICE); 2022 Jan 18. (NICE Guideline, No. 211.) Available from: https://www.ncbi.nlm.nih.gov/books/NBK579697/

[2] Dumovich J, Singh P. Physiology, Trauma. [Updated 2022 Sep 19]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK538478/

[3] Ohio Division of Emergency Medical Services, Ohio Department of Public Safety. (2024). *Trauma Acute Care Agency* [Dataset].

Cancer

During their lifetime, 1 in 3 people in the United States will be diagnosed with cancer – a disease in which some of the body's cells grow uncontrollably and spread to other parts of the body.[1,2] As noted in *HealthMap2025's* Leading Causes of Death section, cancer ("malignant neoplasms") is the 3rd leading cause of death among Franklin County adults aged 18-59 and the 2nd leading cause of death among Franklin County adults aged 60+.

The incidence for two leading types of cancers (**lung & bronchus; colon and rectum**) has decreased.	⬇ Down from HM2022
The incidence for one leading types of cancers (**breast**) has increased.	⬆ Up from HM2022
The cancer that most frequently led to the death of Franklin County residents is **lung & bronchus**.	≈ Similar to HM2022

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Unavailable	Unavailable	Observed (see below)	Observed (see map)

Prostate cancers and breast cancers continue to have the highest incidence rates[3] among Franklin County residents, followed by lung and bronchus cancers.

Cancer Incidence (age-adjusted rate per 100,000)

	HM2025	**HM2022**	**HM2019**	**Ohio**	**US**
1st	Prostate: 133.5	Prostate: 140.1	Prostate: 124.7	Prostate: 121.3	Prostate: 114.7
2nd	Breast: 81.4 ▲	Breast: 72.2	Breast: 74.9	Breast: 73.0	Breast: 70.4
3rd	Lung & Bronchus: 56.4 ▼	Lung & Bronchus: 63.1	Lung & Bronchus: 71.3	Lung & Bronchus: 60.6▼	Lung & Bronchus: 49.1▼
4th	Other Sites/Types:38.6	Colon & Rectum: 38	Colon & Rectum: 40	Colon & Rectum: 38.3	Colon & Rectum: 36.0
5th	Colon & Rectum: 32.5 ▼	Other Sites/ Types:35.8	Other Sites/ Types: 37.1	Uterus: 29.8	Uterus: 27.3

Cancer Incidence by Race (age-adjusted rate per 100,000)

	White (non-Hispanic)	Black (non-Hispanic)	Asian	Hispanic
1st	Prostate: 118.9 ▼	Breast: 62.1 ▼	Prostate: 183.1 ▲	Prostate: 60 ▼
2nd	Breast: 81.9	Prostate: 25.4 ▼	Breast: 76.9	Uterus: 44.7
3rd	Lung & Bronchus: 56.9	Other Sites/Types: 25.2▼	Lung & Bronchus: 61.5	Breast: 32.5 ▼
4th	Other Sites/Types: 37.6	Lung and Bronchus: 17.2▼	Other Sites/Types: 38.8	Kidney & Renal Pelvis: 24.2
5th	Colon & Rectum: 33.9	Non-Hodgkins Lymphoma: 14.4	Colon & Rectum: 29.9	Other Sites/Types: 22.1▼

Lung and bronchus cancers have the highest mortality rate among Franklin County residents, followed by other sites/types of cancers.

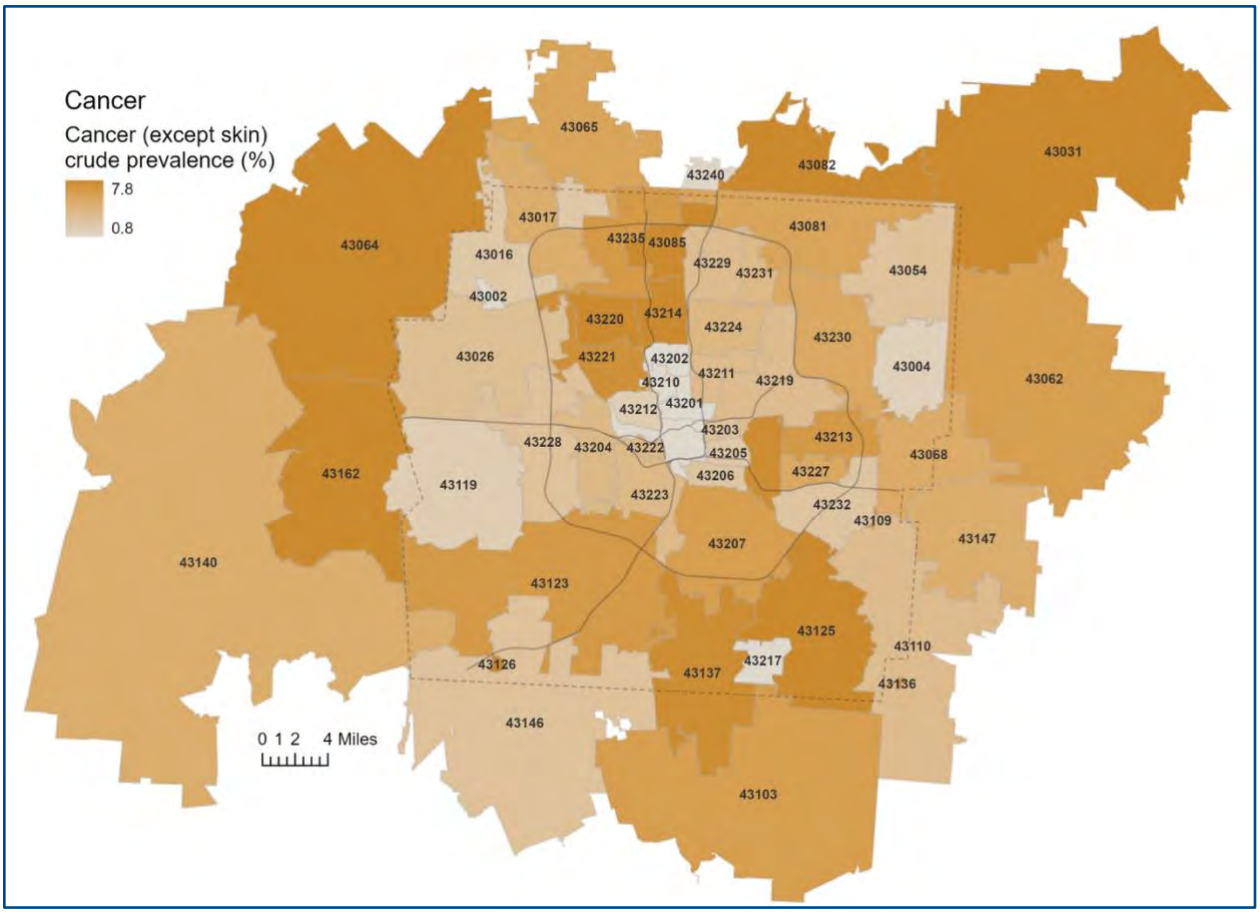
Cancer Mortality (age-adjusted rate per 100,000)

	HM2025	HM2022	HM2019	Ohio	US
1st	Lung & Bronchus: 33.1	Lung & Bronchus: 34.3	Lung & Bronchus: 41.6	Lung & bronchus: 38.8▼	Lung & Bronchus: 31.3▼
2nd	Other Sites/ Types: 21.3	Other Sites/ Types: 20	Other Sites/ Types: 15.6	Prostate: 19.7	Prostate: 18.8
3rd	Pancreas: 11.1	Pancreas: 13.1	Colon & Rectum: 12.8	Colon & Rectum: 13.8	Colon & Rectum: 12.8
4th	Colon & Rectum: 11.1	Breast: 11.5	Breast: 11.9	Pancreas: 11.6	Pancreas: 11.2
5th	Breast: 10.1 ▼	Colon & Rectum: 10.4	Pancreas: 11.1	Breast: 11.1	Breast: 10.5

Cancer Mortality by Race (age-adjusted rate per 100,000)

	White (non-Hispanic)	Black (non-Hispanic)
1st	Lung & Bronchus: 45.98 ▲	Lung & Bronchus: 29.14
2nd	Pancreas: 15.2 ▲	Breast: 12.17 ▲
3rd	Colon & Rectum: 13.81 ▲	Pancreas: 9.61 ▼
4th	Breast: 12.79 ▲	Liver & Intrahepatic Bile Duct: 8.97
5th	Prostate: 8.99	Colon & Rectum: 8.65 ▼

As shown in the map below, cancer prevalence is highest among Franklin County residents in northwest-central zip codes (43221, 43220), north-central zip codes (43214, 43085), and southern zip codes (43137, 43125).



Additional Information & References

Cancer incidence rates were obtained from a variety of sources. For Franklin County, age-adjusted rates from ODH's Invasive Cancer Report were used for the years 2021, 2018, and 2015.[3] For Ohio and the United States, age-adjusted data from Centers for Disease Control and Prevention's WONDER database were used for 2021.[4] Likewise, cancer mortality rates were obtained from a variety of sources. For Franklin County, data from ODH's Mortality Report were used for the years 2022, 2019, and 2016 overall, and 2021 for race.[3] These data were then converted into crude rates by dividing the total number of deaths by the total population in that year. For Ohio and the United States, age-adjusted data from Centers for Disease Control and Prevention's WONDER database were used for the year 2021.[4]

To map cancer prevalence at the zip code level, Franklin County Public Health staff obtained estimates from the CDC's PLACES resource, which uses BRFSS data (2021 or 2022), Census

Bureau data (either the 2020 decennial census or 2022 annual population estimates), and American Community Survey data (2018-2022 estimates).

[1] National Cancer Institute. (n.d.) What is cancer? https://www.cancer.gov/about-cancer/understanding/what-is-cancer

[2] American Cancer Society. (n.d.) Understanding cancer. https://www.cancer.org/cancer/understanding-cancer.html

[3] DataOhio. (2021). Invasive Cancer Report [Interactive Dashboard]. Ohio Department of Health, Bureau of Vital Statistics. Retrieved in 2024 from https://data.ohio.gov/wps/portal/gov/data/view/ohio_births

[4] Centers for Disease Control and Prevention, CDC WONDER Online Database. United States and Puerto Rico Cancer Statistics, 1999-2021 Incidence Results. Accessed at https://wonder.cdc.gov/cancer-v2021.html

[5] DataOhio. (2022). Mortality [Interactive Dashboard]. Ohio Department of Health, Bureau of Vital Statistics. Retrieved in 2024 from https://data.ohio.gov/wps/portal/gov/data/view/ohio_births

[6] Centers for Disease Control and Prevention, CDC WONDER Online Database. United States and Puerto Rico Cancer Statistics, 1999-2021 Mortality Request. Accessed at https://wonder.cdc.gov/cancermort-v2021.html

Violent Crime

High rates of local violent crime are associated with health impacts such as increased cardiovascular disease and lower self-rated health.[1,2] This is theorized to be due in part to greater stress from feeling unsafe, as well as co-occurrence with related risk factors such as poverty and lack of access to healthcare.

There were **401.3 violent crimes** per 100,000 Franklin County residents.

≈ Similar to HM2022 (424.1)

The overall incidence of violent crime has not changed significantly since HM2022, but there is a steady downward trajectory since HM2019. Unfortunately, Franklin County still has higher rates of overall violent crime as well as each individual crime. Murder has risen across Franklin County, Ohio, and the US while robbery has decreased in the same geographies. Rape has increased in Franklin County and aggravated assault has risen in Ohio.

Violent Crime (rate per 100,000)

	Overall	Murder	Rape	Robbery	Aggravated Assault
HM2025	401.3	10.7 ▲	85.1 ▲	113.5 ▼	191.9
HM2022	424.1	9.4	76.9	159.2	178.5
HM2019	455.9	8.9	85.7	206.2	155.1
Ohio	293.6	6.1 ▲	48.4	53.1 ▼	185.9
US	380.7	6.3 ▲	40	66.1 ▼	268.2 ▲

Additional Information & References

Overall violent crime is defined as the combined rate of four different offences: murder, rape, robbery, and aggravated assault. To assess violent crime in Franklin County, we used the Ohio Office of Criminal Justice Services dashboard for crime by county for 2022, 2019, and 2016.[3] Crime rates in Ohio and the United States were sourced from the Federal Bureau of Investigation Crime Data Explorer tool.[4]

Crime rates in Franklin County were calculated by dividing the raw number of incidents reported by the total population and multiplying by 100,000. Overall violent crime was calculated by first adding the individual numbers of murder, rape, robbery, and aggravated assault for the year in question and then converting into a rate.

Data Gap: Future HealthMaps should consider obtaining demographic data (e.g., age, gender, racial/ethnic background) about those who experience violent crime.

Data Gap: Since 2013, the Columbus Division of Police did not report ~119,000 crimes to the Ohio Office of Criminal Justice Services' Incident-Based Reporting System (OIBRS). Because of this, readers should exercise care when interpreting Franklin County's crime rates over time. For more information about this, readers are encouraged to visit the Columbus Division of Police's webpage, which can be accessed at https://www.columbus.gov/Services/Public-Safety/Police.

[1] Eberly, L. A., Julien, H., South, E. C., Venkataraman, A., Nathan, A. S., Anyawu, E. C., Dayoub, E., Groeneveld, P. W., & Khatana, S. A. M. (2022). Association Between Community-Level Violent Crime and Cardiovascular Mortality in Chicago: A Longitudinal Analysis. *Journal of the American Heart Association*, *11*(14), e025168.

[2] Dong, B., White, C. M., & Weisburd, D. L. (2020). Poor Health and Violent Crime Hot Spots: Mitigating the Undesirable Co-Occurrence Through Focused Place-Based Interventions. *American journal of preventive medicine*, *58*(6), 799–806. https://doi.org/10.1016/j.amepre.2019.12.012

[3] Ohio Office of Criminal Justice Services. (2022). *OIBRS Data Dashboard: Crime in Ohio Counties 2016-2022 [Interactive Dashboard]*. Retrieved in 2024 from https://ocjs.ohio.gov/research-and-data/data-reports-and-dashboards/crime-in-ohio-counties

[4] Federal Bureau of Investigation. (2022). *Crime Data Explorer [Interactive Dashboard]*. Retrieved in 2024 from https://cde.ucr.cjis.gov/LATEST/webapp/#/pages/explorer/crime/crime-trend

Overdose Deaths

During the past 20 years, drug overdose deaths have increased exponentially, with a particular spike noted during the COVID-19 pandemic.[1,2] The rise in deaths is attributed to opioids, which includes prescription medications, heroin, fentanyl, and other synthetic opioids.[3] The combination of opioids and other substances, for example the veterinary sedative xylazine, is a rising trend that can increase the potential of fatal overdose.[4]

135.3 per 100,000 residents in Franklin County died of an **overdose**.

Up from HM2022 (115.1)

45.2 per 100,000 residents in Franklin County died of an overdose of a synthetic narcotic such **as fentanyl**.

Down from HM2022 (54.0)

Across all geographies for the last several HealthMap assessments, the leading cause of overdose death has been "other synthetic narcotics", a category that includes fentanyl. In Franklin County, that type of overdose death decreased since the last *HealthMap*; however, it is still much higher than the estimates for Ohio, US, or HM2019.

In Franklin County, overdose deaths due to cocaine use have increased rapidly over time.

Overdose Mortality (rate per 100,000)

	HM2025	HM2022	HM2019	Ohio	US
Total	**135.3▲**	**115.1**	**63.5**	**98.1**	**70.9▲**
1st	Other synthetic narcotics: 45.2▼	Other synthetic narcotics: 54.0	Other synthetic narcotics: 25.2	Other synthetic narcotics: 30.5	Other synthetic narcotics: 21.8
2nd	Cocaine: 28.2▲	Cocaine: 20.1	Cocaine: 13.7	Cocaine: 15.1	Psychostimulants with abuse potential: 10.5
3rd	Psychostimulants with abuse potential: 10.2▲	Psychostimulants with abuse potential: 9.1	Other opioids: 6.8	Psychostimulants with abuse potential: 11.2	Cocaine: 8.8
4th	Other opioids: 4.8▼	Other opioids: 5.4	Heroin: 5.4	Benzodiazepines: 3.5	Benzodiazepines: 3.2
5th	Benzodiazepines: 4.2▲	Benzodiazepines: 3.6	Benzodiazepines: 1.9	Antiepileptic and sedative-hypnotic drugs, unspecified: 3.3	Other opioids: 3.0

Additionally, overdose deaths from psychostimulants with abuse potential (which includes methamphetamines) have increased since the last *HealthMap*, as have overdose deaths from benzodiazepines (e.g., depressants that sedate, relieve anxiety, and reduce seizures, such as Valium®, Xanax®, Klonopin®, and others).

Franklin County has progress to make regarding overdose deaths, particularly from synthetic opioids. Drug abuse is a nationwide crisis, and a comprehensive federal, state, and local approach will be needed to address drug supply, law enforcement, and addiction treatment.

HP2030 objective for Overdose Deaths: Not met[7]

Healthy People Objective:	Most recent Franklin County data (HM2025)
20.7	**135.3**

HP2030 objective for Synthetic Opioid Deaths: Not met[8]

Healthy People Objective:	Most recent Franklin County data (HM2025)
8.9	**45.2**

HP2030 objective for Other Opioid Deaths: Not met[9]

Healthy People Objective:	Most recent Franklin County data (HM2025)
3.4	**4.8**

Additional Information & References

Readers who are interested in learning more about local efforts to decrease overdoses, overdose deaths, and infectious diseases like Hepatitis C and HIV/AIDS should visit the Columbus and Franklin County Addiction Plan, which can be accessed by **clicking here**.

To measure overdose mortality in Franklin County, we sourced data from the Centers for Disease Control and Prevention WONDER portal.[5,6] In alignment with the Healthy People 2030 goals, these statistics included deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as well as drug poisoning as a multiple cause of death (ICD-10 codes T36-T50).

Note that "Other synthetic narcotics" includes fentanyl deaths, "Psychostimulants with abuse potential" includes methamphetamines, and "Other opioids" includes prescribed opioids such as oxycodone.

[1] Fujita-Imazu, S., Xie, J., Dhungel, B., Wang, X., Wang, Y., Nguyen, P., Khin Maung Soe, J., Li, J., & Gilmour, S. (2023). Evolving trends in drug overdose mortality in the USA from 2000 to 2020: an age-period-cohort analysis. *EClinicalMedicine*, *61*, 102079. https://doi.org/10.1016/j.eclinm.2023.102079

[2] DiGennaro, C., Garcia, G. P., Stringfellow, E. J., Wakeman, S., & Jalali, M. S. (2021). Changes in characteristics of drug overdose death trends during the COVID-19 pandemic. *The International journal on drug policy*, *98*, 103392. https://doi.org/10.1016/j.drugpo.2021.103392

[3] Ciccarone D. (2019). The triple wave epidemic: Supply and demand drivers of the US opioid overdose crisis. *The International journal on drug policy*, *71*, 183–188. https://doi.org/10.1016/j.drugpo.2019.01.010

[4] Hays, H. L., Spiller, H. A., DeRienz, R. T., Rine, N. I., Guo, H. T., Seidenfeld, M., Michaels, N. L., & Smith, G. A. (2024). Evaluation of the relationship of xylazine and fentanyl blood concentrations among fentanyl-associated fatalities. *Clinical toxicology (Philadelphia, Pa.)*, *62*(1), 26–31. https://doi.org/10.1080/15563650.2024.2309326

[5] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database. Data are from the final Multiple Cause of Death Files, 2018-2022, and from provisional data for years 2023-2024, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. http://wonder.cdc.gov/mcd-icd10-provisional.html

[6] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999-2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999-2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

[7] Healthy People 2030 objective SU-03, U.S. Department of Health and Human Services

[8] Healthy People 2030 objective IVP-22, U.S. Department of Health and Human Services.

[9] Healthy People 2030 objective IVP-21, U.S. Department of Health and Human Services.

The Columbus and Franklin County Addiction Plan can be accessed at https://cfcap-columbus.hub.arcgis.com/.

ENVIRONMENTAL HEALTH

Elevated blood lead levels (EBLL)

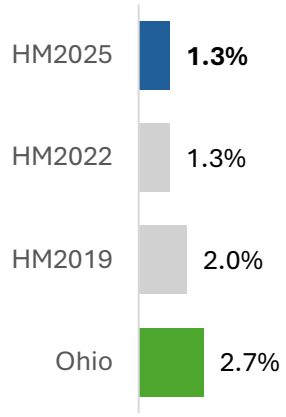
Although elevated blood lead levels (EBLL) are detrimental to all people, they are particularly harmful to children. Young children exposed to high levels of lead are at increased risk for brain damage and developmental delays, lower muscle function, and damage to the kidneys and other organs.[1] Children are primarily exposed to lead by consuming contaminated paint, dust, or water.[1]

1.3% of tested children under 6 years old had an **elevated blood lead level**.

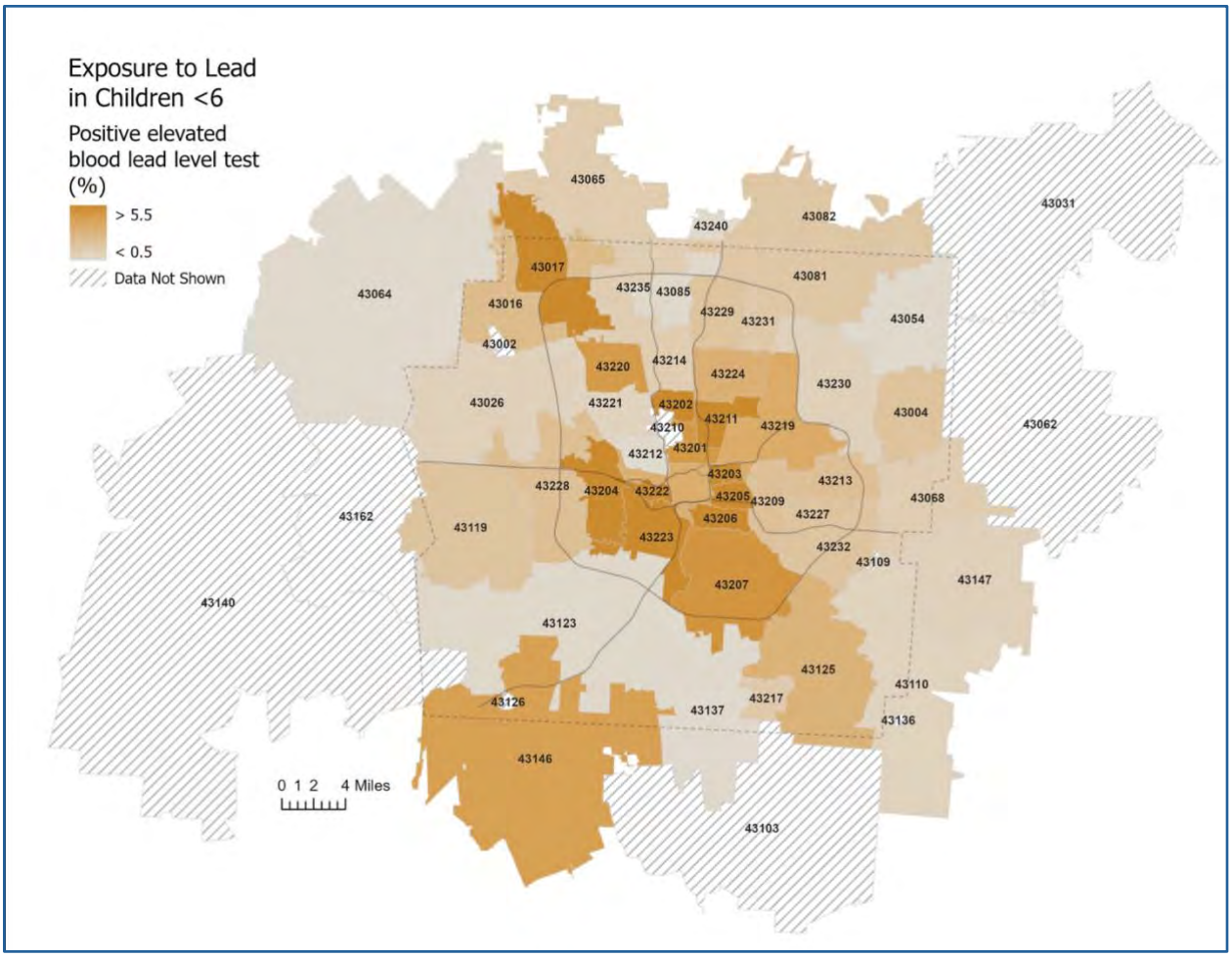
≈ Similar to HM2022 (1.3%)

Since HM2019, the percentage of tested young children with elevated blood lead levels has decreased. Currently, the percentage of tested young children with elevated blood lead levels in Franklin County is less than half that of tested young children in Ohio overall.

Elevated Blood Lead Levels (≥5 µg/dL) among children under age 6 who were tested for lead



As shown in the map on the next page, greater percentages of children under age 6 in the following areas have elevated blood lead levels: east-central Franklin County (43203, 43205), southern Franklin County (43206), west-central Franklin County (43222, 43223, 43204), northern Columbus (43202, 43211), and far northwestern Franklin County/Dublin (43017).



Additional Information & References

To assess elevated blood lead levels in children under 6 years old, data were obtained from Ohio's Blood Lead Testing Program.[2] Although the threshold for determining elevated blood lead levels in Ohio changed in 2023 (i.e., from ≥5 µg/dL to ≥3.5 µg/dL), for the sake of historical comparisons *HealthMap2025* retained the threshold of ≥5 µg/dL. In the map visualizations for 2023, the updated threshold of ≥3.5 µg/dL was used. Franklin County Public Health staff then mapped these data for each zip code in Franklin County.

[1] Abadin, H., Ashizawa, A., Stevens, Y. W., Llados, F., Diamond, G., Sage, G., Citra, M., Quinones, A., Bosch, S. J., & Swarts, S. G. (2007). *Toxicological Profile for Lead*. Agency for Toxic Substances and Disease Registry (US).

[2] DataOhio. (2023). *Blood Lead Testing Public (2016-present)* [Interactive Dashboard]. Ohio Department of Health, Bureau of Vital Statistics. Retrieved in 2024 from https://data.ohio.gov/wps/portal/gov/data/view/blood-lead-testing-public-_2016-present_?visualize=true

Asthma

Asthma is a chronic disease that affects people's lungs, and is one of the most common long-term diseases among children.[1] Because environmental health factors such as outdoor air pollution (e.g., ozone, particulate matter) has been associated with increased asthma symptoms, asthma is included in this section of *HealthMap2025*.[2]

9.9% of Franklin County adults reported asthma.

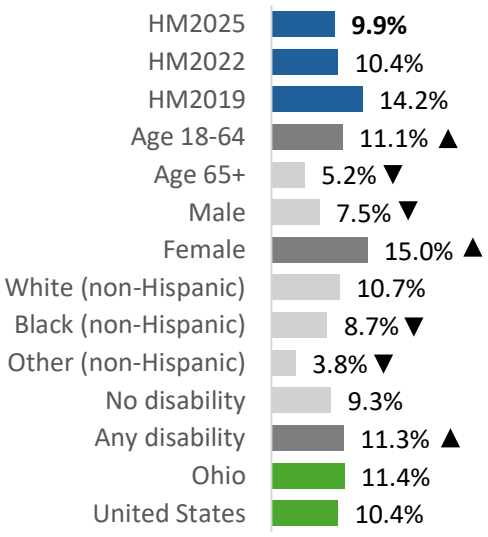
≈ Similar to HM2022 (10.4%)

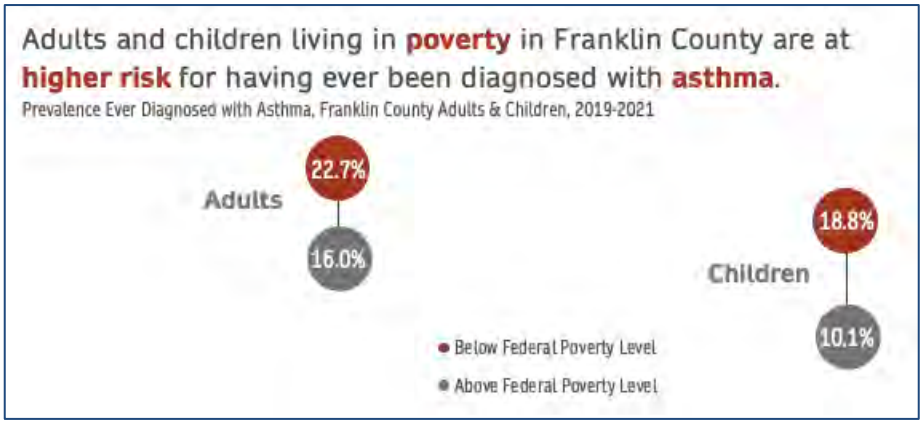
Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Younger more likely	Female more likely	None observed	Observed (see map)

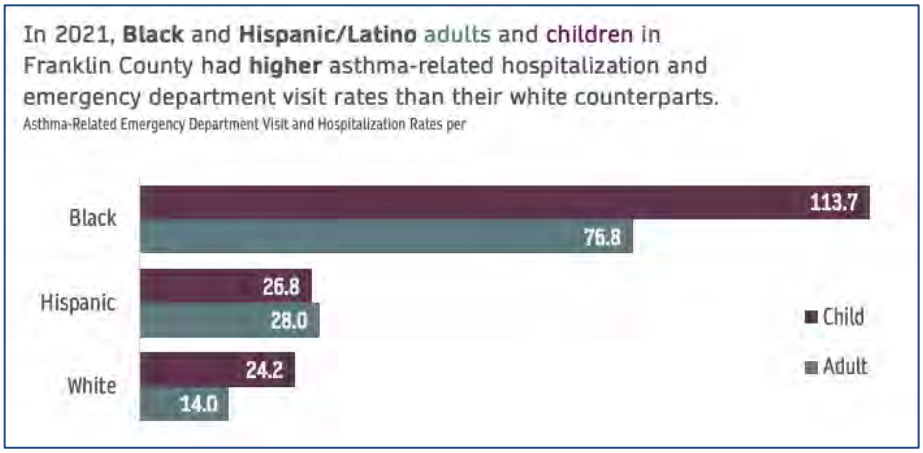
Asthma is lower among older adults than younger adults, which could be due to either changes in diagnoses or superseding respiratory diagnoses in the elderly (e.g., chronic obstructive pulmonary disease, or COPD). Females and individuals with disabilities are both more likely to report this health condition.

A recent analysis of asthma prevalence by poverty status revealed that among Franklin County residents living in poverty, 22.7% of adults and 18.8% of children have ever been diagnosed with asthma (see below).

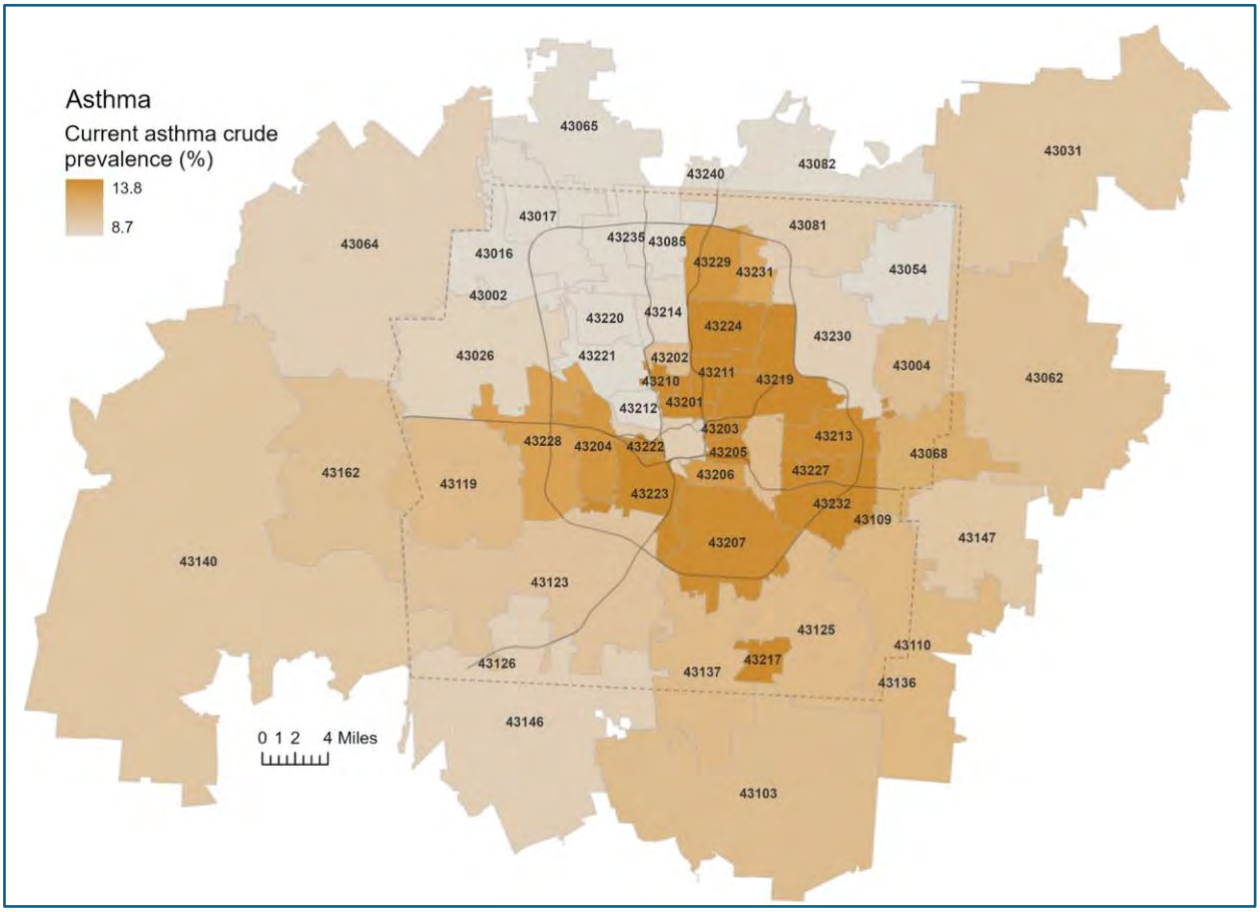




Additionally, a recent analysis revealed that black and Hispanic adults and children in Franklin County had much higher rates of asthma-related hospitalization and emergency department visits as compared to white individuals.



As shown in the map below, asthma prevalence is higher in most Franklin County zip codes that are within I-270, except for those zip codes in the northwestern quadrant.



Additional Information & References

Readers who are interested in learning more about this topic should also consider visiting the Mid-Ohio Regional Planning Commission's 2023 Report on Central Ohio's Air Quality, which can be accessed by **clicking here**, as well as Franklin County Public Health's Data Hub Climate & Health webpage which can be accessed by **clicking here**.

To assess the prevalence of this chronic condition, *HealthMap2025* obtained recent data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS), which completes structured survey interviews with residents via telephone.[3] In most cases, survey respondents were asked if a doctor, nurse, or other health professional ever told them that they had a specific chronic health condition.

To enable comparisons by demographic subgroups (e.g., age, sex, race), Columbus Public Health staff analyzed BRFSS data using the most recent year or two available (typically 2021 & 2022). To map the prevalence of these indicators at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the CDC's PLACES[4] resource, which uses BRFSS data (2021 or 2022), Census Bureau data (either the 2020 decennial census or 2022 annual population estimates), and American Community Survey data (2018-2022 estimates).

Franklin County Public Health staff conducted the analyses of asthma prevalence by poverty status and rates of asthma-related hospitalization by racial/ethnic background and created the visuals depicting the key findings from those analyses.[5]

[1] Centers for Disease Control and Prevention. (n.d.) About Asthma. https://www.cdc.gov/asthma/about/index.html

[2] Centers for Disease Control and Prevention. (n.d.) Environmental Triggers of Asthma. https://www.atsdr.cdc.gov/csem/asthma/treatment_management_prevention.html#outdoor

[3] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data, 2022 (HM2025), 2019 (HM2022), 2015 (HM2019)

[4] Centers for Disease Control and Prevention, PLACES: Local Data for Better Health. (n.d.). https://www.cdc.gov/places/index.html

[5] Franklin County Public Health. (2024). Personal communication: Asthma Grant Statement of Need.

The Mid-Ohio Regional Planning Commission's 2023 Report on Central Ohio's Air Quality can be accessed at https://www.morpc.org/2023/wp-content/uploads/2024/03/MORPC_End-of-season-AQ-report-2023-updated.pdf. Franklin County Public Health's Data Hub Climate & Health webpage can be accessed at https://fcph-data-hub-fca.hub.arcgis.com/pages/climate.

Lyme Disease

Lyme disease is a bacterial infection that can occur after a person is bit by a tick. The Annual Summary of Reportable Diseases (2022) for Columbus and Franklin County, Ohio, which can be accessed by **clicking here**, presented recent data about the number of Lyme disease cases, along with various rate calculations. A snippet from that report is displayed below.

DISEASE SPOTLIGHT:

LYME DISEASE

LYME DISEASE		2022
Number of Cases		38
Rate*	*Overall*	2.9
	Female	2.4
	Male	3.4
Age of cases (in years)	*Mean*	29
	Median	18
	Range	4-72

* Rate per 100,000 population

LOCAL FACTS:

In Columbus and Franklin County in 2022:

- The Lyme disease rate among males was higher than the rate among females.
- 50% of confirmed and probable cases were pediatric cases.
- 96.8% of confirmed and probable cases were among whites of non-Hispanic or non-Latino descent.

EPIDEMIOLOGY[3]

Infectious Agent: *Borrelia burgdorferi* or *Borrelia mayonii*, spirochete-type bacteria

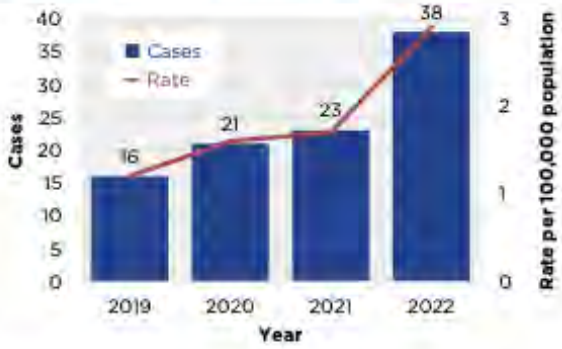
Case Definition: Please see the Ohio Infectious Disease Control Manual: Lyme Disease.

Mode of Transmission: The spirochete-type bacteria is transmitted through the bite of a tick: *Ixodes pacificus* in the western and *Ixodes scapularis* in the eastern and midwestern United States.

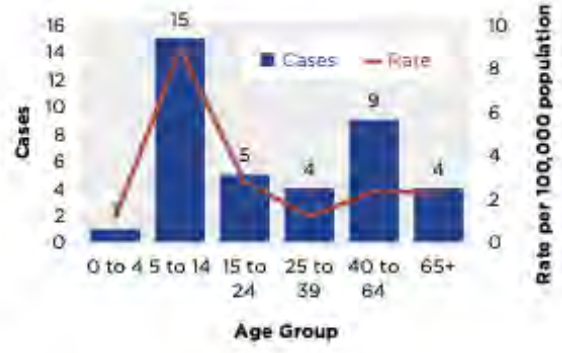
Incubation Period: Erythema migrans rash appears 3-32 days after tick bite (mean 7-10 days); early stages of the illness may be unapparent and the patient may present with later manifestations.

Symptoms: Approximately 70-80% of infected persons develop a circular rash called erythema migrans (EM) that begins at the site of a tick bite after a delay of 3-32 days (average is 7 days). The rash gradually expands over a period of several days, reaching up to 12 inches (30 cm) across. Other symptoms include fatigue, chills, fever, headache, muscle and joint aches, and swollen lymph nodes.

LYME DISEASE CASES AND RATES BY YEAR, FRANKLIN COUNTY, 2019-2022



LYME DISEASE CASES AND RATES BY AGE GROUP, FRANKLIN COUNTY, 2022



VISION OF A HEALTHY FRANKLIN COUNTY

Vision of a Healthy Franklin County

Over the course of eleven community focus groups and multiple Steering Committee meetings, Franklin County residents shared their perceptions of and vision for a healthy community.

According to community members, a healthy community is one in which:

- Residents have **financial stability** at a level that allows them **to meet their basic needs**. In this vein, residents also believe that a healthy community is one in which it is easier to access financial assistance when needed.
- Residents **feel connected to their community**; they know their neighbors and have open communication with members of the community, including government officials.
- Residents can **move more easily around Franklin County**, which includes having better public transportation options and more walkable communities.
- Residents' **health needs are reflected in the built environment,** which would contain more green spaces, spaces to socialize with neighbors, grocery stores, and medical offices.
- Residents feel **safe** in their homes and neighborhoods.
- Residents can **easily access healthy food**, specifically unprocessed and nutritious food.
- The community's **youth have resources they need to thrive.** This includes ensuring youth can access safe and engaging parks and playgrounds. It also includes ensuring parents and others in the community provide youth with the needed support to achieve good outcomes in terms of mental health, education, and jobs.

Community Voices: Financial Stability

Franklin County residents believe that addressing poverty and income inequality is necessary to have a healthy community. They know that residents cannot focus on improving their health when they are worried about finances, and also that a lack of financial stability is related to crime in their communities.

> *"You have to eliminate poverty in order to have a healthy community so that people will see opportunity. They don't see opportunity as long as they don't have any [resources]. If you don't have any resources, then your whole day is taken, scrambling. You only see the next 10 hours, the next 12 hours, the next maybe 24 if you're feeling good on that day. And that's not a way to have a healthy community."*
>
> *"I think where everybody's needs are met, whatever they may be, at whatever level they are at, from the very wealthy to those with pennies. It shouldn't be such a struggle for so many. I think about the single moms…rent is astronomical, and people want to be independent, but they*

> *can't because it's prohibitive. And the equality of just a standard of living, I think should be more easily reachable than it is."*
>
> *"Healthy looks like everybody being able to go 8 hours and be able to pay your bills, because a lack of resources or money leads to crime. Everything is a trickledown effect, and until people that are sitting high and looking low meet people where they're at, it will always look unhealthy because people don't have what they need."*
>
> *"Everybody being able to survive. Not so much worrying about, "I got this, but my neighbor doesn't. So are they gonna try to come and get it?" If everybody was able to, not so much have the same thing, but to be able to afford the same things…being able to get your groceries weekly, being able to keep your lights on, keeping your roof over your head without having to worry…"*

Many Franklin County residents need help securing basic needs due to a lack of financial stability. Residents believe that a healthy community would better promote the resources available to help residents.

> *"I think a healthy community could be a community that is well educated and knows what resources are available to them. And because we've got all these generational gaps, the information is given in certain ways that it's hard to say for the masses, 'This is where you can go get food at Mid-Ohio. These are the times that this church will let you come and get clothing, or this is what the Buckeye Ranch is for. This is what the Lions International does here in Grove City or our Rotary department.' Like, what are all our nonprofits that are available throughout Franklin County, and what they do."*
>
> *"I noticed that my whole community is families. And at one point in time, I was just gonna put my feet on the ground, just go out there and just start passing off flyers because there's so much stuff that goes on that people don't know about. We have people out there who are not computer literate. You have grandparents raising their grandkids that don't know about resources or that need help with certain things and they can't get it because how can they know if you're not out there advocating in the community?"*
>
> *"Resources, like the community just coming out advocating— I noticed in my neighborhood we have churches, and those churches do not come out there and say, 'Hey, we're having this or we're having that.' None of that. I stay in the area which is off of Fairwood. I get most of my resources over off of Parsons. It's really bad."*

Residents also think that in a healthy community, it would be easier to access resources for assistance. They named specific barriers to utilizing childcare support and housing support that need to be addressed in Franklin County.

"A lot of the older community doesn't know how to access [things], because it used to be picking up the phone. They don't know how to text, and now you have to text or you have to use your laptop or your computer."

"Don't make them beg for it, if they need it. It takes six months [to get assistance], when they was hungry six months ago. Don't do that."

"Even with Title 20, I could not afford work because daycare for my two babies cost me $2,600 a month. I think they work backwards. I understand that you have to have the job, but you take forever to process my application to put my kids in daycare. So if I say I start work this day and you say, 'Well, your application is not processed,' then what am I supposed to do with my kids? So there goes my job. Now I got to start back over again."

"They were supposed to have something set up within the city where landlords could not restrict certain people who did not meet the income criteria if they had a voucher. Well, they've gotten around that. [housing program] just recently gave over 10,000 vouchers. And so you look at all the people who have had vouchers before on top of that, and then when [housing program] switched over to [housing program], people have just been losing places where they live because the process has not been set straight properly yet, and so it's just not a good thing all the way."

Community Voices: Feeling Connected to their Community

Franklin County residents think a healthy community is one where people feel connected with each other, where lines of communication between neighbors and others in the community are open and mutually beneficial.

"I think it's a community where you feel safe to share what you truly need, and you can go to any neighbor for what that need is. Maybe they can help, maybe they can't. But you feel safer to share what you need and who you are."

"The ability to interact with other people and meet people. It's really important to have a social community."

"I think a healthy community is what people make it. So I feel like a lot of togetherness and a lot of people coming together to promote healthiness, do group walks or things like that."

"Communication in the community. I grew up, we were never friends with our neighbor. She told us the neighbors just want to be in your business. It was like a 'hi', 'bye.' But I think now, as I got older, I realized that communicating with other people in the community actually helps the neighborhood. We're all on the court, let's help clean this up. Like, we had

> *an older gentleman who couldn't cut his grass. So we started taking turns helping him out with his yard."*
>
> *"There's more and more interaction between the people living there…when we think about our government officials and making decisions about laws and financial decisions, even involving property taxes and all those types of things. It feels like there's a big disconnect in many different levels between community members, legislators, neighbors. And it'd be great if we could all just get along."*

Residents believe that in a healthy community, neighbors feel safe talking to each other about issues in the community and ways that they can better coexist.

> *"Being able to communicate with your neighbors. Just having that dialogue, if something's going on, knowing that you are safe to go to that person and say, 'Hey.'…Just being able to have that, without a fear of retaliation kind of thing."*
>
> *"Sensitivity and respect to boundaries. I think that a simple one could be, 'Hey, I would prefer you not to walk through my grass.' And picking up after dogs. Some people can just be completely disrespectful, disregard things like that."*

Residents also feel that in a healthy community, residents would not fear or stigmatize people based on their race, religion, or past incarceration.

> *"Neighborhoods where anybody can belong, no matter what color, what religion."*
>
> *"People don't trust each other anymore. People, they need to talk and come together. And I think it's almost like a racial divide… A lot of times I'm profiled…Just assuming 'she got a bookbag, she must be—' It happens, especially in the summertime. I love books. I'm in [a neighborhood bookstore]. A lot of people [there], they're scared of me. Why are you scared of me? That's why people need to come and talk to each other, period."*
>
> *"Breaking stigmas [around] restored citizens, no matter what their background is. Normalizing, getting over a stigma for your neighbors, like, what if it is your brother? What if it is your sister? I think helps build relationships and be more accepting. Because I do believe, even if they have done some of the most egregious crimes…they still have to be our neighbors, and they still deserve a second chance, in my opinion."*

Community Voices: Mobility in Franklin County

Franklin County residents believe that public transportation needs to be improved for the community to be healthy.

> *"I think there has to be good transportation. It's great if you have a car, but if you don't have a car, it's hard to get places. It takes a long time. You really have to think about it. Like, it's a task. And I think that's detrimental to getting people where they need to be. And I just think that it would be nice if there was some sort of transportation that would make getting places easier."*
>
> *"[public transportation provider] is not always the best. They have some sketchy characters and different things that don't make you feel as safe."*

Residents also think their communities could be healthier if they were more walkable. Along with having more resources within walking distance, residents say sidewalks need to be improved for people to feel safe walking in their communities.

> *"Walkability to do your errands, like grocery shopping, post office, or whatever it could be."*
>
> *"Where I live at, there's not a lot of sidewalks. So a lot of times you see people walking the brims or drain part or whatnot. There's accidents that be out there. You walk at night, there's not a lot of lights. So you could be out there and nobody sees you."*
>
> *"I live in a really more aging community. Even though I find it walkable, because we do have sidewalks, a lot of people have a hard time getting around if the sidewalks aren't fixed or if they can't necessarily drive themselves. And we don't have a lot of public transportation where I live."*
>
> *"When I think of a healthy community, I think of places where there are sidewalks, the sidewalks are accessible, and ideally clean. Not only that, but walkable access to resources. So it's not mandatory that you have to have a car to be able to get to those resources."*

Community Voices: A Healthy Built Environment

A healthy community would also have improvements to the built environment, including more parks, more places to socialize aside from bars, and more grocery stores, daycares, and medical facilities. Overall, the residents would be more mindful of the environment, keeping it clean and quiet.

"Having a lot of places where neighbors can gather, even if that's like a park or coffee shop or like, a grassy space available. And ideally, places where neighbors can gather that aren't always driven by alcohol, like a bar. Both of those options…those physical elements can kind of facilitate those social elements. So I'm thinking, like, unless I'm going door to door, how would I meet my neighbors if I'm not going for a walk in my neighborhood or something like that?"

"Access to green space."

"We don't have any grocery stores. We don't have daycares. I've got to go over to OSU East in order to find medical care. I mean, there's a clinic on Main Street, but it's just overflowing."

"People take care of their yards or, you know, keeping the trash off the streets. [No] noise pollution. That drives me crazy."

Community Voices: Accessing Nutritious Food

Residents believe that for the community to be healthier, it needs to be easier to access quality and nutritious foods. Multiple residents brought up the fact that their neighborhoods are currently in food deserts, and more opportunities to access food need to be brought into the community.

"The community has quality food, accessible grocery stores, farmers markets and things like that."

"A healthy neighborhood for me is in my neighborhood they provide pantries, and a lot of things go on in our community center, like a fish fry Friday and stuff like that. So they provide to those that have lower incomes."

"Having access to free produce."

"Natural foods being grown and sold."

"Healthy neighborhood has diversity and resources. But we are in a food desert."

"We're still in a food desert, obviously. I gotta drive to, like, Whitehall or wherever is closest cause I live off of Fairwood. We just need more resources."

Community Voices: Feelings of Safety

Residents think that there could be improvements to how safe they feel in their homes and out in their communities. In a healthy community, they would see more evidence that crimes are addressed, and they would feel it is safer for children to play outside. Community members also worry about how safe youth are at school.

"Some sense of security, like physical security. If there is some type of crime, to have an actual response. Currently, if there's an issue that happens in our neighborhood, it's very rare that an officer comes out. You do an online report which just kind of disappears. I think that's a concern from an officer's standpoint. But security makes your neighborhood feel healthy."

"I think feeling safe in your community. And in your house and walking."

"Children feel safe to play in a neighborhood. Where they don't have to be concerned about what's happening around them. They can just be kids and play."

"We really want our kids to be outdoors and walk or ride their bikes and stuff. That's a health thing, right? That helps your health a lot. But all these speeding drivers on your streets, that's a barrier for our kids to be outside. Or for us to be outside."

"A safe and adequate education. Shouldn't have to worry they are gonna die every day they walk out the door. Safe getting there. Safe in the building. Safe."

Community Voices: Resources for Youth to Thrive

Many Franklin County residents say that a community looks healthy when they see children playing outside. They think that to encourage more children to do this, they need more opportunities and better infrastructure for playgrounds and parks.

"I was able to buy a house. And the street's awesome. And there's kids playing outside. And to me seeing kids playing and having fun, that's a sign of a healthy community."

"Kids really don't play outside. The engagement of kids being outside and them knowing their neighbors and being able to go to the park…But even parks nowadays need to be updated, they're run down, rusting, or have been torn down completely. So even when they're going to the park, they don't have anything to entertain them."

> *"Something as simple as having sidewalks in all communities, so kids can get up and get out all around…just playgrounds, sports courts, things like that to get kids outside active."*

Residents also believe a healthy community better supports youth when it comes to their education. They believe that the issues that keep kids from having good grades, school attendance, and future success are part of larger problems that need to be addressed.

> *"We lost the slogan of 'It Takes a Village.' I honestly believe that even with the school system, I feel like the support is just not there. Even when COVID happened, they threw these kids in homes talking about 'get on the computer and do the work.'"*
>
> *"Y'all don't know who they're staying with. Y'all don't know their living situations. Y'all don't even know if they're even living anywhere. Y'all don't even know what's going on. So I just feel like the support is just not there like it used to be…You're worried about attendance and kids coming to school every day, but y'all really need to be asking, why aren't these kids coming?...Because you've got older kids that have to stay home with the younger kids so that parents and guardians can go to work to keep a roof over their head. And these are problems that this town is not looking at."*
>
> *"We work in this school system…and school is nothing like it used to be. Because you have so many kids that are traumatized…You have more children with behavioral problems and emotional problems. And you can look at each classroom, maybe six or seven in each classroom that are doing what you're supposed to be doing. And it's a zoo. I mean, all the resources are there. You have psychologists, you have counselors, you have all this, and then you have a lot of wonderful parents. But then you got parents that don't care."*
>
> *"I work with the kids who have been kicked out of their home schools. And it is just really hard to get them motivated in this day and age to want to work or to learn a new skill. If we could have more resources to get them those hands-on skills to work jobs…I mean, I have a student who's 18, I've tried to get him to get his temps. I tried to get him to get a job or to volunteer, and they just say, 'I don't want to work fast food. I don't want this.' And I'm like, you have to try something."*

Other features of healthy communities brought up by community members included:

- A greater variety of small businesses in their communities.
- More accessible and affordable health care options throughout the county, such as mobile clinics that they typically only see in the inner city.
- Better access to mental health resources.

Community Assets and Resources

The list of non-profit and private organizations working to impact the priority health needs reviewed in this document is endless. The Central Ohio community is well positioned to impact adverse health outcomes because of these collective efforts.

The partners and multi-sector partnerships described in this section are currently working to address aspects of each prioritized health need identified by *HealthMap2025*; see page 185 for a visualization of the interrelated nature of this work. A more extensive resource list will be identified during subsequent health improvement planning; it will be included in future documents and at centralohiohospitals.org.

- **Alcohol, Drug, and Mental Health Board of Franklin County (ADAMH)** - plans, funds, and evaluates behavioral health care services that address mental health, addiction, and substance abuse. More information can be found at www.adamhfranklin.org.
- **Beautiful Beginnings** - a program funded by the Franklin County Board of Commissioners that provides home visiting and care coordination services to pregnant and postpartum individuals and their infants up to age 3. This program is one of several home visiting programs that are focused on serving Black community members and community members of color to impact racial disparities in maternal and child health outcomes. Examples of key focus areas include reducing infant mortality, reducing maternal mortality and other maternal complications, and increasing access to social determinants of health.
- **CelebrateOne** - created in November 2014 as a collective impact approach to carry out the Greater Columbus Infant Mortality Task Force's recommendations and to ensure Franklin County meets its ambitious goal. More information can be found at https://www.columbus.gov/Government/Mayors-Office/Initiatives/CelebrateOne/CelebrateOne-About-Us .
- **Columbus and Franklin County Addiction Plan** - a collaborative, multi-sector, comprehensive effort to address addiction and behavioral health issues impacting Franklin County residents. More information can be found at https://cfcap-columbus.hub.arcgis.com/.
- **Columbus Community Action Resilience Coalition (CARE)** - the CARE Coalition works to build a resilient community that honors survival and fosters hope by strengthening trauma-related policies, programs, and practices through collaboration and collective impact, and by mitigating the impact trauma has on the health and wellbeing of individuals and communities. More information can be found at

https://www.columbus.gov/Services/Public-Health/Find-Health-Care-Resources/Neighborhood-Social-Services/Columbus-CARE-Coalition.

- **Columbus Urban League** - the mission of the local affiliate of National Urban League is to empower African Americans and disenfranchised groups through economic, educational, and social progress. Visit www.cul.org for more information.
- **Community Shelter Board** - Community Shelter Board (CSB) leads a coordinated, community effort to make sure everyone has a place to call home, and is a collective impact organization driving strategy, accountability, collaboration, and resources to achieve the best outcomes for people facing homelessness in Columbus and Franklin County. More information on CSB can be found at https://www.csb.org.
- **Franklin County Human Service Chamber** - serves and represents over 200 health and human service nonprofit organizations that prioritize public policies that include food and nutrition, health, housing, transportation, legal and reentry services, refugee and immigration services, workforce development, as well as youth and education policy. A comprehensive list of members can be found at www.humanservicechamber.org.
- **Franklin County Suicide Prevention Coalition** – aims to increase communication, coordination, and collaboration efforts in Franklin County to prevent suicide and bring hope and support to those affected by suicide. It bridges organizations together with the end goal of enhancing the overall success of our collective suicide prevention efforts. These efforts include decreasing stigma, increasing awareness of available support, promoting suicide prevention education, and improving suicide data quality. Visit https://franklincountyspc.org for more information.
- **Ohio Better Birth Outcomes** - The Ohio Better Birth Outcomes (OBBO) collaborative is dedicated to reducing the infant mortality rate in Franklin County by improving the delivery of health care services for women and their families using quality improvement science to guide our work. OBBO is focused on three key initiatives: Improving reproductive health; Expanding access to prenatal care; and Enhancing clinical quality initiatives to help reduce prematurity. Visit https://ohiobetterbirthoutcomes.org for more information
- **Rise Together Innovation Center** - oversees implementation of "A Blueprint for Reducing Poverty in Franklin County," which was released by the Franklin County Commissioners in 2019 and includes 13 overarching goals and 120 action plans to address jobs, housing, health, and youth. More information on the Center can be found at https://risetogether.franklincountyohio.gov/.
- **The Kirwan Institute for the Study of Race and Ethnicity** - an interdisciplinary research institute at The Ohio State University that strives to connect individuals and communities with opportunities needed to thrive. More information can be found at https://kirwaninstitute.osu.edu.
- **United Way of Central Ohio** - fights poverty by funding and coalescing a network of more than 90 non-profit partners providing opportunities and resources to meet basic needs. More information can be found at www.liveunitedcentralohio.org.

Organization / Collective Impact Effort	Mental Health	Adverse Childhood Experiences (ACEs)	Maternal and Infant Health	Violence and Injury-related Deaths	Social Drivers of Health (with a focus on housing)
Alcohol, Drug, and Mental Health Board of Franklin County (ADAMH)	✓	✓		✓	
Beautiful Beginnings			✓		
CelebrateOne			✓		
Columbus and Franklin County Addiction Plan	✓	✓		✓	
Columbus Community Action Resilience Coalition (CARE)	✓	✓		✓	
Columbus Urban League	✓	✓	✓	✓	✓
Community Shelter Board					✓
Franklin County Human Service Chamber		✓		✓	✓
Franklin County Suicide Prevention Coalition	✓	✓			
Ohio Better Birth Outcomes			✓		
Rise Together Innovation Center		✓		✓	✓
The Kirwan Institute for the Study of Race and Ethnicity	✓	✓	✓	✓	✓
United Way of Central Ohio		✓			✓

Summary

Franklin County HealthMap2025 provides a comprehensive overview of our community's health status and needs. There are numerous indicators that suggest the health of Franklin County, Ohio's residents compares favorably with the state and country.

Franklin County HealthMap2025 also uncovered several indicators that suggest areas in which the health of Franklin County's residents either has diminished over time or compares unfavorably to Ohio or the nation.

Consistent with requirements, the participating hospitals and health departments will use this report to inform development and implementation of strategies to address its findings. It is intended that a wide range of stakeholders – many more than are represented on *Franklin County HealthMap2025's* Community Health Needs Assessment Steering Committee – will also use this report for their own planning efforts. Subsequent planning documents and reports will be shared with stakeholders and with the public.

Users of *Franklin County HealthMap2025* are encouraged to send feedback and comments that can help to improve the usefulness of this information when future editions are developed.

Questions and comments about *Franklin County HealthMap2025* may be shared with:

Jeff Klingler, Central Ohio Hospital Council
614-358-2710 | jeffk@centralohiohospitals.org

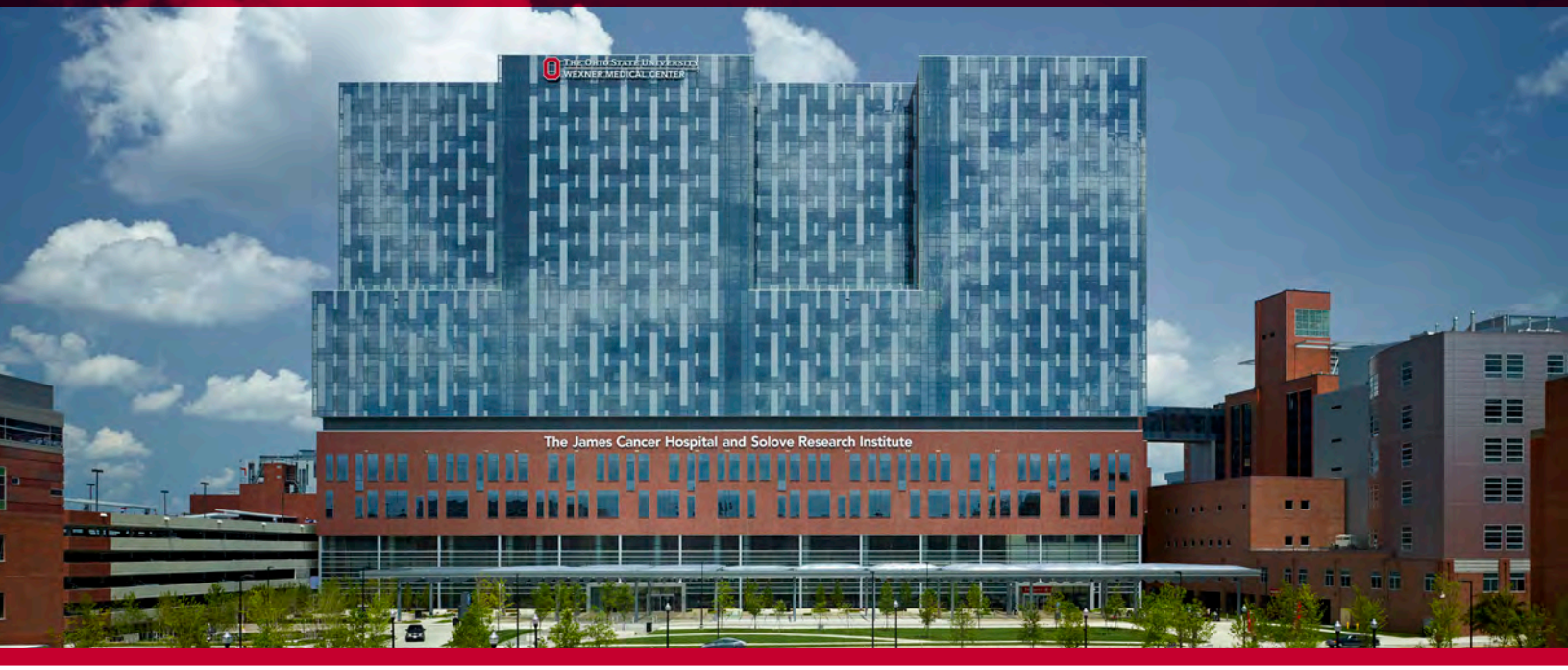
Orie Kristel, PhD, Illuminology
614-447-3176 | orie@illuminology.net

Central Ohio Hospital Council

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH

Franklin County Public Health

Navigating Our Way to a Healthier Community Together



The Arthur G. James Cancer Hospital and
Richard J. Solove Research Institute

Community Health Needs Assessment 2025

The James

The Ohio State University
Wexner Medical Center

Our mission is to eradicate cancer from individuals' lives by creating knowledge and integrating groundbreaking research with excellence in education and patient-centered care.

David E. Cohn, MD, MBA, FACHE

Interim Chief Executive Officer, James Cancer Hospital and Solove Research Institute

460 W. 10th Ave.

Columbus, OH 43210

Board approval of CHNA Report:

Initial Web posting of CHNA Report:

Tax identification number:

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INTRODUCTION

Accreditation

- Ranked the No. 1 adult hospital in Columbus and No. 2 in Ohio in 2024 by *U.S. News & World Report.*
- Eight nationally ranked and four high-performing specialties.
- Ranked College of Medicine, seven hospitals, a network of primary and specialty care practices and more than 45 research centers and institutes.
- More "Top Doctors" than any other central Ohio hospital.
- The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute has been designated as an NCI Comprehensive Cancer Center since 1976.

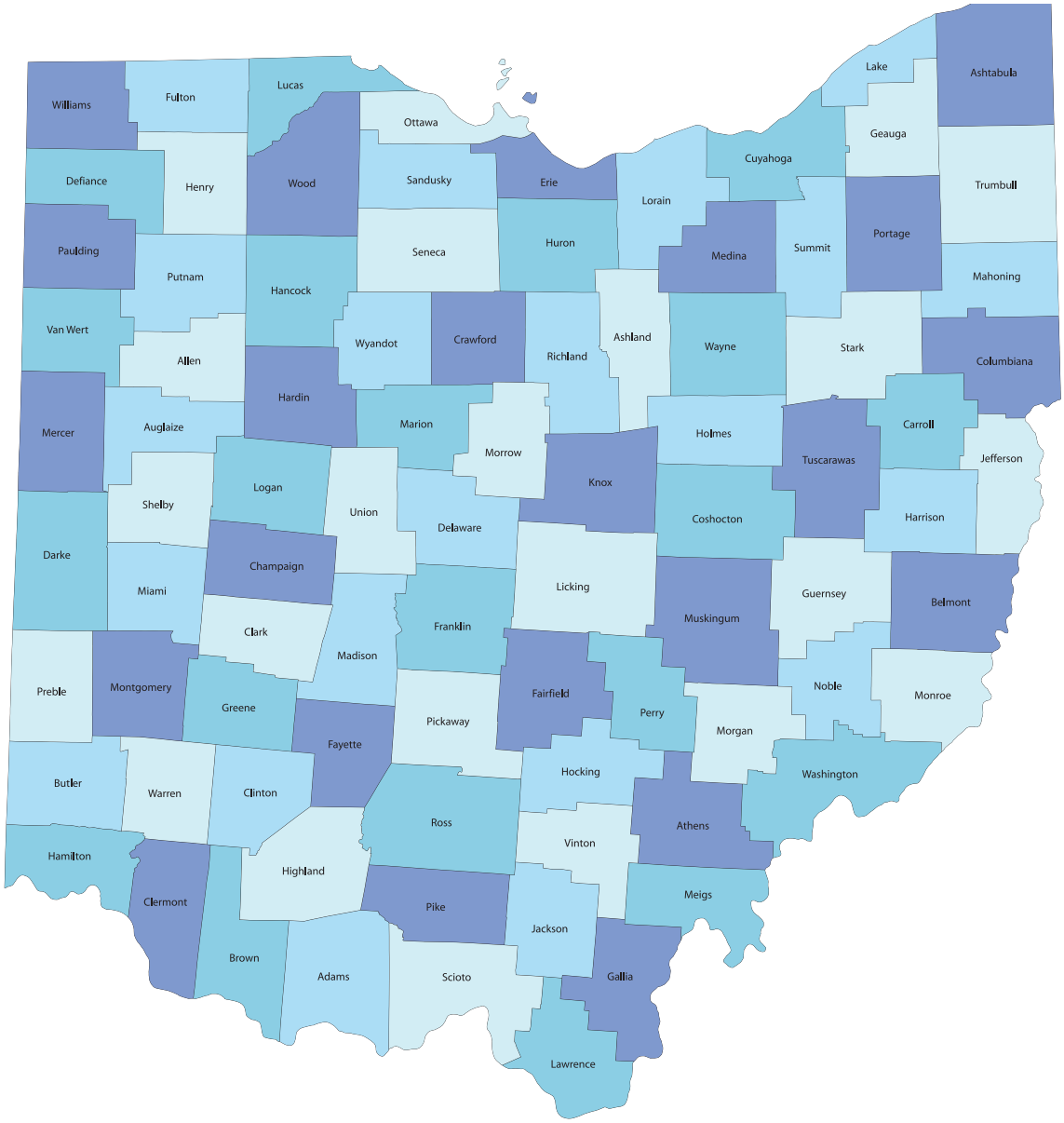
The Ohio State University Wexner Medical Center comprises:

- Brain and Spine Hospital
- Dodd Rehabilitation Hospital
- East Hospital
- Harding Hospital
- Richard M. Ross Heart Hospital
- University Hospital

Adjacent to the medical center is The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, a dedicated cancer hospital and research center with its own governance structure coordinated with the medical center.

For information about The Ohio State University Wexner Medical Center's Community Health Needs Assessment (CHNA) processes and for a copy of the reports, please visit https://wexnermedical.osu.edu/healthy-community/community-health-needs-assessment, or email Annie.Marsico@osumc.edu, to obtain hard copies of the CHNA reports at no charge. Written comments regarding this CHNA report and related implementation strategy may be submitted to Annie Marsico at Annie.Marsico@osumc.edu.

COMMUNITIES SERVED BY THE OHIO STATE WEXNER MEDICAL CENTER



UNIVERSITY HOSPITAL

Time Frame	CY24 Discharges				
Patient State	**Patient County**	**Main**	**East**	**Total**	**% of Total**
OH	Franklin	19,248	6,961	26,209	53%
	Delaware	1,527	161	1,688	3%
	Licking	1,201	245	1,446	3%
	Fairfield	1,207	145	1,352	3%
	Ross	947	88	1,035	2%
	Pickaway	849	49	898	2%
	Union	738	67	805	2%
	Madison	698	67	765	2%
	Logan	661	97	758	2%
	Muskingum	625	87	712	1%
	Knox	585	87	672	1%
	Richland	573	63	636	1%
	Scioto	569	65	634	1%
	Clark	525	48	573	1%
	Montgomery	496	32	528	1%
	Allen	488	23	511	1%
	Crawford	439	66	505	1%
	Marion	406	32	438	1%
	Jackson	318	62	380	1%
	Pike	333	33	366	1%
	Hocking	289	72	361	1%
	Fayette	307	42	349	1%
	Perry	283	44	327	1%
	Highland	285	29	314	1%
	Champaign	273	22	295	1%
	Gallia	242	52	294	1%

UNIVERSITY HOSPITAL

Patient State	Patient County	Main	East	Total	% of Total
OH	Belmont	268	25	293	1%
	Coshocton	256	30	286	1%
	Athens	241	37	278	1%
	Washington	227	20	247	1%
	Greene	223	19	242	0%
	Guernsey	184	26	210	0%
	Wyandot	184	26	210	0%
	Auglaize	184	12	196	0%
	Hancock	177	13	190	0%
	Mercer	138	30	168	0%
	Morrow	137	24	161	0%
	Warren	153	6	159	0%
	Meigs	127	30	157	0%
	Shelby	140	11	151	0%
	Seneca	141	8	149	0%
	Miami	128	19	147	0%
	Vinton	120	19	139	0%
	Hardin	125	12	137	0%
	Lorain	130	1	131	0%
	Lawrence	117	12	129	0%
	Wayne	108	7	115	0%
	Morgan	103	9	112	0%
	Noble	101	8	109	0%
	Ashland	76	9	85	0%
	Lucas	78	5	83	0%
	Putnam	75	7	82	0%
	Clinton	62	10	72	0%
	Hamilton	65	4	69	0%
	Monroe	52	17	69	0%

UNIVERSITY HOSPITAL

Patient State	Patient County	Main	East	Total	% of Total
OH	Jefferson	57	9	66	0%
	Tuscarawas	61	3	64	0%
	Darke	55	7	62	0%
	Butler	51	6	57	0%
	Cuyahoga	44	10	54	0%
	Adams	49	3	52	0%
	Van Wert	46	3	49	0%
	Wood	39	5	44	0%
	Huron	33	7	40	0%
	Stark	37	2	39	0%
	Holmes	33	1	34	0%
	Clermont	31	1	32	0%
	Trumbull	25	6	31	0%
	Summit	25	3	28	0%
	Preble	21	5	26	0%
	Mahoning	19	1	20	0%
	Erie	16	3	19	0%
	Defiance	15	1	16	0%
	Fulton	16		16	0%
	Paulding	15	1	16	0%
	Sandusky	12		12	0%
	Brown	8	2	10	0%
	Carroll	10		10	0%
	Harrison	8	2	10	0%
	Portage	9		9	0%
	Columbiana	8		8	0%
	Medina	8		8	0%
	Henry	5	2	7	0%
	Lake	7		7	0%

UNIVERSITY HOSPITAL

Patient State	Patient County	Main	East	Total	% of Total
OH	Williams	7		7	0%
	Ottawa	4	1	5	0%
	Geauga	4		4	0%
	Ashtabula	2		2	0%
Non-Ohio	790	102	892	2%	0%
Grand Total		**39,802**	**9,381**	**49,183**	**100%**

OSUCCC – JAMES

Time Frame	CY24 Discharges		
Patient State	**Patient County**	**Discharges**	**% of Total**
OH	Franklin	5,176	35%
	Delaware	687	5%
	Licking	637	4%
	Fairfield	486	3%
	Montgomery	367	2%
	Clark	337	2%
	Ross	305	2%
	Scioto	291	2%
	Richland	290	2%
	Muskingum	250	2%
	Madison	238	2%
	Allen	237	2%
	Pickaway	236	2%
	Knox	224	2%
	Logan	224	2%
	Athens	163	1%

OSUCCC – JAMES

Patient State	Patient County	Discharges	% of Total
OH	Perry	163	1%
	Marion	161	1%
	Union	158	1%
	Auglaize	143	1%
	Greene	135	1%
	Miami	126	1%
	Champaign	122	1%
	Mercer	122	1%
	Fayette	120	1%
	Crawford	119	1%
	Jackson	117	1%
	Belmont	115	1%
	Hancock	115	1%
	Guernsey	110	1%
	Gallia	105	1%
	Hocking	104	1%
	Coshocton	103	1%
	Highland	100	1%
	Hamilton	98	1%
	Pike	98	1%
	Morrow	88	1%
	Warren	87	1%
	Washington	80	1%
	Clinton	78	1%
	Seneca	78	1%
	Shelby	77	1%
	Meigs	75	1%
	Wyandot	74	0%
	Hardin	72	0%

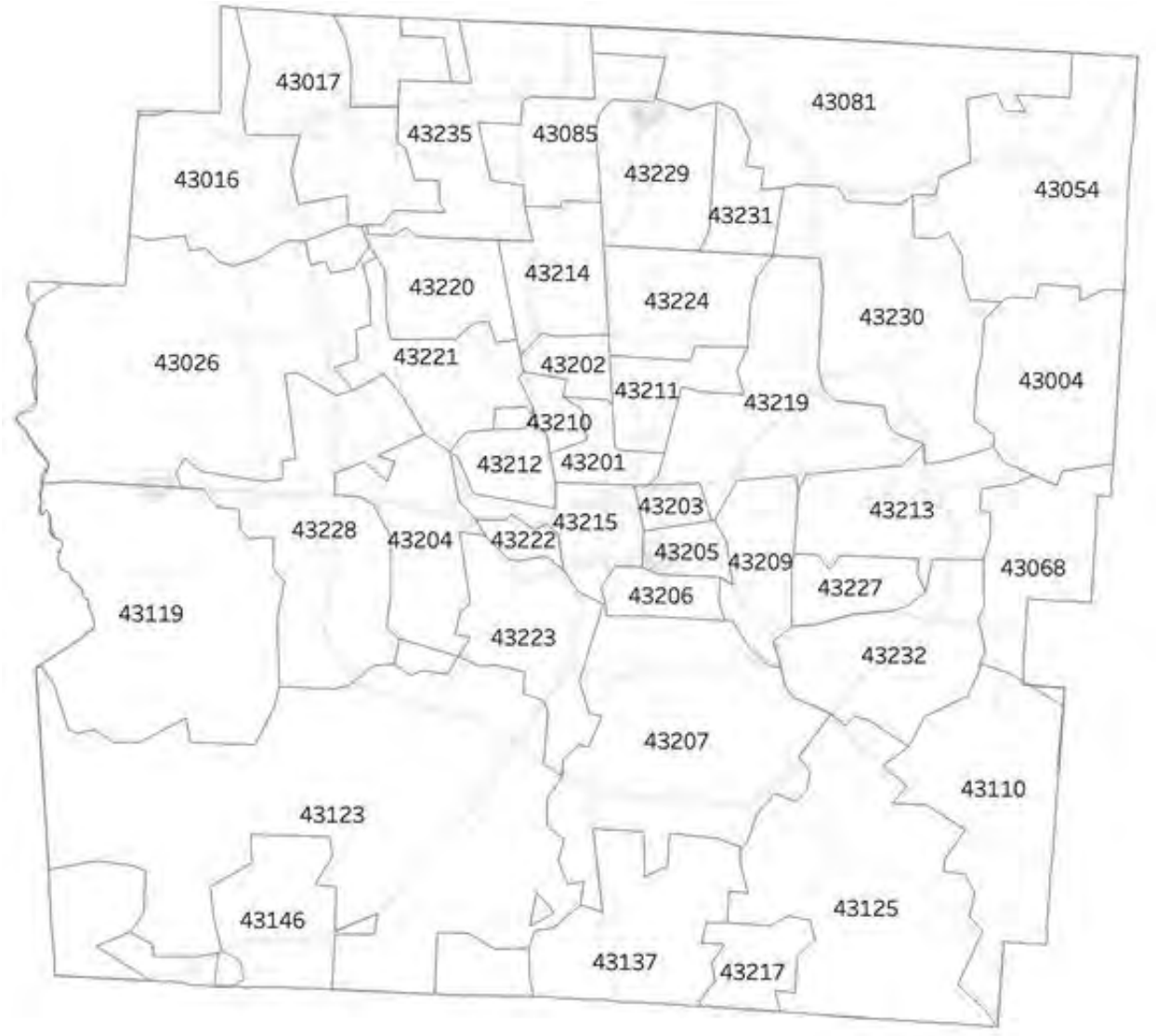
OSUCCC – JAMES

Patient State	Patient County	Discharges	% of Total
OH	Putnam	72	0%
	Butler	71	0%
	Lawrence	71	0%
	Darke	63	0%
	Wayne	56	0%
	Wood	50	0%
	Clermont	43	0%
	Morgan	40	0%
	Preble	39	0%
	Ashland	38	0%
	Lucas	37	0%
	Vinton	36	0%
	Jefferson	34	0%
	Monroe	32	0%
	Van Wert	31	0%
	Stark	30	0%
	Tuscarawas	30	0%
	Adams	26	0%
	Huron	25	0%
	Noble	20	0%
	Lorain	19	0%
	Holmes	18	0%
	Defiance	13	0%
	Cuyahoga	12	0%
	Harrison	10	0%
	Mahoning	10	0%
	Henry	9	0%
	Medina	9	0%
	Portage	9	0%

OSUCCC – JAMES

Patient State	Patient County	Discharges	% of Total
OH	Summit	9	0%
	Brown	8	0%
	Fulton	8	0%
	Sandusky	7	0%
	Trumbull	7	0%
	Lake	6	0%
	Paulding	6	0%
	Erie	4	0%
	Ottawa	4	0%
	Columbiana	3	0%
	Williams	3	0%
	Carroll	1	0%
Non-Ohio		574	4%
Grand Total		**14,884**	**100%**

FRANKLIN COUNTY SERVED BY THE OHIO STATE WEXNER MEDICAL CENTER



UNIVERSITY HOSPITAL

Time Frame	CY24 Discharges			
County	Franklin, OH			
ZIP Code	Main	East	Total	%
43219	700	806	1,506	6%
43207	893	489	1,382	5%
43211	903	445	1,348	5%
43232	745	397	1,142	4%
43213	540	454	994	4%
43230	722	234	956	4%
43224	728	219	947	4%
43227	468	453	921	4%
43209	450	406	856	3%
43204	703	116	819	3%
43229	675	140	815	3%
43201	693	115	808	3%
43228	718	89	807	3%
43223	688	108	796	3%
43123	686	106	792	3%
43206	484	300	784	3%
43081	643	108	751	3%
43026	671	54	725	3%
43203	242	440	682	3%
43068	521	137	658	3%
43205	310	327	637	2%
43235	479	51	530	2%
43110	427	91	518	2%
43221	458	35	493	2%
43212	429	49	478	2%
43215	337	139	476	2%
43214	398	48	446	2%

UNIVERSITY HOSPITAL

ZIP Code	Main	East	Total	%
43220	357	32	389	1%
43210	278	111	389	1%
43004	302	82	384	1%
43085	326	47	373	1%
43202	331	35	366	1%
43016	333	23	356	1%
43017	322	24	346	1%
43119	310	27	337	1%
43054	283	43	326	1%
43231	219	46	265	1%
43125	201	58	259	1%
43222	163	55	218	1%
43217	45	5	50	0%
43137	35	3	38	0%
43216	8	5	13	0%
43126	7		7	0%
43226	2	2	4	0%
43218	3	1	4	0%
43086	3	1	4	0%
43260	2	1	3	0%
43236	1	2	3	0%
43234	2	1	3	0%
43109	2	1	3	0%
43195	1		1	0%
43002	1		1	0%
Grand Total	**19,248**	**6,961**	**26,209**	**100%**

OSUCCC – JAMES

Time Frame	CY24 Discharges	
County	Franklin, OH	
ZIP Code	Discharges	%
43230	250	5%
43081	249	5%
43123	242	5%
43207	221	4%
43068	211	4%
43026	208	4%
43223	186	4%
43219	181	3%
43235	179	3%
43232	178	3%
43224	169	3%
43228	168	3%
43229	160	3%
43204	150	3%
43016	148	3%
43211	147	3%
43017	147	3%
43213	142	3%
43110	137	3%
43054	131	3%
43221	123	2%
43085	120	2%
43206	119	2%
43209	118	2%
43227	117	2%
43220	105	2%

OSUCCC – JAMES

Time Frame	CY24 Discharges	
County	Franklin, OH	
ZIP Code	Discharges	%
43214	105	2%
43201	98	2%
43004	88	2%
43212	79	2%
43231	74	1%
43119	69	1%
43215	68	1%
43205	65	1%
43125	55	1%
43203	50	1%
43202	49	1%
43222	30	1%
43137	17	0%
43210	11	0%
43217	7	0%
43236	3	0%
43126	1	0%
43086	1	0%
Grand Total	5,176	100%

Source: Ohio Hospital Association

Review of the Ohio State Wexner Medical Center internal data has shown that for Fiscal Year 2021, 54% of all patients who were admitted to the Wexner Medical Center resided in Franklin County at the time of discharge. Accordingly, Franklin County, Ohio, has been determined to be the community served by the Wexner Medical Center.

Review of OSUCCC – James internal data has shown that for Fiscal Year 2021, 32% of all patients who were admitted to The James resided in Franklin County at the time of discharge. Because no other county reached above 5% for patient discharges, Franklin County, Ohio, has been determined to be the community served by The James.

DEMOGRAPHICS OF COMMUNITIES WE SERVE

This section provides demographic information about Franklin County's residents and households. These graphs were taken from HealthMap2025. For purposes of the graphs, HealthMap has been abbreviated as HM with the corresponding year.

Franklin County Residents[1-3]

		Franklin County		
		HM2019	HM2022	HM2025
Total population	Population of Franklin County	1,264,518	1,316,756	1,321,820
Sex	Male	48.8%	48.8%	49.2%
	Female	51.2%	51.2%	50.8%
Age	Under 5 years	7.3%	7.0%	6.5%
	5-19 years	19.0%	19.1%	19.2%
	20-64 years	62.3%	61.4%	61%
	65 years and over	11.3%	12.4%	13.3%
Race (any ethnicity)	White	68.1%	66.5%	65.1%
	Black	23.1%	23.9%	24.9%
	Asian-American/Pacific Islander	5.4%	6.0%	6.0%
	American Indian/Alaskan Native	0.1%	0.3%	0.4%
	Two or more races	3.2%	3.4%	3.7%
Ethnicity	Hispanic or Latino (of any race)	5.4%	5.8%	7.3% ▲
Foreign-born	Foreign-born	-	11.4%	12.6% ▲
	(Among foreign-born) Naturalized	-	*48.2%*	*45.4%*
	(Among foreign-born) Not a U.S. citizen		*51.8%*	*54.6%*
English proficiency	Percent of people age 5+ who speak English less than "very well"	-	5.3%	6.4% ▲
Most common languages spoken by people who speak a non-English language at home	Spanish	-	49,949	56,793▲
	Amharic, Somali, or other Afro-Asiatic languages	-	25,051	27,074
	Arabic	-	8,437	15,285▲
	Yoruba, Twi, Igbo, or other languages of Western Africa	-	10,904	12,435▲
	Nepali, Marathi, or other Indic languages	-	9,668	11,076▲
	Chinese (incl. Mandarin, Cantonese)	-	13,072	8,188 ▼
	French (incl. Cajun)	-	5,789	7,579 ▲
	Swahili or other languages of Central, Eastern, and Southern Africa	-	3,608	6,634▲

* An upward-facing triangle (▲) indicates the HealthMap2022 (HM2022) statistic is greater than the one reported in HealthMap2019 (HM2019) by 10% or more. A downward-facing triangle (▼) indicates the HM2022 statistic is less than the one reported in HM2019 by 10% or more. Use caution when interpreting indicators with small values, which only need relatively small changes to produce a 10% difference.

		Franklin County		
		HM2019	HM2022	HM2025
Educational Attainment	No/Some high school, no degree	9.7%	8.8%	8.7%
	High school graduate	25%	24.6%	24.5%
	Some college (no degree)	20.2%	19.6%	18%
	Associate's degree	6.8%	6.9%	6.5%
	Bachelor's degree	24.4%	25.3%	25.8%
	Graduate/Professional degree	14%	14.8%	16.5% ▲

Although the number of households in Franklin County has increased over time, other household characteristics remained relatively stable over time (e.g., household size, household type).

Franklin County Households[1]

		Franklin County		
		HM2019	HM2022	HM2025
Total households	Number of households	502,932	522,383	550,153
Household size	Average household size	2.5	2.5	2.4
	Average family size	3.2	3.2	3.1
Household type	Family households	58.0%	58.5%	55.8%
	Nonfamily households	42.0%	41.5%	44.2%
	Single parent households	-	18.4%	18.3%

* Household size includes all people occupying a housing unit, while family size includes the family householder and all other people in the housing unit related to the householder by birth, marriage or adoption.

References

[1]U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019 (HM2022), 2016 (HM2019), 2013 (HM2016)

Impact of Actions to Address Priority Needs in 2022 Community Health Needs Assessment

HealthMap 2022 Priorities

The Franklin County Community Health Needs Assessment Steering Committee identified three priority areas: basic needs, behavioral health and maternal and infant health.

1. Basic Needs:

- **At the time of *HealthMap 2022*, the total persons under 65 with health insurance in Franklin County was 91.1%, which did not meet the national goal of 92.2%.**
- **Franklin County has 201,099 people below the 100% federal poverty level.**
- **According to *HealthMap 2022*, 12.8% of residents and 17.5% of children experienced food insecurity.**

Key Indicators

- **Housing security (decreasing homelessness, increased affordability)**
- **Financial stability**
- **Neighborhood safety (reduced crime)**
- **Food security**
- **Increased access to nutritious foods**
- **Access to care**

Efforts by the Ohio State Wexner Medical Center to address these indicators include:

- Opening the Healthy Community Center on the Near East Side in May 2024. Designed in collaboration with neighborhood residents, the facility fills a major gap in the community and demonstrates Ohio State's commitment to its neighbors' well-being.

- Expanding access to the Mid-Ohio Farmacy program, a partnership with Mid-Ohio Food Collective, to better connect Ohio State patients with documented food insecurity with enhanced access to fresh produce and other nutrient-rich foods.
- Opening the new Outpatient Care Dublin, opening new primary care locations in Grove City and Pickerington as well as purchasing/opening urgent care locations in Gahanna and Hilliard to expand access to care for the residents of central Ohio.
- Providing fresh food through a partnership with Mid-Ohio Food Collective and housing assistance for Moms2B participants.
- Supporting Partners Achieving Community Transformation's (PACT) work on needed community services and supports through a place-based program and project investments. PACT signature programs include:
    - The Ohio State University Employee Homeownership Incentive Program
    - Exterior home repair grants
    - Connected Communities (closing the digital divide)
    - Neighborhood Leadership Academy
    - Health Science Academies and Parent University
    - Community Safety Advisory Group
    - Growing and Growth Collective (the collaboration of community gardens in partnership with The James Mobile Education Kitchen and OSU Extension)
    - Maroon Arts Group annual film series
    - Venture Suite
- Supporting The James Mobile Education Kitchen, which focuses on nutrition-related issues and cancer-risk reduction through education on healthy foods and preparation.

2. Behavioral Health:

- **At the time of *HealthMap 2022*, 23.1% of Franklin County residents reported being told that they had a form of depression, up 1.3% from *HealthMap 2019*.**
- **Attempting suicide leading to hospitalization rates were also up nearly 2 percentage points from *HealthMap 2019*, at a rate of 6.8.**
- **Likewise, psychiatric admissions rates rose as compared with *HealthMap 2019*, to a rate of 36.1.**
- **Narcan administration in *HealthMap 2022* increased by 733 usages, but deaths attributed to opioids also rose.**
- **Unintentional drug/medication mortality rates nearly doubled.**

Key Indicators

- **Access to mental health care resources**
- **Screening for mental health issues**
- **Decreased unintentional drug and alcohol deaths**
- **Youth mental health supports (clinical, social)**

Efforts by the Ohio State Wexner Medical Center to address these indicators include:

- Supporting Alcohol, Drug and Mental Health (ADAMH) Board of Franklin County's Mental Health and Addiction Crisis Center with an early investment to help with the construction of the new center. The Ohio State Wexner Medical Center will also serve as the medical partner for the new facility.
- Partnering with Franklin County ADAMH by placing NaloxBoxes on The Ohio State University's campus around the Wexner Medical Center to expand access to emergency response tools.
- Partnering with the other health systems, public health, Federally Qualified Health Centers (FQHCs) and community organizations to address addiction through the work of the Columbus and Franklin County Addiction Plan.
- Providing Ohio State STAR (Stress, Trauma And Resilience) services for first responders through its collaboration with ADAMH to provide peer support group sessions and create an app for first responders that will assess mental health and provide tools.
- Increased naloxone education and distribution by integrating naloxone distribution models further within emergency departments and hospitals, addiction services and other treatment settings.

- Partnering with Columbus Division of Fire's RREACT (Rapid Response Emergency Addiction Crisis Team) program to increase the number of on-campus and community sites that can distribute naloxone, fentanyl test strips, drug disposal bags and education on harm reduction and treatment resources.
- Enhanced Medication for Opioid Use Disorder (MOUD) access by providing technical assistance and support to providers (both internally and externally throughout the community).
- Supporting the Substance Abuse Treatment, Education and Prevention Program (STEPP) Clinic as it provides addiction and mental health services and weekly education sessions to promote a healthy pregnancy and postpartum period for its moms with the goal of having healthy, full-term babies.
- Partnering with Southeast Healthcare's RREACT team to transfer patients presenting in the emergency department to treatment facilities including Maryhaven Addiction Stabilization Center and Talbot Hall.
- Growing outpatient operations from one clinic at Harding Hospital to four clinics, ensuring a behavioral health presence wherever ambulatory is expanding.
- Closing gaps in the continuum of care for people requiring behavioral health services by opening a Behavioral Health Urgent Care Clinic.

3. Maternal and Infant Health:

- **Overall health of pregnant women before delivery.**
- **Prevention of preterm births.**
- **The infant mortality rate for Franklin County reduced to 6.9 in *HealthMap 2022*.**

Key Indicators

- **Infant mortality**
- **Maternal pre-pregnancy health**

Efforts by the Ohio State Wexner Medical Center to address these indicators include:

- Supporting the work of Moms2B, a prevention program for expectant moms at high risk for infant mortality, through virtual and in-person education sessions, baby and mom well-checks and support for wrap-around services from patient navigators.

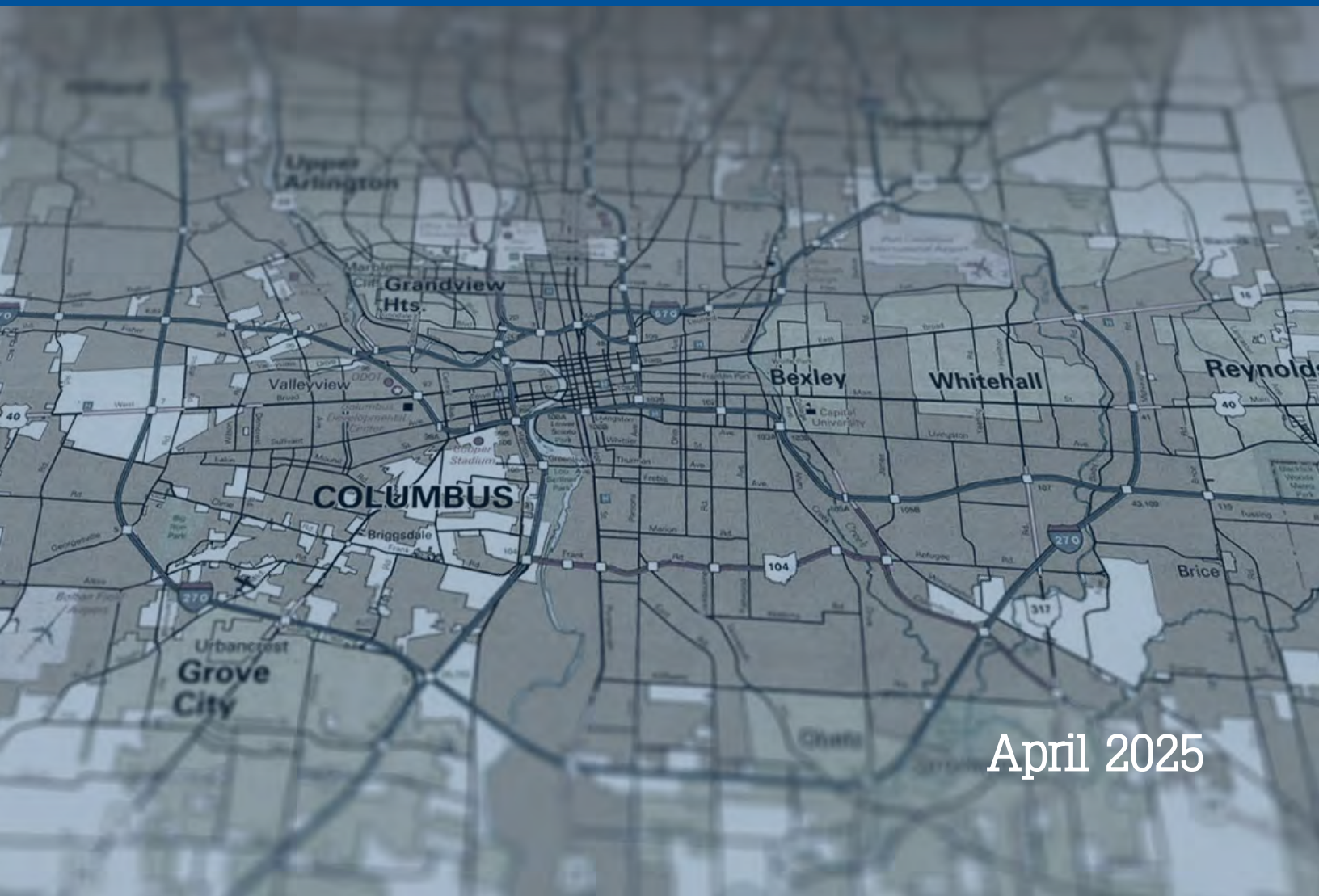
- Continuing to highlight the importance of safe sleep practices (ABC - Alone, on Back, in Crib) through Moms2B and STEPP education sessions and a video at discharge.
- Identifying women who currently smoke tobacco and refer them to Columbus Public Health's Baby & Me Tobacco Free program for cessation counseling.
- Increasing access to care through maternal fetal medicine expansion to Outpatient Care East and the use of the Community Care Coach.
- Collaborating with the other health systems to enhance prenatal and postpartum care through Ohio Better Birth Outcome's (OBBO) workgroups.
- Partnering with OBBO to offer community health workers in the McCampbell Outpatient Care Ob/Gyn clinic to provide linkages to care and wrap-around services for our patients.
- Offering prenatal and postpartum care on the Near East Side through the College of Nursing's Total Health Care Center FQHC, housed at East Hospital.
- Continuing a partnership with Nationwide Children's Hospital to support our first-time, low-income mothers from early pregnancy until the child's second birthday with nurse home visitation. The nurses have been trained by Nurse-Family Partnership to improve pregnancy outcomes by encouraging preventive health practices that enhance child health outcomes.
- Supporting Multimodal Maternal Infant Perinatal Outpatient Delivery System (MOMI PODS), a mom-baby dyad Care. MOMI PODS integrates a multimodal health engagement system (incorporating home visits, mobile health and telehealth) into traditional outpatient care models to provide high-quality primary and postpartum care to both the mother and child in the critical first 1,000 days after delivery.
- Continuing the Fourth Trimester Group Clinic, a family-centered approach to increasing breastfeeding rates among high-risk mothers.

There were no comments on the Ohio State Wexner Medical Center's 2022 CHNA.

Franklin County

HealthMap2025

Navigating Our Way to a Healthier Community Together



April 2025

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ABOUT HEALTHMAP2025

Introduction

The Franklin County Community Health Needs Assessment Steering Committee is pleased to provide residents of central Ohio with a comprehensive overview of our community's health status and needs via *Franklin County HealthMap2025*.

Franklin County HealthMap2025 is the result of a continuing, collaborative effort coordinated by the Central Ohio Hospital Council (COHC), Columbus Public Health (CPH), and Franklin County Public Health (FCPH). As part of its mission, COHC serves as the forum for community hospitals to collaborate with each other and with other community stakeholders to improve the quality, value, and accessibility of health care in the central Ohio region. Although COHC's not-for-profit member hospitals have service areas that extend across central Ohio, for the purposes of this report, the local geographic focus area is Franklin County, Ohio. CPH serves the residents of the City of Columbus and the City of Worthington, and FCPH serves the residents of all other cities, towns, and villages in Franklin County.

The intent of this effort is to help health departments, hospitals, social service agencies, and other community organizations identify and address the unmet health needs of Franklin County residents. By characterizing and understanding the prevalence of acute and chronic health conditions, access to care barriers, and other health issues, these community partners can ensure resources are focused so that they have the greatest impact.

To that end, central Ohio's hospitals and health departments will begin using the data reported in *Franklin County HealthMap2025* to inform the development and implementation of strategic plans (e.g., community health improvement plans; implementation plans) that address the community's health needs. Consistent with federal requirements, *Franklin County HealthMap2025* will be updated in three years.

The Franklin County Community Health Needs Assessment Steering Committee hopes *Franklin County HealthMap2025* serves as a guide to target and prioritize limited resources, a vehicle for strengthening community relationships, and a source of information that contributes to keeping people healthy.

Franklin County HealthMap2025's Process

The process for *Franklin County HealthMap2025* reflects an adapted version of Robert Wood Johnson Foundation's County Health Rankings and Roadmaps: Assess Needs and Resources process.[1] This process is designed to help stakeholders "understand current community strengths, resources, needs, and gaps," so they can better focus their efforts and

[1] See https://www.countyhealthrankings.org/take-action-to-improve-health/action-center/assess-needs-resources

collaboration. The primary phases of this process, as adapted for use with *Franklin County HealthMap2025*, included the following steps.

(1) Prepare to Assess. Members of the community were closely involved throughout the design and implementation of *Franklin County HealthMap2025*. On January 17, 2024, new members of the *Franklin County HealthMap2025* Community Health Needs Assessment Steering Committee[2] gathered via Zoom to learn about the upcoming community health needs assessment process and how their experience and involvement would be critical for the success of the effort.

On January 31, 2024, the full Steering Committee gathered in person to discuss their perspectives on emerging health issues in Franklin County, to participate in conversation with one another about the current state of health in the county (e.g., "What would a healthy Franklin County look like to you?"), and to identify potential health indicators for inclusion in *Franklin County HealthMap2025*. Both small group discussions and large group "report-outs" occurred during this session.

The *Franklin County HealthMap2025* Community Health Needs Assessment Executive Committee then used the information from these preceding working meetings and community visioning survey to identify which indicators could be assessed via secondary sources and which indicators could be gathered via primary data collection efforts.

(2) Collect and Analyze Secondary Data. Indicators identified by the Steering Committee for inclusion in the *Franklin County HealthMap2025* were collected and entered into a database for review and analysis. Quantitative secondary data for health indicators came from national sources (e.g., U.S. Census, Centers for Disease Control and Prevention's Behavior Risk Factor Surveillance System) and state sources (e.g., Ohio Department of Health's Data Warehouse, Ohio Hospital Association, Ohio Department of Public Safety, Ohio Department of Development). Rates and/or percentages were calculated when necessary.

To ensure community stakeholders can use this report to make well-informed decisions, only the most recent data available at the time of report preparation are presented. To be considered for inclusion in *Franklin County HealthMap2025*, quantitative secondary data must have been collected or published in 2021 or later; in most cases, the data reported in *HealthMap2025* are from 2022. In some instances, comparable state and/or national data were unavailable at the time of report preparation and therefore were not included.

The following table lists the quantitative indicators included in Franklin County's *HealthMap2025*.

[2] These individuals are listed on page 12 of this report.

Indicator	*Indicator Details*	Indicator	*Indicator Details*
COMMUNITY PROFILE			
Total population	*Number of people in Franklin County, Ohio*	**Educational attainment**	-
Sex	-	**Foreign-born status**	*Born outside of the United States*
Age	-	**English proficiency**	*Percent of people age 5+ who speak English less than "very well"*
Race	-	**Non-English languages spoken at home**	*Leading non-English languages spoken by people while at home*
Ethnicity	-	**Household size**	*Average household, family size*
Total households	*Number of households in Franklin County, Ohio*	**Household type**	*Family, nonfamily, single parents*
BASIC NEEDS			
Poverty status	*Less than 125% Federal Poverty Limit (FPL)*	**Eviction filing rate**	*Per 100 renter-occupied households*
Income distribution	*Less than 125% FPL; 125%-200% FPL; 200% FPL or below, 200%-400% FPL*	**Food insecurity**	*People who lack access, at times, to enough food for an active, healthy life*
Median household income	-	**Health insurance rate (insured; uninsured)**	*People who have health insurance*
Cost-burdened households	*Households that spend ≥30% of income on housing*	**Health insurance type**	*People who have different types of health insurance*
Renter-occupied housing	*Occupied housing units that are rented*	**Adverse childhood experiences (ACEs)**	*Adults who experienced an ACE before the age of 18*
Unhoused community members	*People who are homeless at a single point in time*		
CHRONIC CONDITIONS			
High cholesterol prevalence	*Adults told by a doctor that they have high cholesterol*	**Stroke prevalence**	*Adults told by a doctor that they had a stroke*
High blood pressure prevalence	*Adults told by a doctor that they have high blood pressure*	**Heart disease prevalence**	*Adults told by a doctor that they have heart disease*
Arthritis prevalence	*Adults told by a doctor that they have arthritis*	**Disability prevalence by type**	*Adults with different types of disabilities*
Diabetes prevalence	*Adults told by a doctor that they have diabetes*		
HEALTH BEHAVIORS			
Breast cancer screening	*Adult females (age 40+) who recently had a mammogram*	**Current cigarette smokers**	*Adults who smoke cigarettes some days or every day*
Colorectal cancer screening	*Adults (age 45-75) who recently had a colonoscopy*	**Current e-cigarette users**	*Adults who use e-cigarettes some days or every day*
Alcohol abuse	*Adults who binge drank in the past month*	**Obesity/overweight status**	*Per body mass index (BMI) categories*

Indicator	*Indicator Details*	Indicator	*Indicator Details*
MATERNAL AND INFANT HEALTH			
Prenatal chronic health conditions	*Anxiety; depression; gestational diabetes; or pregnancy-onset hypertension*	**Prenatal racial bias**	*Pregnant women who reported experiencing racial bias from a healthcare provider*
Pre-pregnancy vitamin usage	*Taking (multi)vitamins in month before pregnancy*	**Infant mortality rate**	*Deaths that occurred before 1 year of age, per 1,000 babies born*
Pre-pregnancy diabetes	*Type 1 or 2 diabetes in the three months before pregnancy*	**Low birthweight prevalence**	*Infants who weighed less than 2500 grams*
Unintended pregnancy	*Those who wanted to be pregnant later or did not want to be pregnant*	**Preterm birth prevalence**	*Infants who were delivered before 37 weeks gestation*
Prenatal healthcare	*Women who had a healthcare visit in year before pregnancy*	**Neonatal abstinence syndrome birth rate**	*Rate per 1,000 babies born*
Postnatal healthcare	*Women who had a healthcare visit in the 4-6 weeks after delivery*	**Teen fertility rate**	*Rate per 1,000 girls age 15-19 in the same age*
INFECTIOUS DISEASES			
Most common infectious disease rates: adults	*Rate per 1,000 individuals*	**New HIV diagnosis rate**	*Rate per 100,000 individuals*
Most common infectious disease rates: children	*Rate per 1,000 individuals*	**Kindergarten vaccinations**	*Youth who entered kindergarten with all required vaccines complete*
HEALTH CARE ACCESS			
Emergency Department utilization	*Treated & released; Admitted into the hospital; Visit severity; Top 10 diagnoses*	**Dental care access**	*Needed dental care but could not secure it (past 12 months)*
INJURY AND DEATH			
Mental/Social health	*Self-harm and suicide; loneliness; depression; alcohol attributable deaths; child abuse; domestic violence*	**Trauma hospitalization**	*Leading types of traumatic injuries*
Mortality	*Life expectancy; mortality rate*	**Cancer**	*Incidence and mortality*
Leading causes of death	*Rate per 100,000 individuals*	**Violent crime**	*Murder, rape, robbery, and aggravated assault, per 100,000 individuals*
		Overdose deaths	*Rate per 100,000 individuals*
ENVIRONMENTAL HEALTH			
Elevated blood lead level (EBLL)	*Among children under 6 years old*	**Lyme disease**	*Cases and rates, per 100,000 individuals*
Asthma prevalence	*Adults told by a doctor that they have asthma*		

Throughout the report, a (▲ or ▼) symbol next to the HM2025, Ohio, or US estimate indicates that estimate is at least 10% higher or at least 10% lower than the HM2022 estimate for that geography. A (▲ or ▼) symbol next to an age, sex, race/ethnicity, or disability estimate indicates that estimate is at least 10% higher than or at least 10% lower than the overall Franklin County estimate (i.e., HM2025).

(3) Collect and Analyze Primary Data. Qualitative primary data were obtained from a series of eleven 90-minute focus groups held from May 13, 2024 through July 26, 2024. Most of these focus groups were held in convenient, trusted locations throughout the community (e.g., Columbus Metropolitan Library branches; a community center; Columbus Public Health's administrative headquarters) and were facilitated by professional researchers. One focus group was held virtually via Zoom. A combination of professional/paid and grassroots/volunteer recruiting efforts were used to invite a diverse mix of Franklin County residents to participate in these sessions, including those with different types of disabilities.[3]

Overall, 111 Franklin County adults who reside within the primary jurisdictions of the COHC-member hospitals (as defined for this process), CPH, and FCPH participated in these focus groups, sharing their thoughts and observations about a wide range of health topics. These discussions included a focus on underlying factors that contribute to health issues, such as poverty and racism. Transcripts of these discussions can be provided upon request.

(4) Identify Priority Heath Needs. On October 22, 2024, the Steering Committee members received a draft copy of *Franklin County HealthMap2025*. They were asked to review the draft document and to record and share any comments or questions they had about it.

On October 31, 2024, the full Steering Committee met in person to review *Franklin County HealthMap2025* and to identify priority health issues. The meeting participants were divided into small groups, with each group asked to review a specific section of *Franklin County HealthMap2025* and, within that section, to identify potential priority health issues for consideration by the larger group. In addition to sharing their personal experience and history during these small-group conversations, meeting participants were asked to consider the following criteria when identifying potential priority health issues:

- **Equity:** Degree to which specific groups are disproportionately affected by an issue.
- **Size:** Number of persons affected, taking into account variance from benchmark data and targets.
- **Seriousness:** Degree to which the health issue leads to death or disability, and impairs one's quality of life.

[3] The Steering Committee wishes to acknowledge and thank the Ohio Department of Health's Center for Public Health Excellence for recruiting disabled residents to share their experiences and opinions in one of these focus groups and for providing ASL interpreters to help facilitate that conversation.

- **Feasibility:** Ability of organization or individuals to reasonably combat the health issue given available resources. Related to the amount of control and knowledge (influence) organization(s) have on the issue.
- **Severity of the Consequences of Inaction:** Risks associated with exacerbation of the health issue if not addressed at the earliest opportunity.
- **Trends:** Whether or not the health issue is getting better or worse in the community over time.
- **Intervention:** Any existing multi-level public health strategies proven to be effective in addressing the health issue.
- **Value:** The importance of the health issue to the community.
- **Social Determinant / Root Cause:** Whether or not the health issue is a root cause or social determinant of health that impacts one or more health issues.

Overall, a total of 29 potential priority health issues were identified by Steering Committee members. A multi-voting technique,[4] featuring three rounds of voting, was used to narrow down that list to **five priority health issues** that affect Franklin County residents.

On December 19, 2024, Steering Committee members received an invitation to participate in an online survey that would lead to the identification of the final set of priority health needs for the community. This prioritization survey was structured as follows. First, it provided an orientation to the purpose and intent of the effort. It presented an array of criteria that respondents should use when identifying priority health needs (e.g., the list of nine factors presented above). Then, after reading descriptions of the five priority health issues, respondents were asked to rank those issues. Overall, 28 Steering Committee members completed this survey. After tabulating the responses, there was clear consensus about the community's priority health needs. These priority health needs are reviewed in the next section of this report.

From these exercises, the Steering Committee was able to complete its charge to identify the prioritized health needs of Franklin County.

(5) Identify Community Assets and Resources. In December 2024, the Executive Committee identified community assets and resources that could potentially address the prioritized health needs, including existing healthcare facilities, community organizations, and programs or other resources. Inclusion of these potential partners and resources in *Franklin County HealthMap2025* is consistent with hospital requirements for conducting a needs assessment.

(6) Share Results with the Community. In December 2024, COHC conducted a review of *Franklin County HealthMap2025* to ensure that it was compliant with Internal Revenue Service

[4] See NACCHO's Guide to Prioritization Techniques, which can be accessed at https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf.

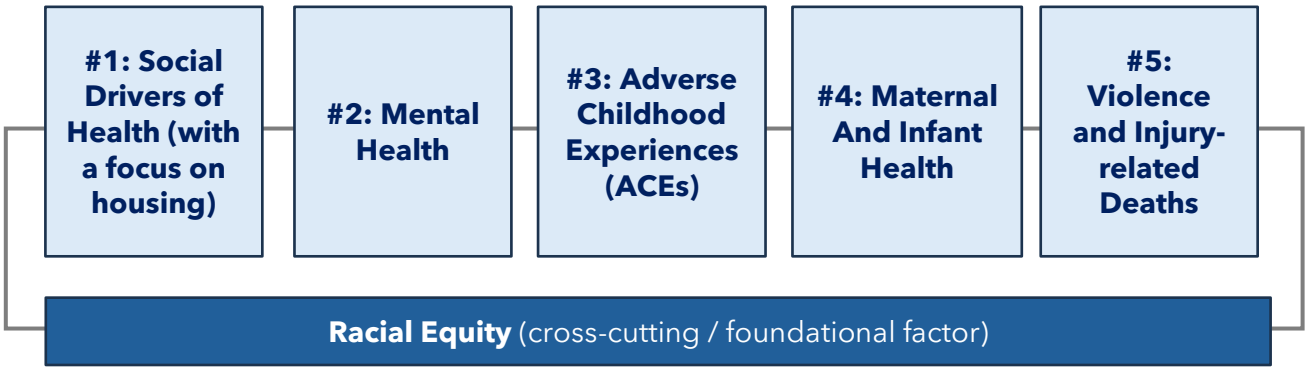
regulations for conducting community health needs assessments. CPH and FCPH also conducted internal reviews to ensure the report satisfied the requirements set forth by the Public Health Accreditation Board (PHAB). No information gaps that may impact the ability to assess the health needs of the community were identified during or after this process.

This report will be posted on COHC's, CPH's, and FCPH's websites, will be used in subsequent community prioritization and planning efforts, and will be widely distributed to organizations that serve and represent residents in the county.

Prioritized Health Needs

The five prioritized health needs affecting Franklin County residents, as identified by the Community Health Needs Assessment Steering Committee, are displayed below and discussed in this section.

Prioritized Health Needs Identified By *HealthMap2025*



Priority #1: Social Drivers of Health (with a focus on housing)

- Non-medical factors, such as economic stability, education and healthcare access, transportation and neighborhood safety, are key drivers of good health outcomes. According to Healthy People 2030, addressing the quality of housing as a public health issue may help prevent and reduce negative health outcomes. This is because poor housing quality and inadequate housing conditions can contribute to negative health outcomes, including chronic disease and injury. Furthermore, the presence of lead, mold, or asbestos, poor air quality and overcrowding can lead to irreversible health effects. In addition, overcrowded homes may be at risk for poor mental health, food insecurity, and infectious disease.
- Steering Committee members noted the many linkages between housing and health conditions and argued that policy changes are likely necessary to address varied challenges with the availability and affordability of different types of housing in Franklin County. Furthermore, Steering Committee members noted that cost-burdened households – those that spend more than 30% of their income on housing costs – tend to

be concentrated in zip codes that are associated with greater levels of racial and financial inequities, likely reflecting the historical practice of redlining in central Ohio.

Relevant indicators	See pages
Cost-burdened household prevalence	36
Unhoused community members (point-in-time count)	37

Priority #2: Mental Health

- According to the National Alliance on Mental Illness (NAMI), 23% of U.S. adults (1 in 5 adults) experienced mental illness in 2021 with 5.5% of adults (1 in 20 adults) experiencing a serious mental illness. And per the CDC, social isolation and loneliness are widespread problems in the U.S. and pose a serious threat to both mental and physical health. Social isolation can increase a person's risk for heart disease, self-harm, dementia and eventually may lead to an earlier death.
- Steering Committee members mentioned loneliness and depression as areas of concern, noting that over a quarter of residents report feeling lonely, and that the prevalence of loneliness is higher among recently pregnant women, individuals who have a household income that places them at or under the 100% federal poverty level, and among individuals with a disability. Furthermore, females, white (non- Hispanic) individuals, adults under the age of 65, and individuals with a disability are more likely than other groups to report ever being told by a healthcare professional that they have a depressive disorder (e.g., depression).
- Hospitalizations due to self-harm and deaths from suicide have both increased in Franklin County since the last HealthMap. The Franklin County Suicide Prevention Coalition has identified high-risk populations, including the Black and African-American community, older adults, refugees and immigrants, veterans, and youth.

Relevant indicators	See pages
Depression prevalence	136
Loneliness prevalence	135
Suicide death rate	135

Priority #3: Adverse Childhood Experiences (ACEs)

- Adverse childhood experiences, or ACEs, are traumatic events that occur during childhood (i.e., before age 18) and impact mental health. Examples of ACEs include violence, abuse, or neglect, as well as contextual factors that might negatively affect a child's sense of safety or stability, such as growing up in a household with people who have substance use problems, mental health problems, or parents who were separated or in jail. Research shows that ACEs can have lasting effects on health and wellbeing in childhood, as well as impact one's education and job potential into adulthood. These experiences can increase the risks of injury, maternal and child health problems including teen pregnancy, pregnancy complications, and fetal death. Also impacted are a range of chronic diseases and leading causes of death, such as cancer, diabetes, heart disease, and suicide.

- Steering Committee members noted that the prevalence of those who report having 4 or more ACEs when they were children is highest among black (non-Hispanic) individuals, those who are younger than age 65, and individuals with a disability. Furthermore, Steering Committee members noted that ACEs are considered a root cause for many physical and mental health issues and social determinant of health outcomes.

Relevant indicators	See pages
Adverse childhood indicators prevalence	52
Depression prevalence	136

Priority #4: Maternal and Infant Health

- Healthy children need healthy parents. The health of the mother – before, during, and after pregnancy – has a direct impact on the health of the child. Biological and neurological sciences show that the predictors of healthy child development begin before pregnancy, with the health of the mother, and continue after the birth, with the mother-child relationship.
- According to the CDC, each year, more than 50,000 pregnant people are affected by severe maternal morbidity, 800 women die due to pregnancy-related complications and over 20,000 infants die. And per CelebrateOne, a public/private impact collaborative addressing and reducing infant mortality, 126 babies died in Franklin County before their first birthday in 2023, with 20 due to sleep-related conditions.
- From the Steering Committee members' perspective, an increased focus on maternal health could lead to a reduction of the infant mortality rate, which unfortunately has not decreased significantly in recent years. Steering Committee members also suggested broadening the focus of maternal health to include the pre-pregnancy period, prenatal period, and well after delivery. Furthermore, Steering Committee members noted that many pregnant women report racial bias in the prenatal health care they received, which is a cross-cutting factor that also must be addressed.

Relevant indicators	See pages
Maternal health (multiple indicators)	96-112
Infant mortality rate	108

Priority #5: Violence and Injury-related Deaths

- Injury and violence affect everyone, regardless of age, race, or economic status. According to the CDC, Americans aged 1 to 44 die from injuries and violence – such as motor vehicle crashes, suicide, overdoses, or homicides - more than any other cause. Suicide is the second leading cause of death for this age group, while homicide remains in the top five leading causes of death. Overall, drug overdose remains the leading cause of injury-related death among adults in the United States.
- Steering Committee members noted that both drug overdose deaths and deaths from alcohol-attributable causes have increased since the last HealthMap. Additionally, Steering Committee members were concerned about traumatic injuries and the presence of numerous disparities by age, gender, and race.

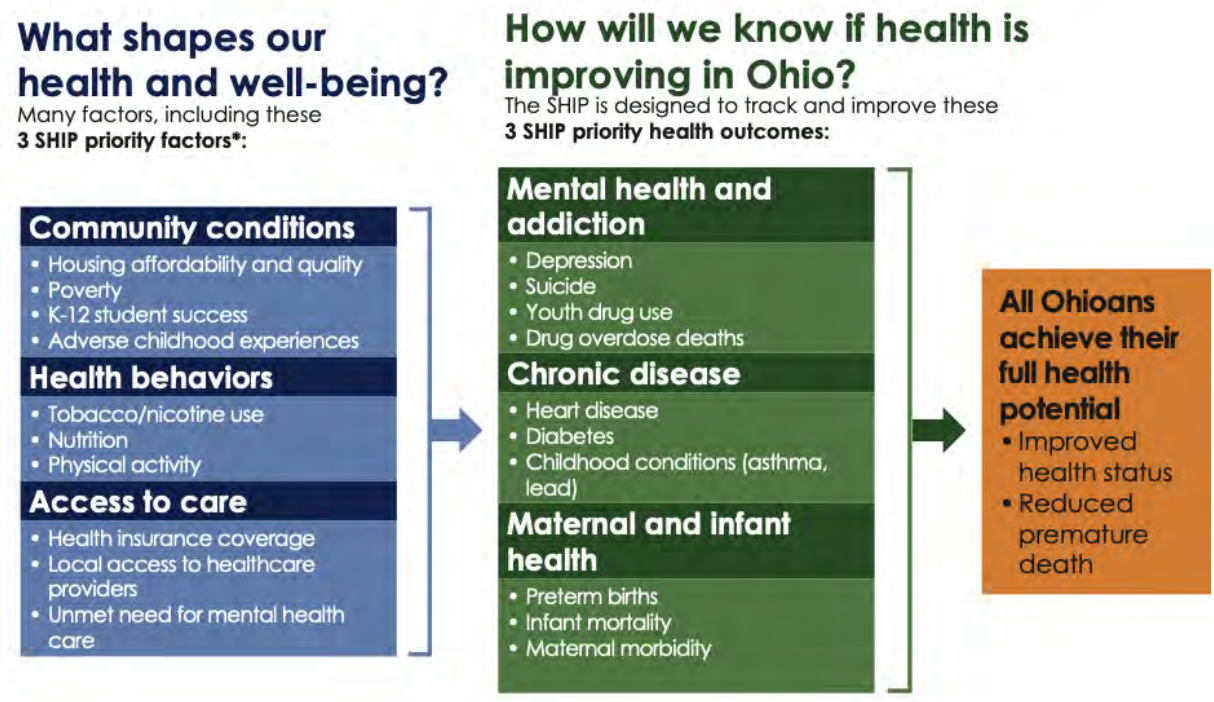
Relevant indicators	See pages
Drug overdose death rate	164
Alcohol-attributable death rate	138
Traumatic injury prevalence	151-157
Violent crime	162

Page 183 of this report presents a list of community assets and resources that could potentially help to address these prioritized health needs.

Note that these prioritized health needs are interrelated, and in many cases likely co-occur. Furthermore, the Steering Committee acknowledges that large scale coalitions currently address **infant mortality** and **addiction**, and that those efforts could be supplemented with an increased focus on the potential causes of those issues.

For context, Ohio's 2020-2022 State Health Improvement Plan (SHIP) identified three cross-cutting factors (i.e., social determinants of health that include community conditions, health behaviors, and access to care) as well three health outcome categories (i.e., mental health and addiction, chronic disease, and maternal and infant health) that should be considered when planning to improve the community's health (see next page). Overall, there is good alignment between *HealthMap2025's* prioritized health needs and Ohio's 2020-2022 SHIP.

Priority Factors And Outcomes Identified By Ohio's 2020-2022 SHIP



Source: Ohio's 2020-2022 State Health Improvement Plan (SHIP), available at https://dam.assets.ohio.gov/image/upload/odh.ohio.gov/SHIP/2020-2022/2020-2022-SHIP.pdf

Lastly, it should be noted that several other health issues were also considered by the Steering Committee as part of this prioritization process. Although these other issues play an important role in affecting the health of Franklin County residents, they did not receive the same level of endorsement as compared to the priority health needs reviewed previously.

The other health issues considered by the Steering Committee are listed below in no particular order.

- Racial bias in health care (note: this is mentioned as a cross-cutting factor affecting maternal health, above)
- Access to dental care
- Accessing care in the appropriate setting
- Overweight and obesity status
- Tobacco use (smoking and vaping)
- Life expectancy
- Cancer screening
- Motor vehicle accidents
- Food preparation knowledge
- Diversity of housing stock
- Asthma / respiratory disease
- Maternal & child health: Access to care; Cultural competence
- Maternal & child health: Chronic conditions
- Maternal & child health: Infant mortality
- Heart disease
- Stroke
- Diabetes
- Transportation
- Suicide deaths | Self-harm hospitalizations

Community Health Needs Assessment Steering Committee

Work on *Franklin County HealthMap2025* was overseen by a Steering Committee consisting of the following community members. Consistent with federal requirements for conducting health needs assessments, entities which represent specific populations within the community are identified. Executive Committee members are indicated with a * symbol.

ADAMH Board (Mental Health)
Kelly Bragg

B.R.E.A.D. Organization (Faith Communities)
Blanche Luczyk, Cora Harrison

Central Ohio Hospital Council (Hospital/Medical)
*Jeff Klingler**

Center for Public Health Practice at The Ohio State University (University System)
Andy Wapner

City of Columbus (Government)
Hannah Jones

Columbus City Schools (Education)
Sara Bode

Columbus Public Health (Public Health)
Kathy Cowen, Ann Mehl, Laurie Dietsch, Michelle Groux*

Community Shelter Board (Housing Insecure Community)
Steven Skovensky

Directions for Youth & Families (Mental Health)
Duane Casares

Educational Service Center (Education)
Wade Lucas

Equitas Health (LGBTQ+)
Francisco Caro

Ethiopian Tewahedo Social Services (Social Services; New American Communities)
Seleshi Ayalew Asfaw

Franklin County Coroner (Hospital/Medical)
Nathaniel Overmire, Patrick McLean, Jeremy Blake

Franklin County Office of Aging (Senior Community)
Caroline Rankin, Chanda Wingo

Franklin County Public Health (Public Health)
Joe Mazzola, Theresa Seagraves, Abby Boeckman, Sierra MacEachron*

Future Ready Five (Education)
Vanisa Turney

Health Impact Ohio (Public Health)
Tanikka Price

Human Services Chamber (Social Services)
Bhumika Patel

Mid-Ohio Food Collective (Food Insecure Community)
Amy Headings

Mid-Ohio Regional Planning Commission (Transportation, Data)
Melinda Vonstein

Mount Carmel Health System (Hospital/Medical)
Candice Coleman, Brian Pierson

Nationwide Children's Hospital (Hospital/Medical)
Libbey Hoang, Brittany Kremer, Laura McLaughlin

Ohio Association of Community Health Centers (Medical)
Dana Vallangeon

Ohio Department of Health Disability and Health Program (Disabled Community)
David Ellsworth

OhioHealth (Hospital/Medical)
Rebecca Barbeau, Jeff Kasler

OSU Extension - The Ohio State University (Education/Rural Community)
Brian Butler

The Ohio State University Wexner Medical Center (Hospital/Medical)
Annie Marsico, Ben Anthony

United Way of Central Ohio (Low-income/Medically Underserved Communities)
Lisa Courtice

Workforce Development Board (Workforce Development)
Lauren Rummel

The following hospitals (listed by health system) participated in the *HealthMap2025* process:

Mount Carmel Health System
Mount Carmel East Hospital
Mount Carmel Grove City Hospital
Mount Carmel St. Ann's Hospital

Nationwide Children's Hospital

OhioHealth
OhioHealth Doctors Hospital
OhioHealth Dublin Methodist Hospital
OhioHealth Grant Medical Center
OhioHealth Grove City Methodist Hospital
OhioHealth Riverside Methodist Hospital

OSU Wexner Medical Center
University Hospital, Main Campus
University Hospital East
The James Cancer Hospital and Solove Research Institute

Input from all required sources was obtained for this report.

COHC, CPH, and FCPH contracted with various organizations to help create *Franklin County HealthMap2025*. Representatives of those organizations, along with their qualifications and addresses, are provided below.

Illuminology – located at 5258 Bethel-Reed Park, Columbus, OH 43220. Illuminology, represented by Orie V. Kristel, Ph.D., led the process for locating health status indicator data, for designing and moderating the focus groups, and for creating the summary report. Dr. Kristel is Illuminology's principal researcher and has 27 years of experience related to research design, analysis, and reporting, with a focus on community health assessments.

Center for Public Health Practice – located within the College of Public Health at The Ohio State University, 1841 Neil Avenue, Columbus, OH 43210. The Center, represented by Andy Wapner and Georgia Sasser, provided data collection, analysis support, and contributed to the summary report. The Center was also represented on the Steering Committee. Center staff combine for over 30 years of experience in local, state, and academic public health and routinely provide health needs assessment services.

INCompliance, an affiliate law firm of Bricker Graydon LLP – located at 100 South Third Street, Columbus, Ohio 43215. INCompliance provided overall guidance in ensuring that the conduct of the CHNA was compliant with the Internal Revenue Service regulations. Jim Flynn is a managing partner with Bricker Graydon and senior consultant to INCompliance. He and has 34 years of practice experience related to health planning matters, certificate of need, non-profit and tax-exempt health care providers, and federal and state regulatory issues. Christine Kenney is Director of Regulatory Services for INComplaince and has over 44 years of experience in health care planning and policy development, federal and state regulations, certificate of need, and assessment of community need.

The Community Health Needs Assessment Steering Committee wishes to acknowledge and thank the following people who contributed their time and expertise to assist with some of the analyses and maps included in *HealthMap2025*: Sierra MacEachron (Franklin County Public Health); Kathy Cowen, Michelle Groux, Emily Alexy, and Becky Zwickl (Columbus Public Health's Office of Epidemiology).

Community Profile

Overall, Franklin County's total population continues to increase. Compared to the last *HealthMap*, the county's demographic profile has remained similar, with three notable exceptions: the proportion who identify as Hispanic or Latino has increased; the proportion who were born in another country has increased; and the proportion of people age 5+ who speak English less than "very well" has increased.

Franklin County Residents[1-3]

		Franklin County		
		HM2019	HM2022	HM2025
Total population	Population of Franklin County	1,264,518	1,316,756	1,321,820
Sex	Male	48.8%	48.8%	49.2%
	Female	51.2%	51.2%	50.8%
Age	Under 5 years	7.3%	7.0%	6.5%
	5-19 years	19.0%	19.1%	19.2%
	20-64 years	62.3%	61.4%	61%
	65 years and over	11.3%	12.4%	13.3%
Race (any ethnicity)	White	68.1%	66.5%	65.1%
	Black	23.1%	23.9%	24.9%
	Asian-American/Pacific Islander	5.4%	6.0%	6.0%
	American Indian/Alaskan Native	0.1%	0.3%	0.4%
	Two or more races	3.2%	3.4%	3.7%
Ethnicity	Hispanic or Latino (of any race)	5.4%	5.8%	7.3% ▲
Foreign-born	Foreign-born	-	11.4%	12.6% ▲
	(Among foreign-born) Naturalized	-	*48.2%*	*45.4%*
	(Among foreign-born) Not a U.S. citizen		*51.8%*	*54.6%*
English proficiency	Percent of people age 5+ who speak English less than "very well"	-	5.3%	6.4% ▲
Most common languages spoken by people who speak a non-English language at home	Spanish	-	49,949	56,793▲
	Amharic, Somali, or other Afro-Asiatic languages	-	25,051	27,074
	Arabic	-	8,437	15,285▲
	Yoruba, Twi, Igbo, or other languages of Western Africa	-	10,904	12,435▲
	Nepali, Marathi, or other Indic languages	-	9,668	11,076▲
	Chinese (incl. Mandarin, Cantonese)	-	13,072	8,188 ▼
	French (incl. Cajun)	-	5,789	7,579 ▲
	Swahili or other languages of Central, Eastern, and Southern Africa	-	3,608	6,634▲

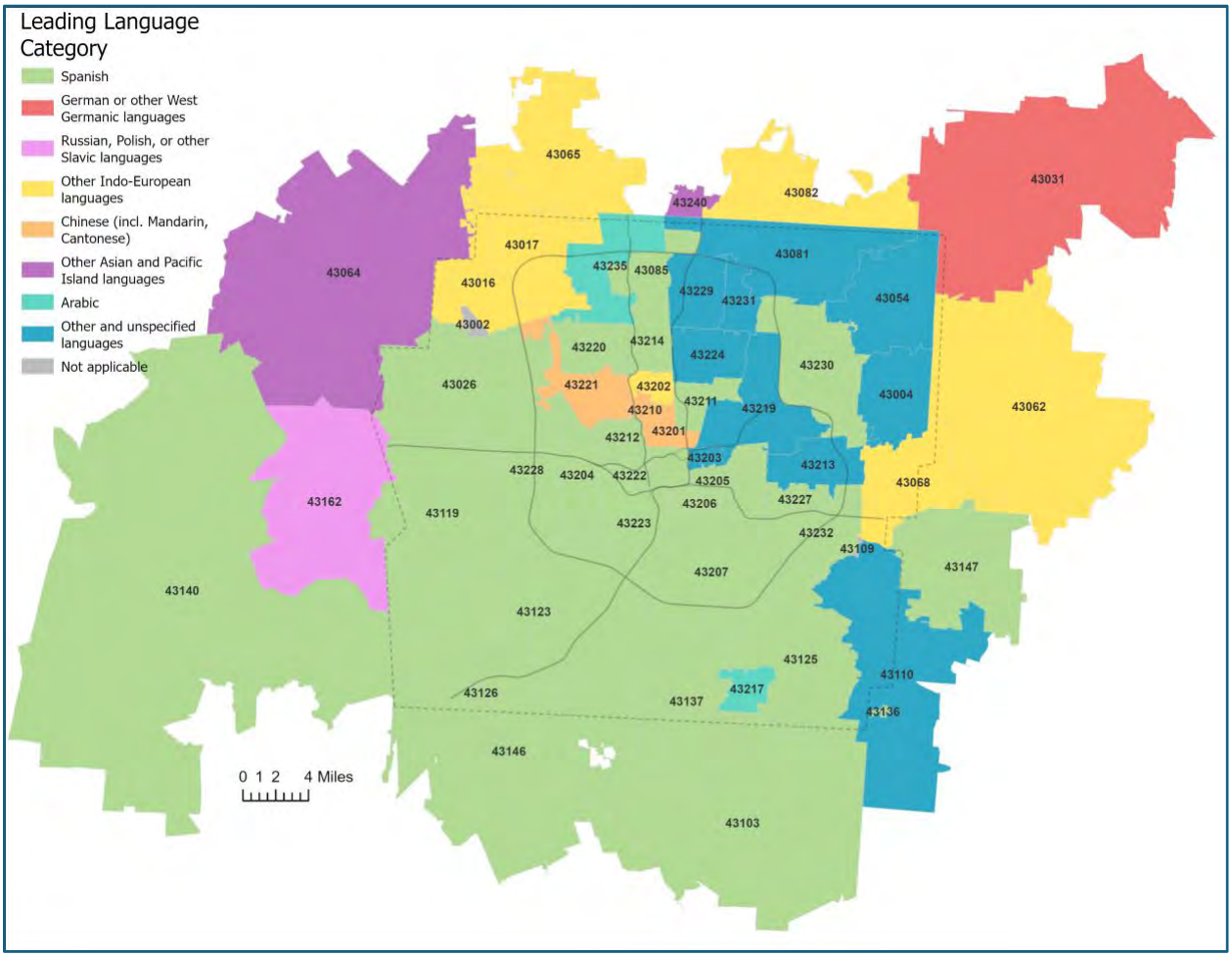
		Franklin County		
		HM2019	HM2022	HM2025
Educational Attainment	No/Some high school, no degree	9.7%	8.8%	8.7%
	High school graduate	25%	24.6%	24.5%
	Some college (no degree)	20.2%	19.6%	18%
	Associate's degree	6.8%	6.9%	6.5%
	Bachelor's degree	24.4%	25.3%	25.8%
	Graduate/Professional degree	14%	14.8%	16.5% ▲

Although the number of households in Franklin County has increased over time, other household characteristics remained relatively stable over time (e.g., household size, household type).

Franklin County Households[1]

		Franklin County		
		HM2019	HM2022	HM2025
Total households	Number of households	502,932	522,383	550,153
Household size	Average household size	2.5	2.5	2.4
	Average family size	3.2	3.2	3.1
Household type	Family households	58.0%	58.5%	55.8%
	Nonfamily households	42.0%	41.5%	44.2%
	Single parent households	-	18.4%	18.3%

The leading non-English language category spoken at home[4] in each Franklin County zip code is shown below.

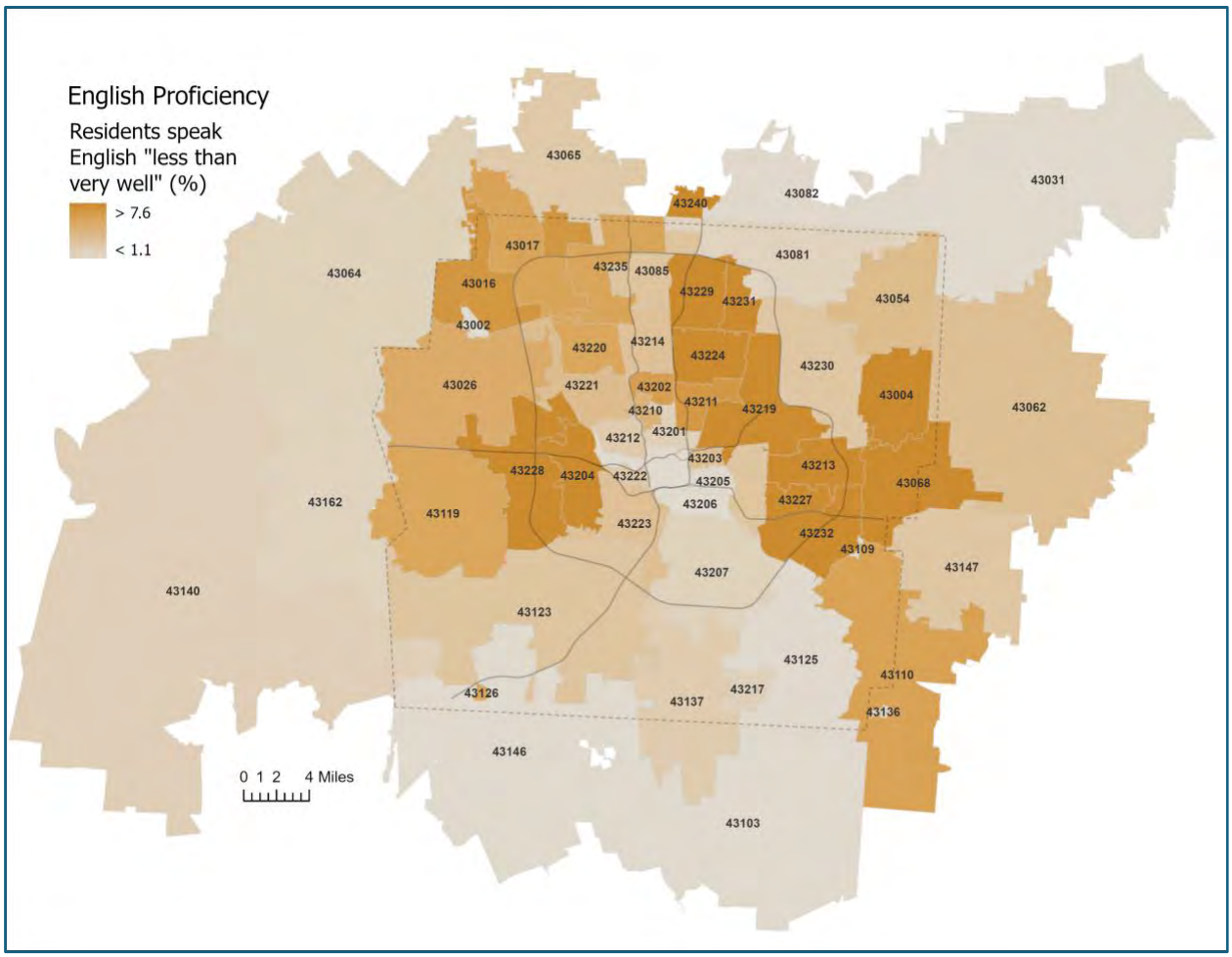


The following zip codes have the highest percentage of residents who speak a non-English language at home. Per the United States' Census Bureau[4]:

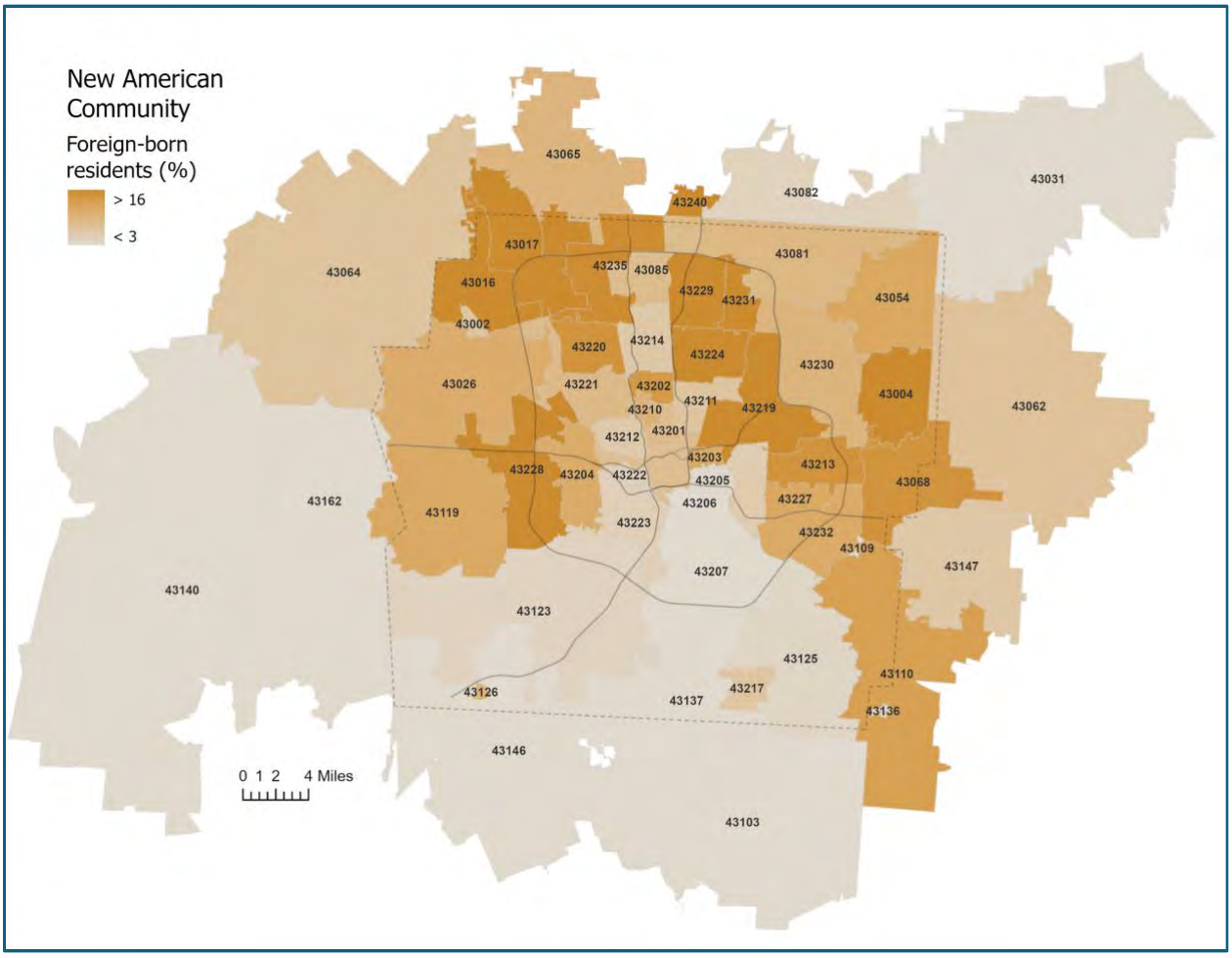
- 26% of residents in zip code **43231** speak a language other than English at home. In that zip code, the most common countries of birth besides the United States are Somalia, Ghana, and Kenya.
- 21% of residents in zip code **43229** speak a language other than English at home. In that zip code, the most common countries of birth besides the United States are Ghana, El Salvador, and Somalia.
- 20% of residents in zip code **43224** speak a language other than English at home. In that zip code, the most common countries of birth besides the United States are Somalia, Ghana, and Mexico.
- 16% of residents in zip code **43219** speak a language other than English at home. In that zip code, the most common countries of birth besides the United States are Somalia, Mexico, and India.

- 14% of residents in zip code **43068** speak a language other than English at home. In that zip code, the most common countries of birth besides the United States are Bhutan, Nepal, and Ethiopia.

As shown in the map below, those residents who speak English less than "very well" are relatively more likely to be located in Franklin County's far eastern zip codes (e.g., 43068, 43004, 43232, 43227, 43213), its western zip codes (e.g., 43204, 43228, 43119), and its north-central zip codes (e.g., 43219, 43224, 43229, 43231).



Those residents who report being born in another country are relatively more likely to be located in Franklin County's north-central zip codes (e.g., 43219, 43224, 43229, 43231), in the 43228 zip code, and its northwestern zip codes (e.g., 43016, 43017, 43220, 43235).



Additional Information & References

Over the past 15 years, the U.S. Census Bureau has been working to improve how it measures race in America, including those who identify with two or more racial groups. This process resulted in numerous changes to the questionnaires it uses, starting in 2020. If HM2025 used recent American Community Survey data (i.e., 2022 vintage) to estimate the proportion of Franklin County residents who identify with two or more racial groups, that statistic would be 9.3%, representing a 250% increase from what was measured in 2019 (i.e., 3.7%). Because those questionnaire changes produced a substantial change in this statistic over time, HM2025 used a different U.S. Census Bureau dataset to estimate Franklin County residents' race/ethnicity status.[2,3]

Household size includes all people occupying a housing unit, while family size includes the family householder and all other people in the housing unit related to the householder by birth, marriage, or adoption.

To map the prevalence of these indicators at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the Census Bureau's American Community Survey.[4]

Data Gap: The Community Health Needs Assessment Steering Committee requested recent data about the proportion of residents who obtained technical training / certification. Unfortunately, the U.S. Census Bureau does not appear to measure that type of vocational activity.

[1] U.S. Census Bureau, American Community Survey 1-Year Estimates, 2022 (HM2025), 2019 (HM2022), 2016 (HM2019)
[2] U.S. Census Bureau. (2020). *County Population by Characteristics: 2010-2020, Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin [Dataset]. https://www.census.gov/programs-surveys/popest/technical-documentation/research/evaluation-estimates/2020-evaluation-estimates/2010s-county-detail.html*
[3] U.S. Census Bureau. (2022). *County Population by Characteristics: 2020-2023, Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin [Dataset]. https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-detail.html*
[4] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2022 (HM2025)

BASIC NEEDS

Income And Poverty

Socioeconomic status is one of the most well documented influences on health. Lower income is associated with greater chronic illness, more healthcare needs, worse health-related quality of life, and higher mortality.[1-4]

The median household **income** in Franklin County in 2022 was **$69,681**.	≈ Similar to HM2022 ($64,713)
18.8% of Franklin County residents have an income below 125% of the **poverty level**.	≈ Similar to HM2022 (17.7%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Children more likely	None observed	Non-white more likely	Observed (see map)

Community Voices

Many Franklin County residents feel they are vulnerable to poverty, perceiving basic needs as increasingly expensive and their overall financial stability as precarious.

> *"Most of us now, with inflation rates and the way everything is mildly expensive, we are all a couple bad weeks away from being as homeless as the other people on Broad Street. People who feel like they have had a more stable setup or a more conventional foundation, I don't think that is the same as it maybe was five or ten years ago."*

Community members feel that the effort to make ends meet precludes individuals from thinking about their health needs, as well as financially prevents them from accessing health care, nutritious food, and other things needed to lead healthy lives.

> *"If you are someone who's trying to make ends meet and you're working several jobs, oftentimes it's really hard to find the time, to find the motivation to do the things that are ultimately going to improve your health. So you might be fully employed, working 60, 80 hours a week just to keep a roof over your head. And the other things kind of take a back seat to that. You don't have access necessarily to healthy food. You don't have access to doctors in your area where it's a quick trip to that. And our society really pats people on the back who work a lot, basically themselves to death."*

> *"Being stuck on that bottom rung of Maslow's hierarchy of needs. Yes, healthcare should be down there, but it isn't. It's another step up. If you're trying to just subsist and you can't get out of that, you're not going to think about things that are actually problems with your body or mental health."*
>
> *"You can't afford everything. You try to do one thing, because if you try to do it all, and then it's a trickle-down effect and you're in a hole, you can't get yourself out of it. So, you can only do so much for yourself. And if you have a family, it's even harder. You just have to pick and choose what's most important at that right time."*
>
> *"If you're sick, you're not gonna have the energy to make healthy meals, you're not gonna follow the doctor's orders, like take a rest, or do this type of treatment, because you have to work and make money to provide for your family."*

While resources exist to help individuals in poverty, community members say that accessing them is not easy enough; individuals may be unaware what resources exist and unable to get connected to an individual who can help them in a timely manner.

> *"If you are living in poverty, you may not have the ability to know where to access the resources. Because I do think that there are a lot of resources, but I don't think people know how to get to the resources, and people are not helping them get to those resources."*
>
> *"A lot of people are having such a hard time getting a hold of, like, [government agency]. I've heard people call and call. You put your request in for a call back. You never get a call back. There's just no communication. And I don't feel like there's really a willingness to help either."*

There are social ramifications to living in poverty as well, as a community member pointed out. It is difficult for families to spend time together when parents must work multiple jobs to maintain financial stability.

> *"And people working multiple jobs to bridge the gap between the generations, [there's a gap] between parents and their kids. It's hard to see the kids because I'm working multiple jobs and my kid goes to bed before I come back from work. Stuff like that creates this huge gap among ourselves."*

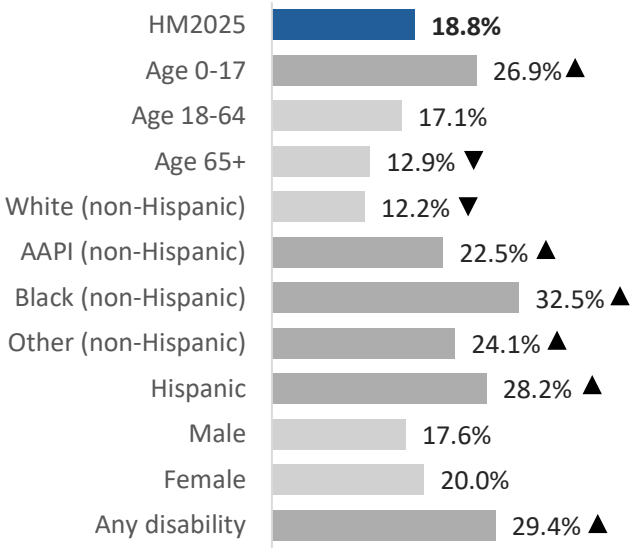
Overall, the median household income among Franklin County residents is higher than Ohio residents overall but lower than US residents overall. However, after adjusting for inflation, the average household income in Franklin County for HM2025 is *slightly less* than what was observed six years ago (i.e., HM2019).

Children, non-white individuals (especially those who are black non-Hispanic, those who are Hispanic, and those who have an other non-Hispanic racial background), and disabled individuals are at increased risk of living near or below the federal poverty level.

Median Income

	Average income	Adjusted for inflation
HM2025	**$69,681**	**$69,681**
HM2022	**$64,713**	**$76,170**
HM2019	**$56,055**	**$70,100**
Ohio	**$65,720 ▲**	**$65,720**
US	**$74,755 ▲**	**$74,755**

Less than 125% Federal Poverty Level

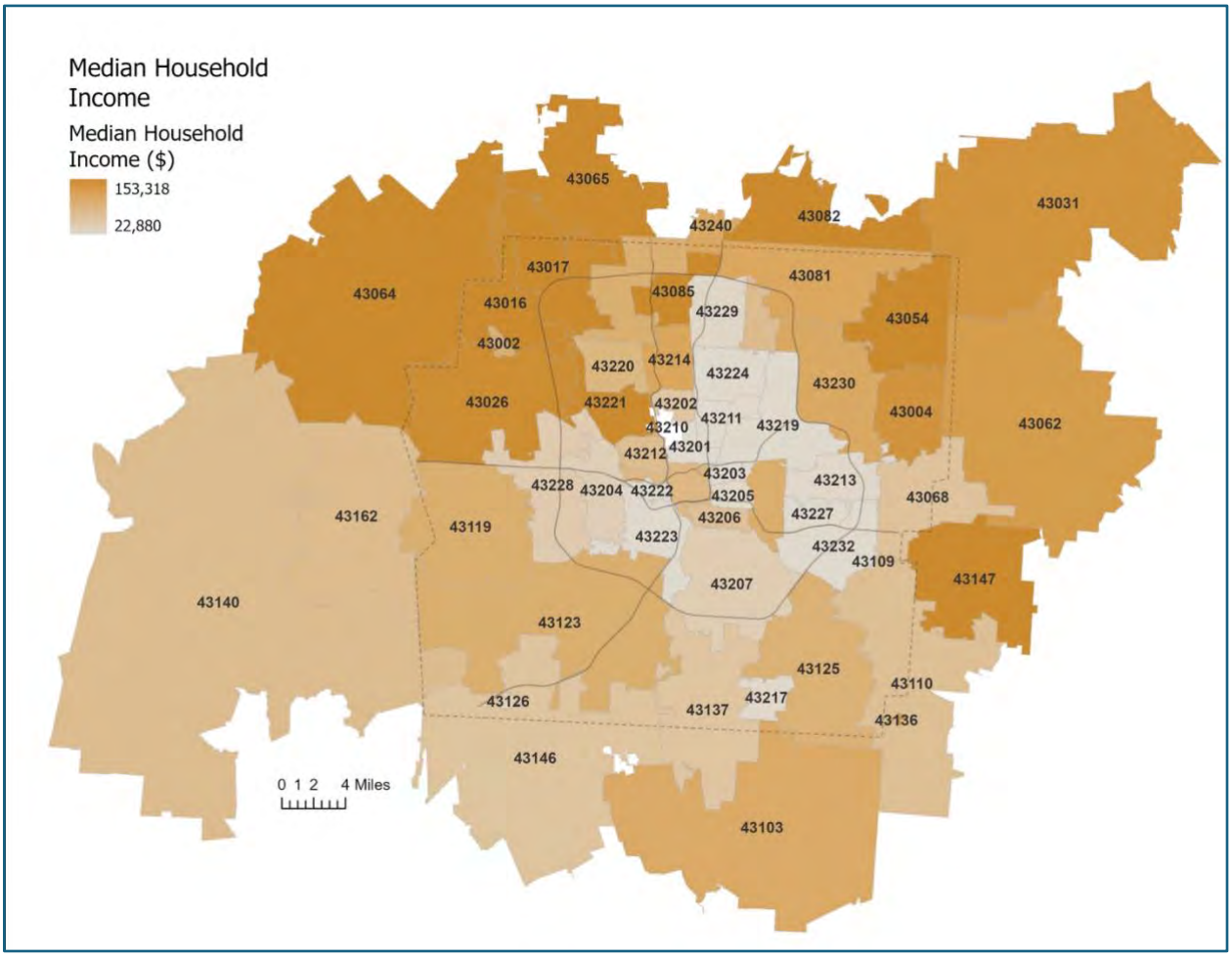


As shown below, income distribution near a variety of federal poverty level thresholds has remained relatively consistent over time. Compared to both the United States and Ohio, Franklin County does have a slightly higher proportion of people in the below 125% bracket.

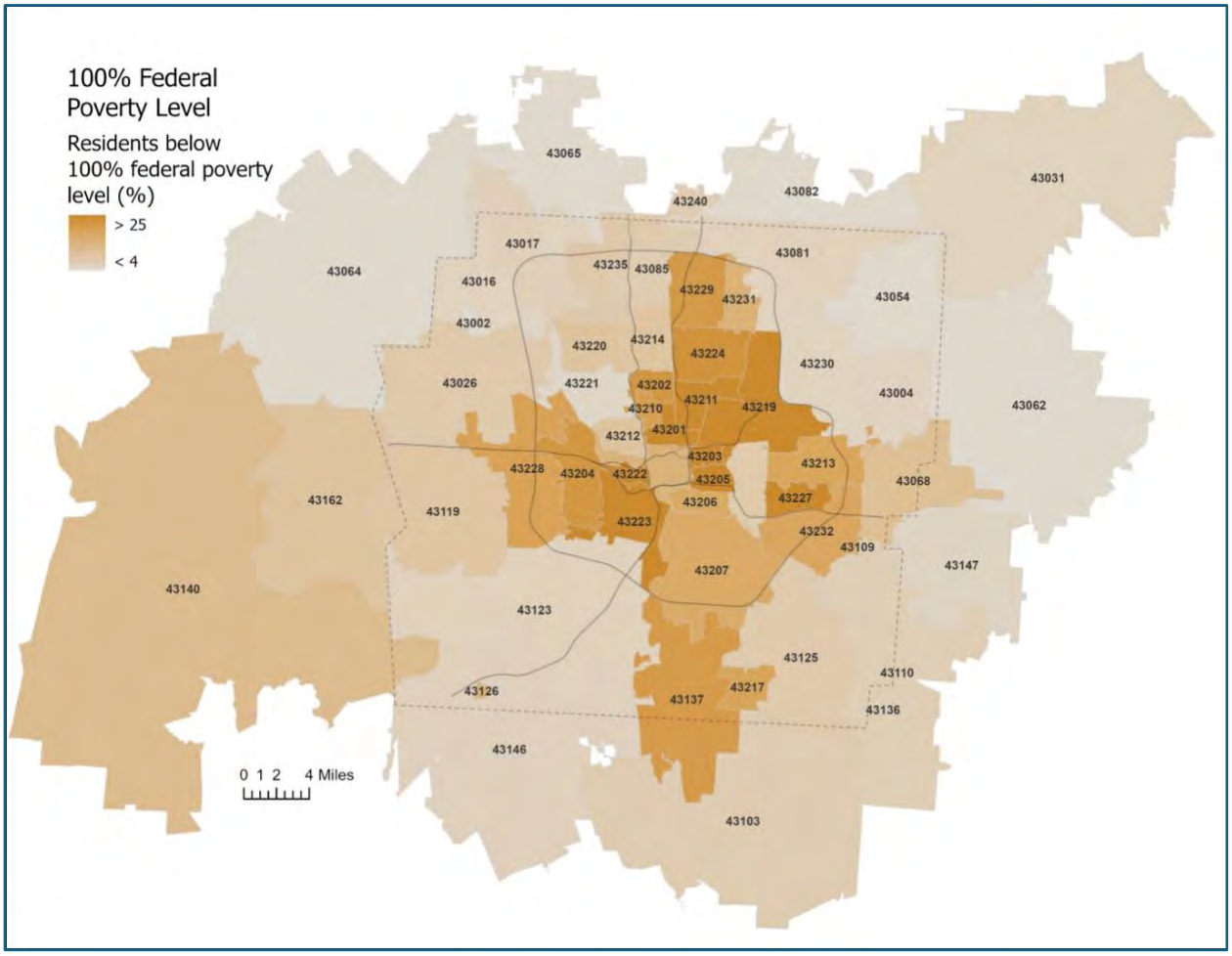
Income Distribution

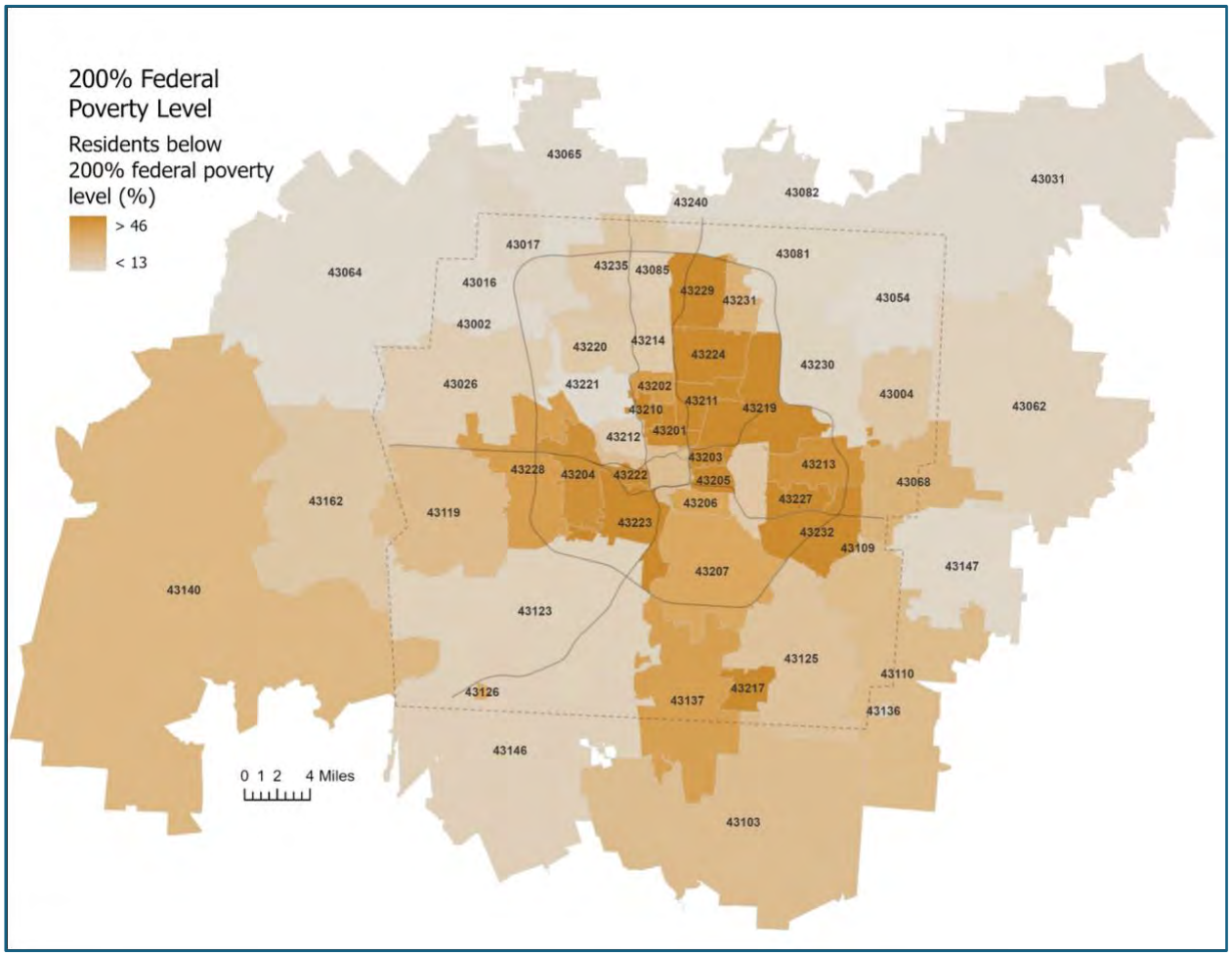
	Below 125% FPL	125%-200% FPL	200% FPL or Below	201%-400% FPL
HM2025	**243,546 (18.8%)**	**147,662 (11.4%)**	**391,208 (30.3%)**	**377,029 (29.2%)**
HM2022	**227,330 (17.7%)**	**162,267 (12.6%)**	**389,597 (30.3%)**	**379,629 (29.5%)**
HM2019	**263,627 (21.4%)**	**143,589 (11.7%)**	**407,216 (33.0%)**	**365,366 (29.6%)**
Ohio	**1,955,282 (17.0%)**	**1,400,699 (12.2%)**	**3,355,981 (29.3%)**	**3,653,884 (31.8%)**
US	**53,141,624 (16.3%)**	**39,178,320 (12.1%)**	**92,319,944 (28.6%)**	**96,703,365 (29.9%)**

As shown in the map below, the zip codes with the lowest median household incomes are concentrated in the north-central part of Franklin County (e.g., 43229, 43224, 43211, 43219), some eastern zip codes (e.g., 43213, 43227, 43232), and some central zip codes (e.g., 43222, 43223).



The next two maps show the percentage of central Ohio residents in each zip code who have an income that is (1) below 100% of the federal poverty level and (2) below 200% of the federal poverty level. Each map tells a similar story: zip codes located in the central-east and central-north areas of Franklin County have greater percentages of residents in poverty.





Additional Information & References

Readers who are interested in learning more about this topic should also read the *HealthMap2025* section that focuses on individuals with disabilities (see page 65).

Data about income and poverty were obtained from the American Community Survey (ACS).[5-7] For *HealthMap2025*, special attention is paid to median income, the percent of individuals near or below the Federal Poverty Level (FPL) as determined by the U.S. Census Bureau, and the number of individuals at specified income brackets.

The income categories 125-200% and 200-400% of the FPL were calculated by subtracting the numbers for 200%-125% and 400%-200%, respectively. Total numbers at each income category were converted into percentages by dividing by the total number for which poverty status was determined in the applicable geographic unit and year.

$$\%(125 - 200\%\ FPL) = \frac{[(n = 200\%FPL) - (n = 125\%FPL)]}{Total\ population\ for\ whom\ poverty\ status\ is\ determined}$$

For example, the HM2025 Franklin County estimate for those with an income at or below the 125-200% FPL was calculated as follows:

$$11.4\% = \frac{[391{,}208 - 243{,}546]}{1{,}290{,}258}$$

The Bureau of Labor Statistics CPI Inflation Calculator[8] was used to adjust the average income values for HM2022 and HM2019 for inflation.

To map the prevalence of these indicators at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the Census Bureau's American Community Survey.[9]

[1] Bosworth B. (2018). Increasing Disparities in Mortality by Socioeconomic Status. *Annual review of public health*, *39*, 237–251. https://doi.org/10.1146/annurev-publhealth-040617-014615

[2] Robert, S. A., Cherepanov, D., Palta, M., Dunham, N. C., Feeny, D., & Fryback, D. G. (2009). Socioeconomic status and age variations in health-related quality of life: results from the national health measurement study. *The journals of gerontology. Series B, Psychological sciences and social sciences*, *64*(3), 378–389.

[3] Kivimäki, M., Batty, G. D., Pentti, J., Shipley, M. J., Sipilä, P. N., Nyberg, S. T., Suominen, S. B., Oksanen, T., Stenholm, S., Virtanen, M., Marmot, M. G., Singh-Manoux, A., Brunner, E. J., Lindbohm, J. V., Ferrie, J. E., & Vahtera, J. (2020). Association between socioeconomic status and the development of mental and physical health conditions in adulthood: a multi-cohort study. *The Lancet. Public health*, *5*(3), e140–e149. https://doi.org/10.1016/S2468-2667(19)30248-8

[4] Begley, C., Basu, R., Lairson, D., Reynolds, T., Dubinsky, S., Newmark, M., Barnwell, F., Hauser, A., & Hesdorffer, D. (2011). Socioeconomic status, health care use, and outcomes: persistence of disparities over time. *Epilepsia*, *52*(5), 957–964. https://doi.org/10.1111/j.1528-1167.2010.02968.x

[5] U.S. Census Bureau. (2022). Median Income in the Past 12 Months (in 2022 Inflation-Adjusted Dollars). *American Community Survey, ACS 1-Year Estimates Subject Tables, Table S1903*. https://data.census.gov/table/ACSST1Y2022.S1903?q=Income and Poverty&g=010XX00US_040XX00US39_050XX00US39049.

[6] U.S. Census Bureau. "Selected Characteristics of People at Specified Levels of Poverty in the Past 12 Months." *American Community Survey, ACS 1-Year Estimates Subject Tables, Table S1703*, 2022, https://data.census.gov/table/ACSST1Y2022.S1703?q=s1703&g=010XX00US_040XX00US39_050XX00US39049.

[7] U.S. Census Bureau. (2022). Poverty Status in the Past 12 Months. *American Community Survey, ACS 1-Year Estimates Subject Tables, Table S1701*. https://data.census.gov/table/ACSST1Y2022.S1701?q=s1701&g=010XX00US_040XX00US39_050XX00US39049.

[8] U.S. Bureau of Labor Statistics. CPI Inflation Calculator. Accessed September 1, 2024 at https://data.bls.gov/cgi-bin/cpicalc.pl?

[9] U.S. Census Bureau. American Community Survey 5-Year Estimates, 2022 (HM2025)

Housing Insecurity

Housing insecurity is associated with decreased healthcare access, increased hospital and emergency department utilization, and worse overall health.[1,2] When individuals must focus on basic needs such as housing, the seemingly "secondary" needs of healthcare may be neglected and cause further downstream health challenges.

31.9% of Franklin County households spend at least 30% of income on **housing**.

↑ Up from HM2022 (28.2%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Unavailable	Unavailable	Unavailable	Observed (see map)

47.5% of Franklin County households are **renting** their housing.

≈ Similar to HM2022 (46.6%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Unavailable	Unavailable	Black, Hispanic more likely	Observed (see map)

2,337 Franklin County residents are **unhoused**.

↑ Up from HM2022 (2,036)

There were **8.7 eviction filings per 100 renter-occupied households in** Franklin County.

↑ Up from HM2022 (7.5)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Unavailable	Unavailable	Unavailable	Observed (see map)

Community Voices

Community members believe it is far too difficult to find an affordable apartment, due not only to the cost of rent, but also to the stipulations of being accepted for low-income apartment options and apartments in general.

> *"I was in an apartment for 18 years, and they put a note on my door and said, we sold the apartment complex, and you have 60 days to move. I had just had surgery, and I found my new apartment, and it was $800 more than what I was paying. And it was the cheaper option. And they sold my apartment to make it low-income housing. But I was out of range for that apartment. But then I wind up paying almost double what I was paying in the old apartment. And it's smaller. I had to rent a garage because I couldn't even fit everything I had in the new apartment, but I'm paying almost double. The pricing is ridiculous."*
>
> *"If you go to just a regular apartment complex and you try to get an apartment, they want you to have a 720 credit score and they want you to have three times the amount of rent every month. And it's like, I don't know anybody who can pay $1,500 or $1,800 and have three times that amount of money a month…and the amount to move in which is like six or seven thousand, because you have to have first month's rent, last month's rent, and security deposit."*

Community members see housing being purchased in their communities by outside investors and say this contributes to the inability of people to buy homes in Franklin County.

> *"There's a guy over here. His name is on everything. I looked him up. He's an investor from New York, and he is buying up everything. Everything. And setting those prices stupid high…I asked the mayor, why can't you guys control [that]? They can't control who buys. I don't know why, but I think that's a horrible thing."*
>
> *"Half of the housing has been bought up by corporations to rent them out. They'll come in all cash, 20% above asking. There's no way in which a person can afford to buy."*
>
> *"Even here on the South Side, it's a lot of gentrification. Houses over here on Thurman Ave, back in the day, you could easily get one of those houses. Now there's nowhere for regular working folks to go."*

Community members believe the quality of housing that is more "affordable" is in poor condition; structural, aesthetic, and security issues go unaddressed by landlords, and the environment overall negatively impacts mental and physical health.

"Say you don't have the money to get the thing that you want. So you only make $1,000 in your paycheck. So you can only afford $500. But the $500 [place], the wall is coming down, the paint peeling. The landlord doesn't care about what it looks like. So now you're living in something that you really don't want to be there. You're stressing about it. 'Oh my God, I need to get out of here. But I can't afford to get out of here.'"

"From what I heard, they're closing all the housing down because they haven't been taking care of it. They've been ran down. Yeah there's affordable housing. At what price? You don't have running water, the hot water goes out, or the locks don't work. And then what? Then you got the people that live there who don't care, who just terrorize the neighborhood. So do you want to live [in] affordable housing where you might get shot when you walk outside, you might have mice, the health department might not even come when you call them? It's one thing if it's just you, but if you got your family, you got kids, you don't want your kids to live like that."

"A lot of these affordable housing units don't have access to doctor's offices that you can get to using public transportation or by walking, or even grocery stores. You can't get fresh food. And so it becomes really difficult for people who maybe don't always have access to a car to get to places where they can take care of their physical or mental health or have access to other things that will improve those things."

"So landlords are just renting and the places are terrible, which is affecting the kids. We have them sign they don't have a lead-based paint, but it doesn't matter because they're not even really doing the repairs, the plumbing. They're letting water sit and kids are coming in with asthma. Our clients have something with the lungs because of black mold. The lack of affordable housing [relates to] the health disparities, especially in the black and brown communities."

Community members also spoke to the difficulty of finding accessible housing for individuals with mobility issues. This causes extra stress on caretakers and can cause unhoused individuals to spend more time in shelters due to the lack of accessible housing in the county.

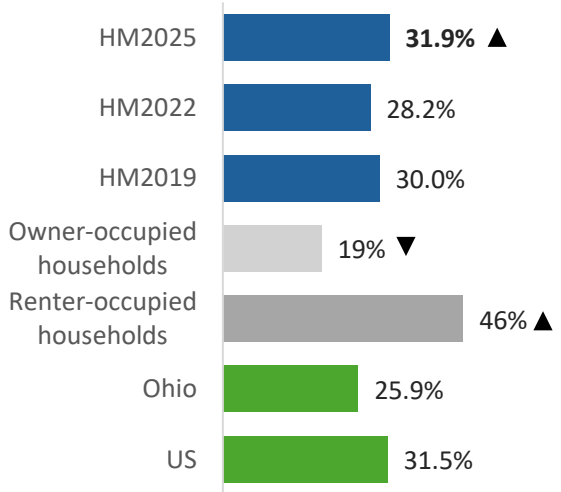
"I work for the homeless shelter, so when it comes to housing, the ones that are on canes, using walkers, it's very hard to find handicap accessible housing. It's not that many options. And the ones that are, they're already filled. So we might have someone who is on a walker who, their stay might be a year and a half because we've been looking for handicapped accessible housing."

> *"Finding housing that's even suitable for somebody who has a lot of healthcare issues has been hard. For example, my mom, she has mobility issues and can't do steps. So finding a ranch home or something just one story was really hard for a long time. And then once you do find a one-story place, you need hallways to be wider to get wheelchairs through. And then you need shower stalls. So I think just in general, if you're disabled and you need housing, where can you find something that's accessible to your needs? That's really hard."*

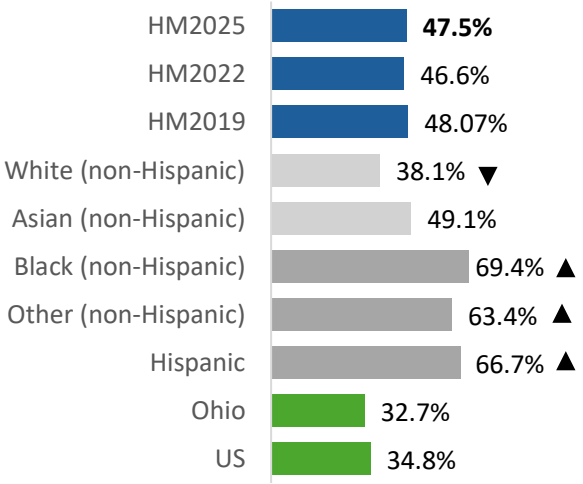
Unfortunately, housing insecurity has not improved since *HealthMap2022*. The percentage of cost-burdened households – those that spend 30% or more of their monthly household income on housing costs – has increased. Furthermore, nearly half of renter-occupied households in Franklin County are cost-burdened.

Homeownership offers an opportunity to for individuals and families to build wealth and economic security.[4] Unfortunately, significant racial disparities were noted among those who don't yet live in (or choose not to live in) owner-occupied housing. Black (non-Hispanic) individuals, Hispanic individuals, and individuals with an other (non-Hispanic) racial background were more likely than white (non-Hispanic) individuals or individuals with an Asian racial background to be renters.

Cost Burdened Households (≥30%)



Renter-occupied Housing Units



The most recent "point-in-time" estimate of unhoused individuals in Franklin County found that this number has increased substantially compared to previous years. Relatedly, the eviction rate in Franklin County has increased since *HealthMap2022* and is above the state average. Per data provided by the Franklin County Municipal Court and collated by the Eviction Lab[3], there were 23,762 evictions in 2023, a 14% increase from 2022.

Unhousked Community Members

	Point in Time Estimate
HM2025	2,380 ▲
HM2022	2,036
HM2019	1,229
Ohio	11,386
US	653,104 ▲

Eviction Filing Rate

	Rate per 100 renter households
HM2025	8.7% ▲
HM2022	7.5%
Ohio	6.2%

Healthy People 2030

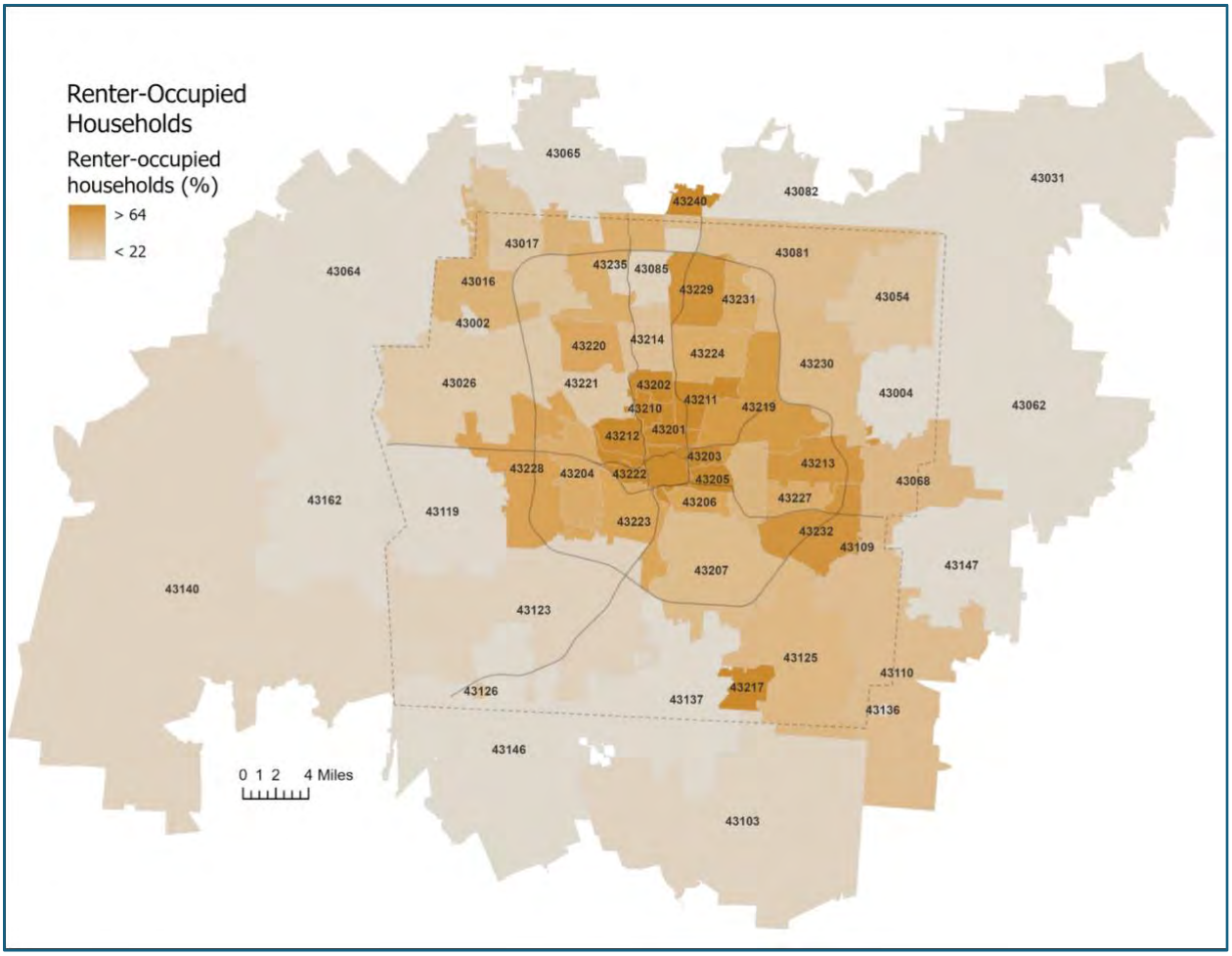
Unfortunately, Franklin County is moving further away from the Healthy People 2030 objective on housing cost burden.[5] Further intervention is likely needed to address this issue facing many Franklin County residents.

HP2030 objective for families spending ≥ 30% of income on housing: Not met

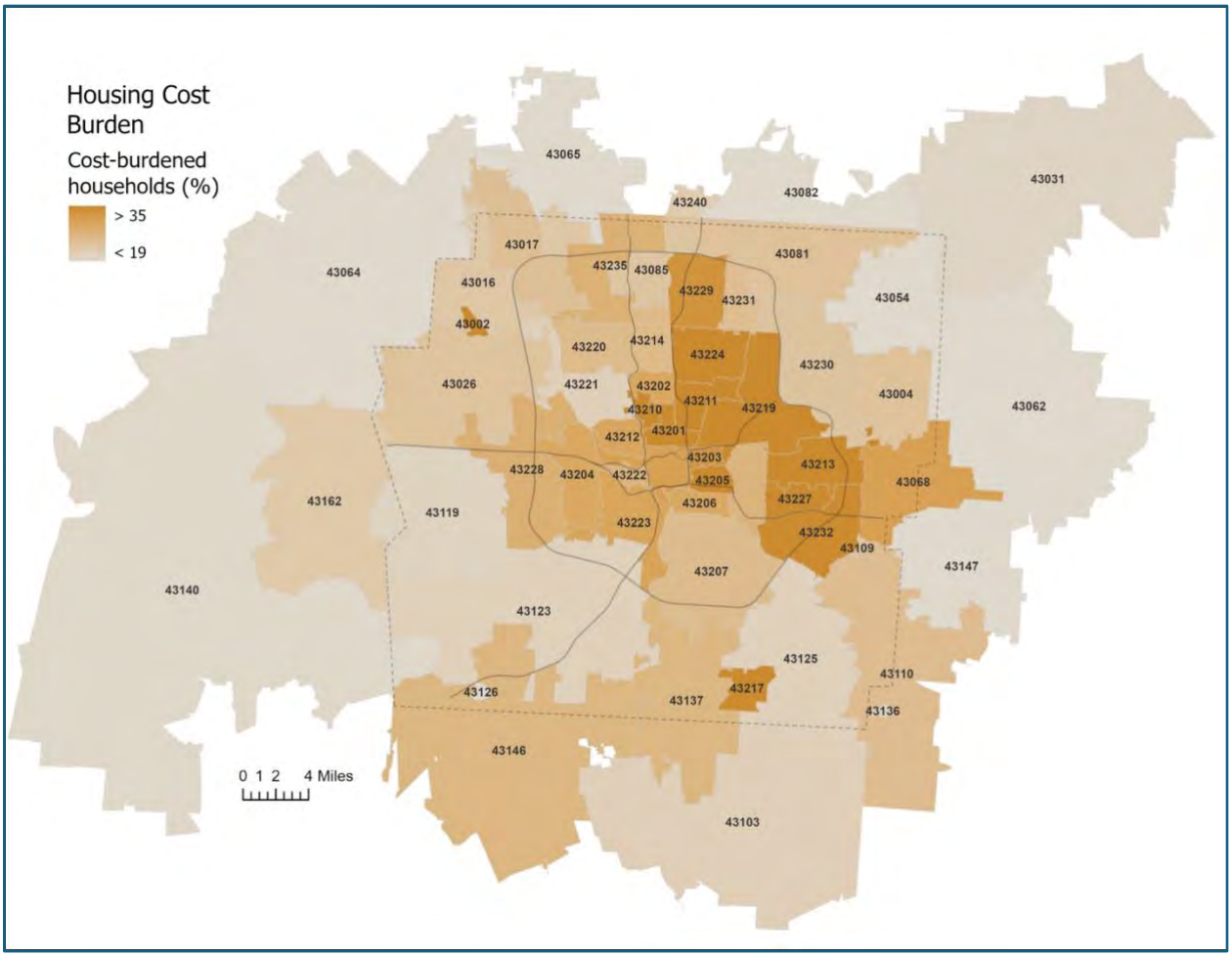
Healthy People Objective:
25.5%

Most recent Franklin County data (HM2025)
31.9%

As shown in the map below, the zip codes with the greatest percentage of renter-occupied housing units are concentrated in the central part of Franklin County (e.g., 43222, 43212, 43201, 43203, 43205, 43210, 43202, 43211).



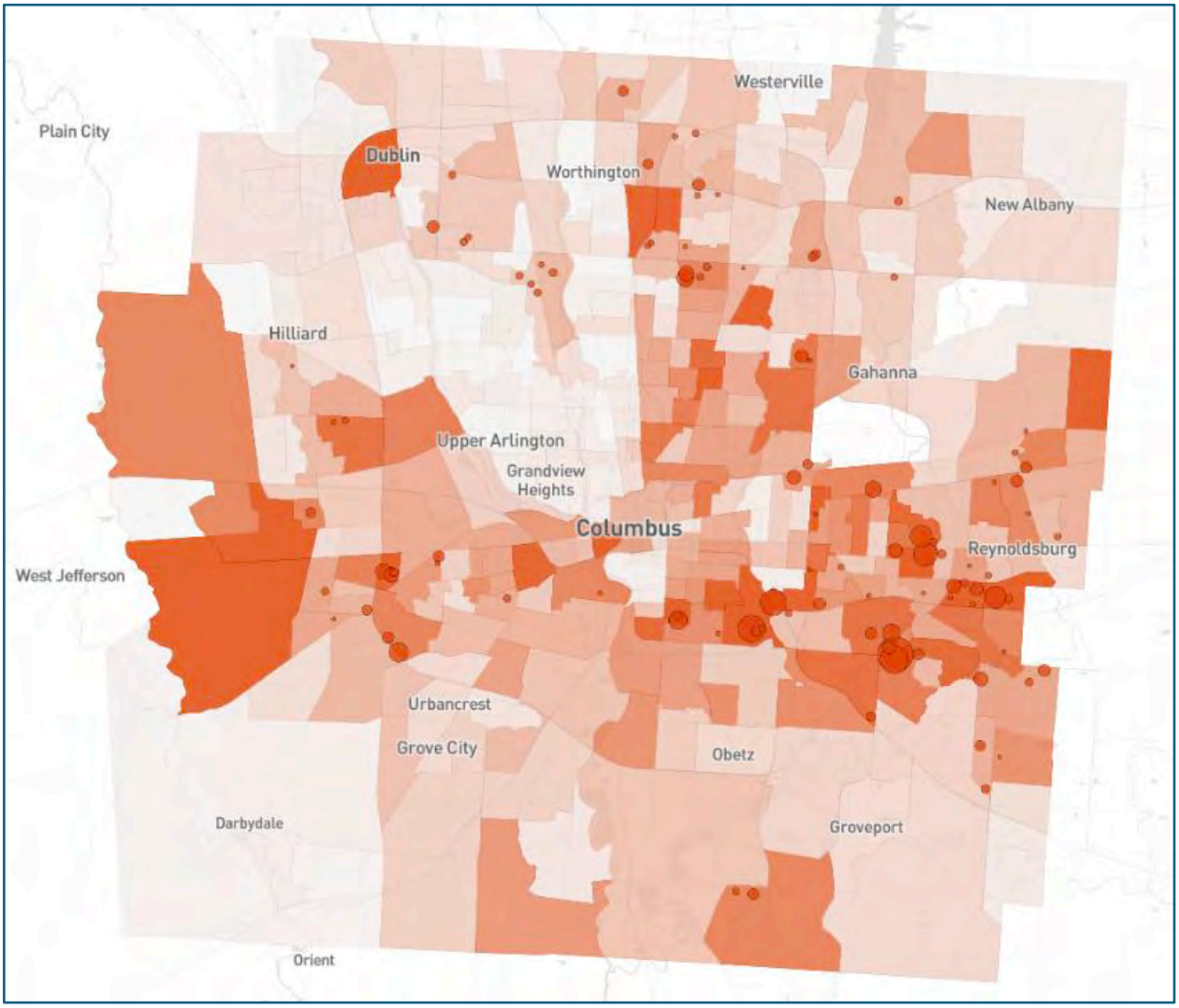
The zip codes with the greatest percentage of cost burdened households (i.e., an overall burden of 30% or higher) are concentrated in the eastern and north-central parts of Franklin County (e.g., 43213, 43227, 43232, 43219, 43211, 43224).



The map below is a screenshot of the eviction filing rate across Franklin County's census tracts since August 1, 2023, as mapped by the Eviction Lab. Census tracts with relatively higher rates of eviction filings are shown in darker colors.

Additionally, the "top 100 eviction hotspots" in the county are shown in the map as circles, with each circle representing a building that had a relatively large number of eviction filings. As the size of a circle increases, the number of evictions associated with that building also increases. Within Franklin County, many eviction hotspots are in east-central and far eastern census tracts (corresponding roughly to zip codes 43205, 43206, 43213, 4327, 43232, and 43068) as well as in western census tracts (corresponding roughly to zip codes 43228, 43123, 43119).

Readers who are interested in learning more about this topic are encouraged to visit the Eviction Lab's interactive map, which can be accessed by **clicking here**.



Additional Information & References

Readers who are interested in learning more about this topic should also read the *HealthMap2025* section that focuses on individuals with disabilities (see page 65).

Data about housing insecurity were obtained from the American Community Survey.[6,7] To assess the count of unhoused individuals, Point-In-Time (PIT) estimates were sourced from the Community Shelter Board of Franklin County and the U.S. Department of Housing Annual Homeless Assessment Report to Congress.[8,9] In this assessment, "unhoused" includes sheltered, unsheltered, and transitional housing residents. Eviction data were obtained from the Ohio Housing Finance Agency and from the Eviction Lab.[3,10,11]

Readers should be cautious when comparing estimates between different geographic regions such as Franklin County and Ohio. For example, estimates of people in renter-occupied housing may differ simply due to how Franklin County is largely a dense, urban/suburban area. The statewide estimate, of course, includes many rural areas that are less populated as well as highly populated urban/suburban areas.

The eviction filing rate is the number of new eviction filings per 100 renter-occupied households. Unfortunately, there are no centralized, recent sources of eviction data at the national level. At the time of this report's writing, the best source for information at that geographic level was the Eviction Lab, which offered nationwide estimates from 2018.

To map the prevalence of these indicators at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the Census Bureau's American Community Survey.[12]

[1] Bhat, A. C., Almeida, D. M., Fenelon, A., & Santos-Lozada, A. R. (2022). A longitudinal analysis of the relationship between housing insecurity and physical health among midlife and aging adults in the United States. *SSM - population health*, *18*, 101128. https://doi.org/10.1016/j.ssmph.2022.101128

[2] Kushel, M. B., Gupta, R., Gee, L., & Haas, J. S. (2006). Housing instability and food insecurity as barriers to health care among low-income Americans. *Journal of general internal medicine*, *21*(1), 71–77. https://doi.org/10.1111/j.1525-1497.2005.00278.x

[3] Eviction Lab. Eviction Tracking > Columbus, OH. https://evictionlab.org/eviction-tracking/columbus-oh/

[4] Urban Institute. (2021). Tracking Homeownership Wealth Gaps. https://apps.urban.org/features/tracking-housing-wealth-equity/

[5] Healthy People 2030 objective SDOH-04, U.S. Department of Health and Human Services

[6] U.S. Census Bureau. (2022). Financial Characteristics. American Community Survey, ACS 1-Year Estimates Subject Tables, Table S2503. https://data.census.gov/table/ACSST1Y2022.S2503?q=housing&g=010XX00US_040XX00US39_050XX00US39049.

[7] U.S. Census Bureau. (2022). Demographic Characteristics for Occupied Housing Units. American Community Survey, ACS 1-Year Estimates Subject Tables, Table S2502. https://data.census.gov/table/ACSST1Y2022.S2502?q=housing&g=010XX00US_040XX00US39_050XX00US39049&y=2022.

[8] Community Shelter Board. (2023). *Columbus region leaders introduce new action on homelessness*. https://www.csb.org/cdn/files-Columbus-region-leaders-introduce-new-action-as-data-shows-increase-in-homeless-count.pdf

[9] De Sousa, T., Andrichik, A., Cuellar, M., Marson, J., Prestera, E., & Rush, K. (2022). *The 2022 annual homelessness assessment report (AHAR) to Congress.* US Department of Housing and Urban Development.

[10] Ohio Housing Finance Agency. (2023) FY 2024 Housing Needs Assessment [Interactive Tool]. Retrieved in 2024 from https://ohiohome.org/research/housinginsecurity-23.aspx

[11] Ohio Housing Finance Agency. (2021) FY 2021 Housing Needs Assessment [Interactive Tool]. Retrieved in 2024 from https://ohiohome.org/research/housinginsecurity-hna.aspx

[12] U.S. Census Bureau. American Community Survey 5-Year Estimates, 2022 (HM2025)

The Eviction Lab's interactive map can be accessed at https://evictionlab.org/eviction-tracking/columbus-oh/.

Food Insecurity

Food insecurity increases the risk for a variety of physical and psychological illnesses, including heart disease and depression.[1,2] This risk is particularly notable for children, who are at risk for developmental and health consequences related to prenatal and early childhood food insecurity.[3]

13.5% of Franklin County residents experience **food insecurity**.

≈ Similar to HM2022 (12.8%)

Community Voices

Community members emphasized that being able to source and prepare healthy foods is related to income status. While the expense of healthy food is one thing that precludes food security, the energy and time it takes to ensure that their families eat healthy also hinders families' efforts to eat nutritious meals.

> *"It takes a certain amount of bandwidth to deal with nutrition. Like if you're already worn out from your day working and you have all these other stresses going on, and you might not necessarily have the finances to buy the more expensive food that's organic or healthier for you…So in our experience, you only have so much energy, whether it's physical, emotional… and you spend it where you spend it. Maybe it would better to spend it on nutrition, but that's usually the last thing or one of the last things that we think about."*
>
> *"In my family, I've seen children who are in a lower income status that [their] parents have to work these multiple jobs, so then they're left to their own devices of microwavable things, air fry things, quick things. So then you're not getting proper nutrition. So then your brain is not even really developing to be of attention at school. So it's all connected."*

Many community members mentioned that their neighborhoods in Franklin County are still healthy food deserts, because grocery stores and healthy restaurant options are not accessible within a short distance of their homes. Residents also mentioned that the quality and variety of healthy food sold by grocery stores is lacking in lower income communities as compared to more affluent communities.

> *"I noticed in my neighborhood, I'm not in a bad area, but it's a lot of fast food and fried stuff. So, when we go out to eat, we go to Bexley, eight minutes' drive west of us. We go there. I grocery shop there. I do everything there."*

"This [grocery store] down here is like the nearest thing to me that has a variety, but they don't have that much either. They limit what we can get there. If you go to another [grocery store], they've got so much more."

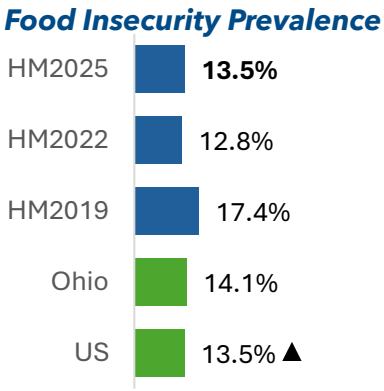
"A grocery store is here, but it's far away from the inner community, so they either have to have somebody bring it to them, or they have to drive. It's not within walking distance. And then there's not a lot of fresh stuff. Like, everything is packaged or processed."

Personal work schedules and transportation issues also contribute to the ability of community members to access nutritious food easily.

"I get off work usually late at night, sometimes 10:00 p.m., even later. There's very few restaurants open that late, especially on weekdays. And your choices if you need to pick up a bite to eat on the way home from work are—since the pandemic, most restaurants I used to go to, they've cut their hours just in order to save money, but that doesn't help me."

"I didn't have a car for three months, and I found myself trying to figure out dinner from Family Dollar because it was the only thing I could walk to. Sometimes you just can't get to some of the other places to do that."

Although food insecurity prevalence in Franklin County has improved since *HM2019* (which reported 2016 data), progress has seemingly stalled since *HM2022* (which reported 2019 data). The slight increase from *HealthMap2022* and *HealthMap2025* (which reports 2022 data) may be attributable in part to the onset of the COVID-19 pandemic, which disrupted food systems for many households. Food insecurity has risen significantly nationwide.



Healthy People 2030

As communities continue their recovery from the COVID-19 pandemic, Franklin County's progress towards the Healthy People 2030 objective for reducing food insecurity should be monitored. [5]

HP2030 objective for Food Insecurity: Not met

Healthy People Objective:	Most recent Franklin County data (HM2025)
6%	**13.5%**

Additional Information & References

Readers who are interested in learning more about this topic should also read the *HealthMap2025* section that focuses on individuals with disabilities (see page 65).

Food insecurity data were gathered from the Feeding America interactive tool. That report estimates the percentage of individuals who lack access, at times, to enough food for an active, healthy life, per a set of variables that correspond with the U.S. Department of Agriculture's definition of "food security" as well as known risk factors.

Data Gap: The Community Health Needs Assessment Steering Committee requested recent data about the proportion of residents who qualify for WIC but who are not enrolled. Unfortunately, the Ohio Department of Health does not currently have a method for estimating the number of eligible WIC participants at the county level; such an estimate can only be generated for the state overall.

[1] Parekh, T., Xue, H., Cheskin, L. J., & Cuellar, A. E. (2022). Food insecurity and housing instability as determinants of cardiovascular health outcomes: A systematic review. *Nutrition, metabolism, and cardiovascular diseases : NMCD*, *32*(7), 1590–1608. https://doi.org/10.1016/j.numecd.2022.03.025

[2] Pourmotabbed, A., Moradi, S., Babaei, A., Ghavami, A., Mohammadi, H., Jalili, C., Symonds, M. E., & Miraghajani, M. (2020). Food insecurity and mental health: a systematic review and meta-analysis. *Public health nutrition*, *23*(10), 1778–1790. https://doi.org/10.1017/S136898001900435X

[3] Simonovich, S. D., Pineros-Leano, M., Ali, A., Awosika, O., Herman, A., Withington, M. H. C., Loiacono, B., Cory, M., Estrada, M., Soto, D., & Buscemi, J. (2020). A systematic review examining the relationship between food insecurity and early childhood physiological health outcomes. *Translational behavioral medicine*, *10*(5), 1086–1097. https://doi.org/10.1093/tbm/ibaa021

[4] Feeding America. (2022) Food Insecurity among the Overall Population in the United States [Interactive Map]. Retrieved in 2024 from https://map.feedingamerica.org/

[5] Healthy People 2030 objective NWS-01, U.S. Department of Health and Human Services

Health Insurance

Health insurance is a vital component of healthcare, particularly in the market-based healthcare model of the United States. Individuals who do not have insurance receive less and poorer quality healthcare, worse health outcomes, and a lower life expectancy.[1] A high proportion of uninsured patients also strains the healthcare system when services are used without subsequent payment, which can reduce overall healthcare availability in the community.[1]

92.4% of Franklin County residents are **insured**.

≈ Similar to HM2022 (92%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
18-64 less likely	Male less likely	Black, Hispanic less likely	Observed (see map)

Community Voices

Members of the community who have Medicaid or Medicare find it difficult to get reliable health care because many organizations do not accept their insurance, or they stop taking it.

> *"Most of our clients have Medicaid, but some of our clients are still under parents' insurance, which that doesn't help. So it doesn't matter if you have Medicaid or private insurance, because a lot of the places that accept private insurance, they don't accept Medicaid, or they accept Medicaid, but they don't accept private insurance. And either way, the waitlist is over six months."*
>
> *"When I moved here trying to get a counselor, I found a counselor and I have insurance from my retirement which is Medicare, but through an employer. So it's decent insurance. Well, then they stopped taking it."*

Community members spoke about the difficulty of affording medications whether they do or do not have insurance.

> *"I have a friend who has to work a second job just for her insulin, just to pay for her insulin. Like, that's it. Her primary job is a good job."*
>
> *"Not being able to afford certain medications or you have a certain medication, they take you off that medication because they can't cover it anymore."*

> *"One of the medications that I was on when we lost our insurance and we didn't have any insurance, it was $1,646 for one month. So obviously, I stopped taking it, and I couldn't even afford to go to the doctor to get a replacement sort of thing. So it's ridiculous how much things cost."*
>
> *"You have to go through this step-by-step process for the insurance to cover it."*

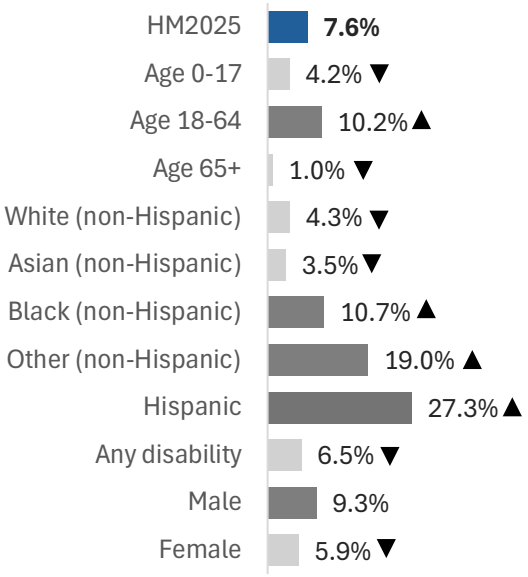
Franklin County residents also perceive that the quality of health care they receive depends on their health insurance. Specifically, they think those with Medicaid are more likely to experience rudeness from medical staff and inadequate treatment.

> *"Because they know that you're on Medicaid, 'Oh this your fifth baby. We tired of you.' I'm a staff member. I see it so much. Because what happens is, 'Is this your fifth baby? You should know what you're doing. You should get your tubes tied.' I've seen a lot of judgment."*
>
> *"I've had [this child] for a year now and with the insurance, you do get different treatment. I found out just last week that she has a brain bleed that has gone untreated for a whole year. So now I'm fighting with them about that. Like, why haven't we seen neurology? Why hasn't there been a follow up MRI or anything? So, yeah, I don't feel confident with the hospital. My kids always had private insurance. So when I would hear people tell me the horror stories about children and the care they've received, I was like, 'we don't go through that.' But since having her I've seen it."*

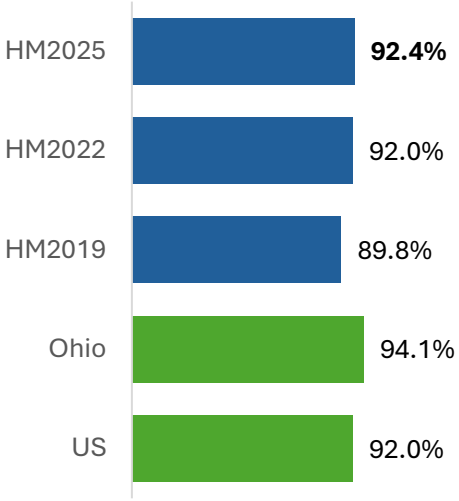
The vast majority of Franklin County residents are insured. The greatest disparities can be seen through the lenses of race and ethnicity, with Hispanic residents being significantly more likely to be uninsured than any other group. This may indicate the presence of cultural, language, or legal/political barriers. Adults age 18-64 are more likely to be uninsured than children or elderly people, which likely reflects the differences in eligibility for government-subsidized insurance plans.

Compared to Ohio or the United States, Franklin County has a higher rate of insured children as well as higher Group VIII Medicaid participation (i.e., an expansion that provided insurance access to adults who were between the ages of 19-64, who had an income less than 138% FPL, and who weren't eligible for another Medicaid category).

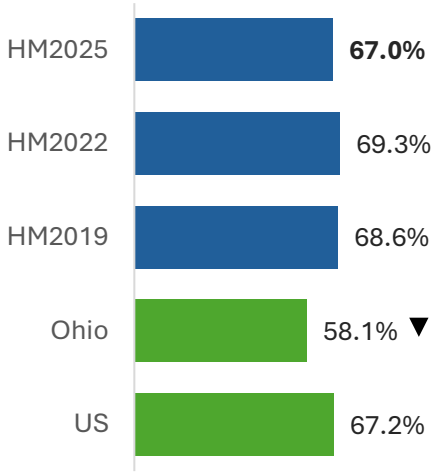
Uninsured Rate



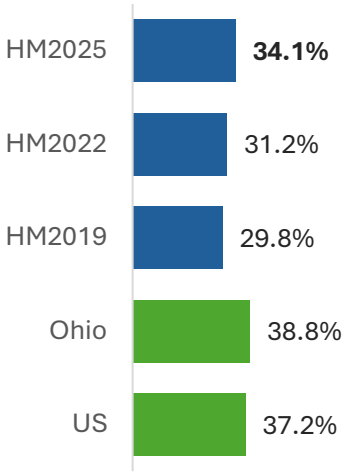
Insured Rate



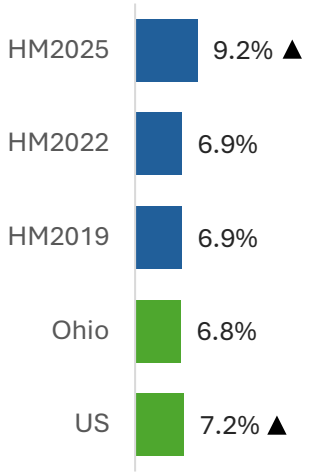
Private Health Insurance



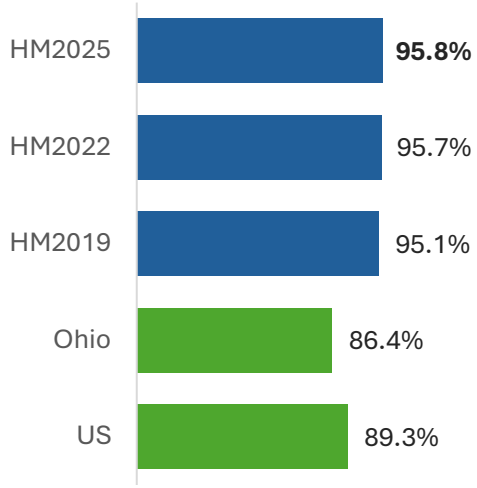
Public Health Insurance



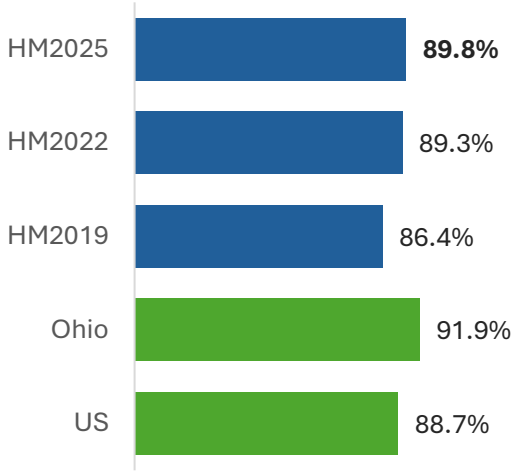
Group VIII Medicaid Insured



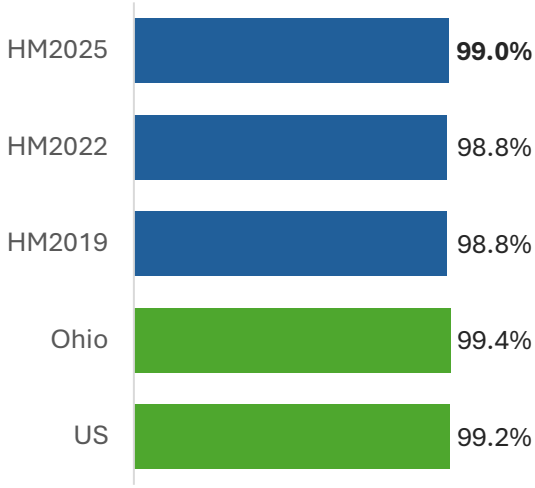
Insured Rate (ages 0-17)



Insured Rate (ages 18-64)



Insured Rate (ages 65+)



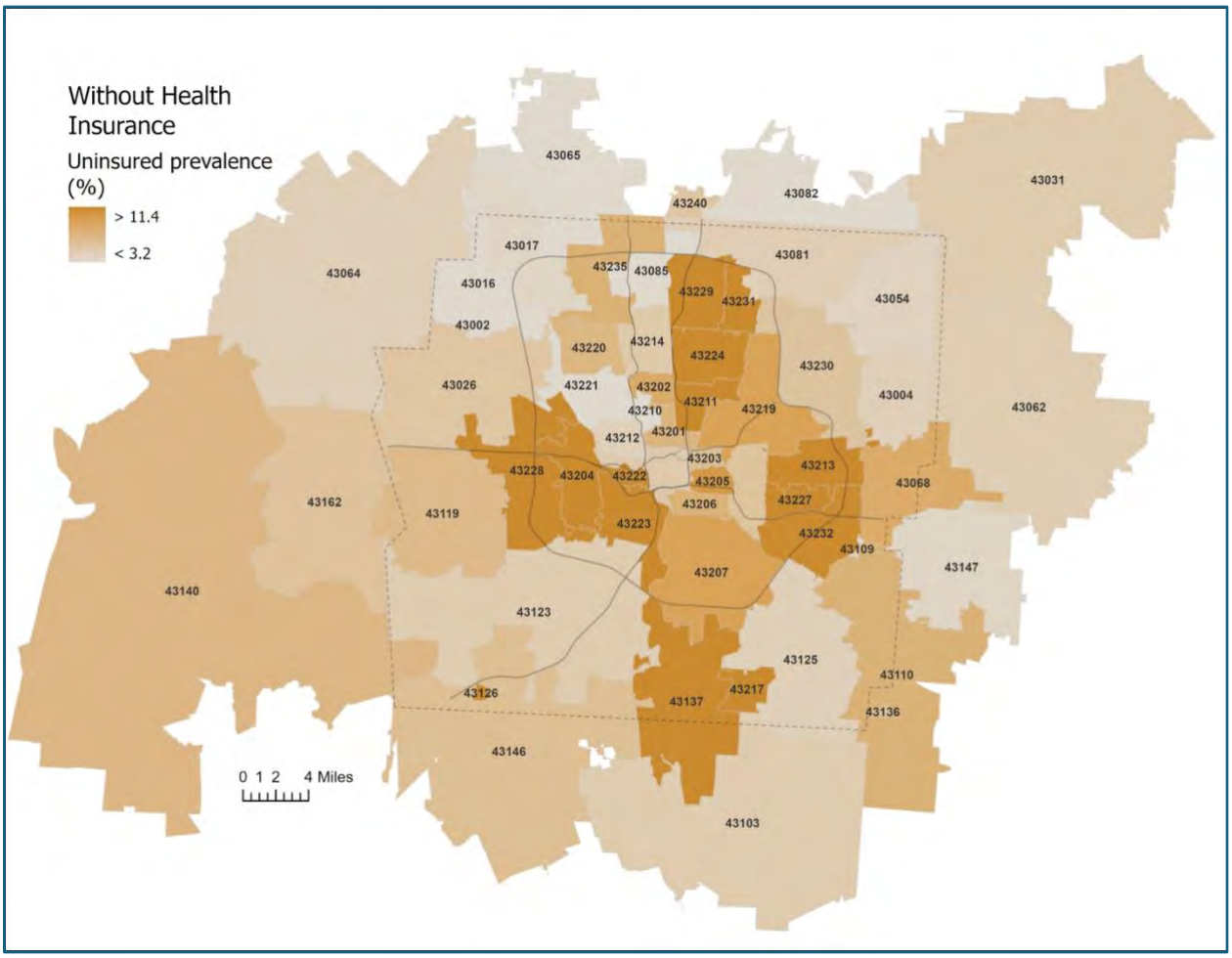
Healthy People 2030

Since HM2022, Franklin County has officially met the Healthy People 2030 objective for health insurance rates.[2] There is still progress to be made among adults age 18-64 as well as for racial and ethnic minorities, but this is a significant achievement for Franklin County.

HP2030 objective for proportion of people with health insurance: Met

Healthy People Objective:	Most recent Franklin County data (HM2025)
92.4%	**92.4%**

Franklin County zip codes with the greatest percentage of people without health insurance are concentrated in west-central zip codes (e.g., 43222, 43223, 43204, 43228), north-central zip codes (e.g., 43211, 43224, 43229, 43231), far eastern zip codes (e.g., 43213, 43227, 43232), and far southern zip codes (e.g., 43137, 43217).



Additional Information & References

To measure the insured status of residents, we used data from the American Community Survey.[3-5] For Medicaid Group VIII (Medicaid Expansion), we used the Ohio Department of Medicaid Annual Enrollment Dashboard and the federal Medicaid enrollment dataset.[6,7] The data for all metrics were collected for 2022, 2019, and 2016.

To map the prevalence of this indicator at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the Census Bureau's American Community Survey.[8]

[1] Institute of Medicine (US) Committee on the Consequences of Uninsurance. (2004). *Insuring America's Health: Principles and Recommendations*. National Academies Press (US).

[2] Healthy People 2030 objective AHS-01, U.S. Department of Health and Human Services

[3] U.S. Census Bureau. (2022). Selected Characteristics of Health Insurance Coverage in the United States. *American Community Survey, ACS 1-Year Estimates Subject Tables, Table S2701*. https://data.census.gov/table/ACSST1Y2022.S2701?q=s2701&g=010XX00US_040XX00US39_050XX00US39049.

[4] U.S. Census Bureau. (2022). Private Health Insurance Coverage by Type and Selected Characteristics. *American Community Survey, ACS 1-Year Estimates Subject Tables, Table S2703*. https://data.census.gov/table/ACSST1Y2022.S2703?q=Health Insurance&g=010XX00US_040XX00US39_050XX00US39049&y=2022.

[5] U.S. Census Bureau. (2022). Public Health Insurance Coverage by Type and Selected Characteristics. *American Community Survey, ACS 1-Year Estimates Subject Tables, Table S2704*. https://data.census.gov/table/ACSST1Y2022.S2704?q=Health Insurance&g=010XX00US_040XX00US39_050XX00US39049&y=2022.

[6] Ohio Department of Medicaid. (2022). Annual Medicaid Demographic and Expenditure Dashboard [interactive tool]. Retrieved in 2024 from https://analytics.das.ohio.gov/t/ODMPUB/views/MDE-AnnualView/Home?%3AshowAppBanner=false&%3Adisplay_count=n&%3AshowVizHome=n&%3Aorigin=viz_share_link&%3AisGuestRedirectFromVizportal=y&%3Aembed=y

[7] U.S. Centers for Medicare & Medicaid Services. (2022). Medicaid Enrollment - New Adult Group [interactive tool]. Retrieved in 2024 from https://data.medicaid.gov/dataset/6c114b2c-cb83-559b-832f-4d8b06d6c1b9

[8] U.S. Census Bureau. American Community Survey 5-Year Estimates, 2022 (HM2025)

Adverse Childhood Experiences (ACEs)

Adverse childhood experiences (ACEs) are traumatic events that occur during childhood (i.e., before age 18), including violence, abuse, or neglect.[1] ACEs also include contextual factors that might negatively affect a child's sense of safety or stability, such as growing up in a household with people who have substance use problems, mental health problems, or parents who were separated or in jail.

Per the Center on the Developing Child at Harvard University, "There is a powerful, persistent correlation between the more ACEs experienced and the greater the chance of poor outcomes later in life, including dramatically increased risk of heart disease, diabetes, obesity, depression, substance abuse, smoking, poor academic achievement, time out of work, and early death."[2]

17% of Franklin County adults have **4 or more ACEs**.

New metric for HM2025

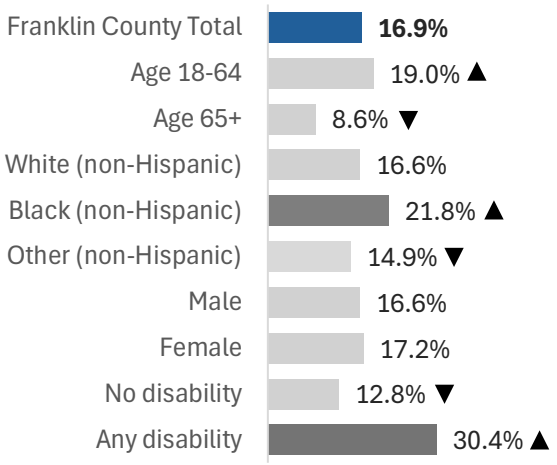
Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
18-64 more likely	None observed	Black more likely	Observed (see map)

Adults with any type of disability are more likely than others to report having 4 or more ACEs when they were children, as are those aged 18-64 and black (non-Hispanic) individuals.[4]

As shown on the next page, the four most frequently reported types of ACEs among Franklin County adults include (1) emotional abuse; (2) parents' separation/divorce; (3) living with someone who was a problem drinker / used illegal drugs / abused prescription medication; and (4) physical abuse.

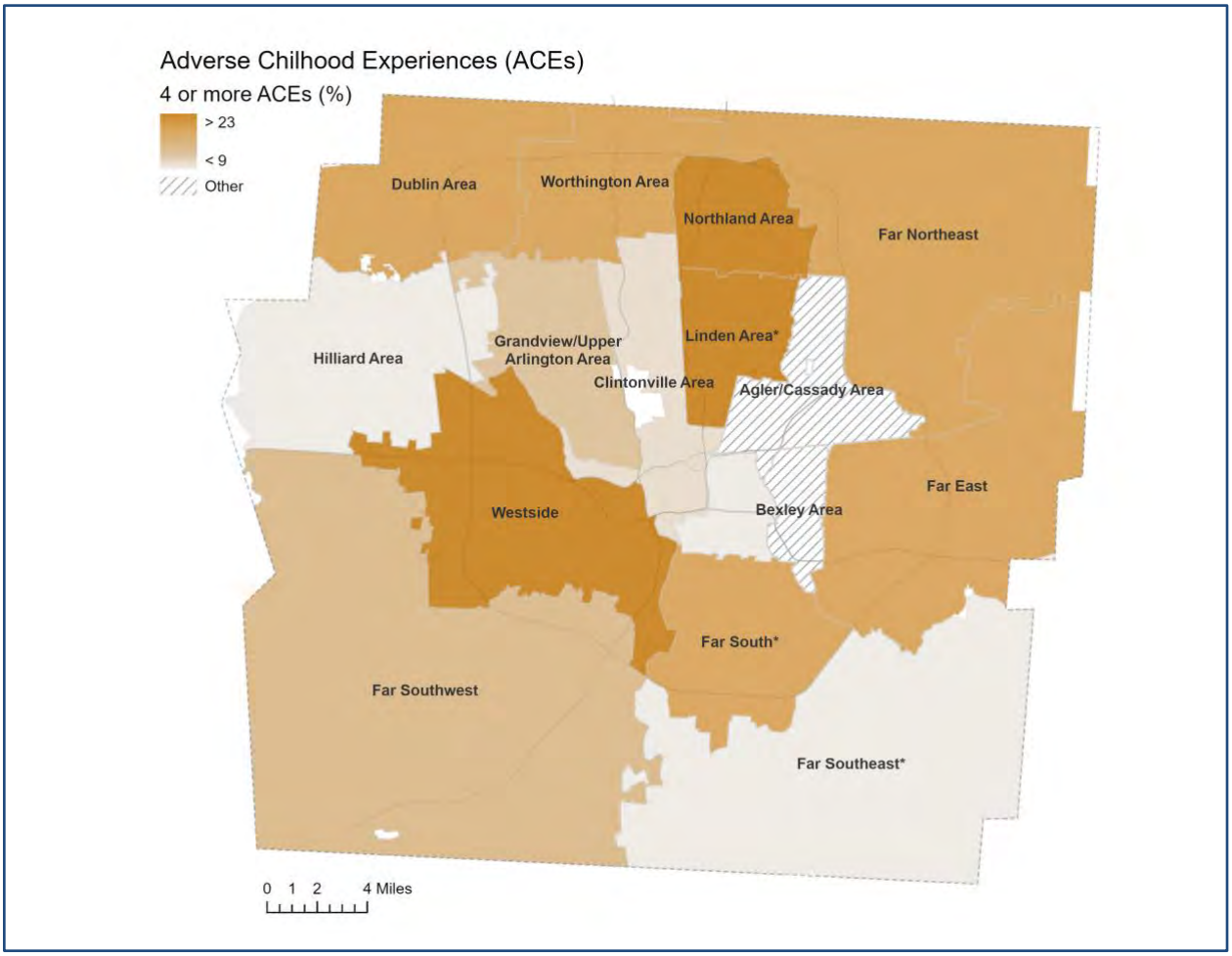
Four or more ACEs among adults 18+ in Franklin County



ACEs prevalence among adults 18+ in Franklin County

Experienced emotional abuse	**40.8%**
Parents separated or divorced (*excludes those whose parents were not married*)	**35.1%**
Someone in household was a problem drinker or alcoholic, or used illegal drugs or abused prescription medication	**30.7%**
Experienced physical abuse	**29.8%**
Someone in household was depressed, mentally ill, or suicidal	23.7%
Parents physically hurt each other	18.2%
Someone in household served time in prison, jail, or other correctional facility	10.9%
Experienced sexual abuse	5.9%

As shown in the map below, a greater percentage of adults in the Linden, Northland, or Westside areas report having experienced 4 or more ACEs as a child, compared to adults in other areas. Estimates marked by an asterisk (*) are based on fewer than 50 respondents and are considered statistically unreliable; therefore, caution should be used when interpreting these estimates.



The Agler/Cassady and Bexley areas are shown in a crosshatch pattern because the estimates for those areas are based on <40 respondents, and therefore are not reported.

Additional Information & References

To assess the prevalence of ACEs among Franklin County's adult population, Columbus Public Health staff obtained recent data from the Behavioral Risk Factor Surveillance System, which completes structured survey interviews with residents via telephone. In addition to combining and analyzing several years of data (2019, 2021, 2022), Columbus Public Health also combined the data from several contiguous zip codes in order to create larger geographic areas; most of those geographic areas then had a sufficient sample size that would permit an analysis and mapping of the indicator.[3] Franklin County Public Health staff then mapped the prevalence of this indicator across the selected geographic areas that had a sufficient sample size.

[1] Centers for Disease Control and Prevention. (n.d.) About Adverse Childhood Experiences. https://www.cdc.gov/aces/about/index.html

[1] Harvard University, Center on the Developing Child. (n.d.) ACEs and Toxic Stress: Frequently Asked Questions. https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions/

[3] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data, 2022 (HM2025), 2019 (HM2022), 2016 (HM2019)

[4] Swedo EA, Aslam MV, Dahlberg LL, et al. Prevalence of Adverse Childhood Experiences Among U.S. Adults — Behavioral Risk Factor Surveillance System, 2011–2020. MMWR Morb Mortal Wkly Rep 2023;72:707–715. DOI: http://dx.doi.org/10.15585/mmwr.mm7226a2

CHRONIC CONDITIONS

Chronic Condition Prevalence

The U.S. Centers for Disease Control and Prevention defines chronic diseases as conditions that last 1 year or more and require ongoing medical attention and/or place limits on one's daily activities. Such diseases are thought to be a major contributor to the nation's annual health care costs, which in recent years has approached $4.5 trillion.[1]

32% of Franklin County adults reported having **high cholesterol**.

≈ Similar to HM2022 (30.2%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
65+ more likely	None observed	White more likely	Observed (see map)

32% of Franklin County adults reported having **high blood pressure**.

↓ Down from HM2022 (36.2%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
65+ more likely	None observed	Black more likely	Observed (see map)

25.4% of Franklin County adults reported ever having **arthritis**.

≈ Similar to HM2022 (27.5%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
65+ more likely	Female more likely	White more likely	Observed (see map)

11.2% of Franklin County adults reported ever having **diabetes**.

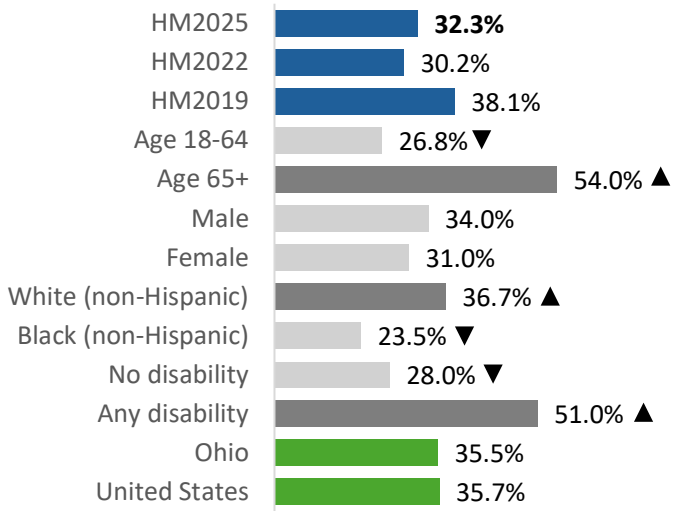
≈ Similar to HM2022 (10.6%)

Disparities by selected social determinants of health

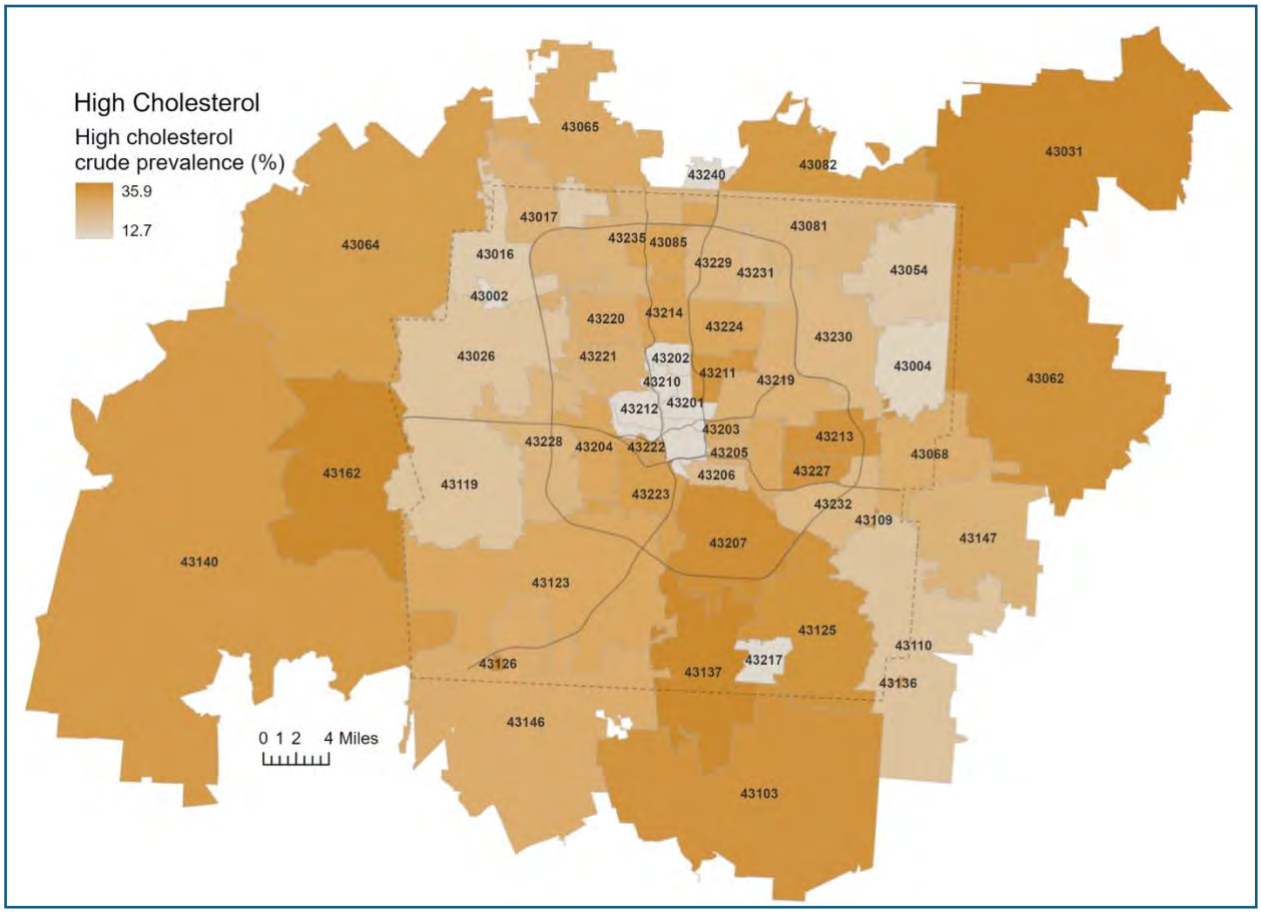
Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
65+ more likely	None observed	Black more likely	Observed (see map)

HIGH CHOLESTEROL

Older adults and individuals with a disability are more likely to report this health condition. Note there is an increased rate of high cholesterol among white (non-Hispanic) residents as opposed to black (non-Hispanic) residents. This is a condition that may not present with urgent symptoms, instead being caught via blood tests that often occur in the context of primary/preventative care. Therefore, the disparities observed among racial groups might also partially reflect healthcare access disparities.[2]



High cholesterol prevalence is higher in most Franklin County zip codes that are to the east and south, especially 43211, 43213, 43227, 43207, and 43137.

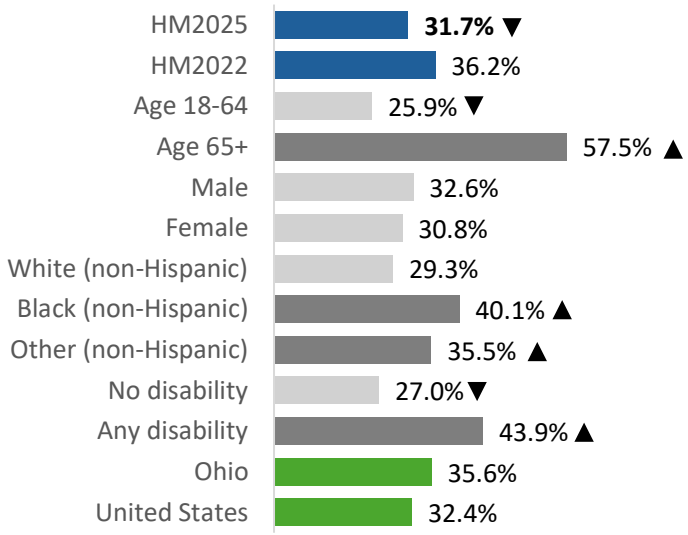


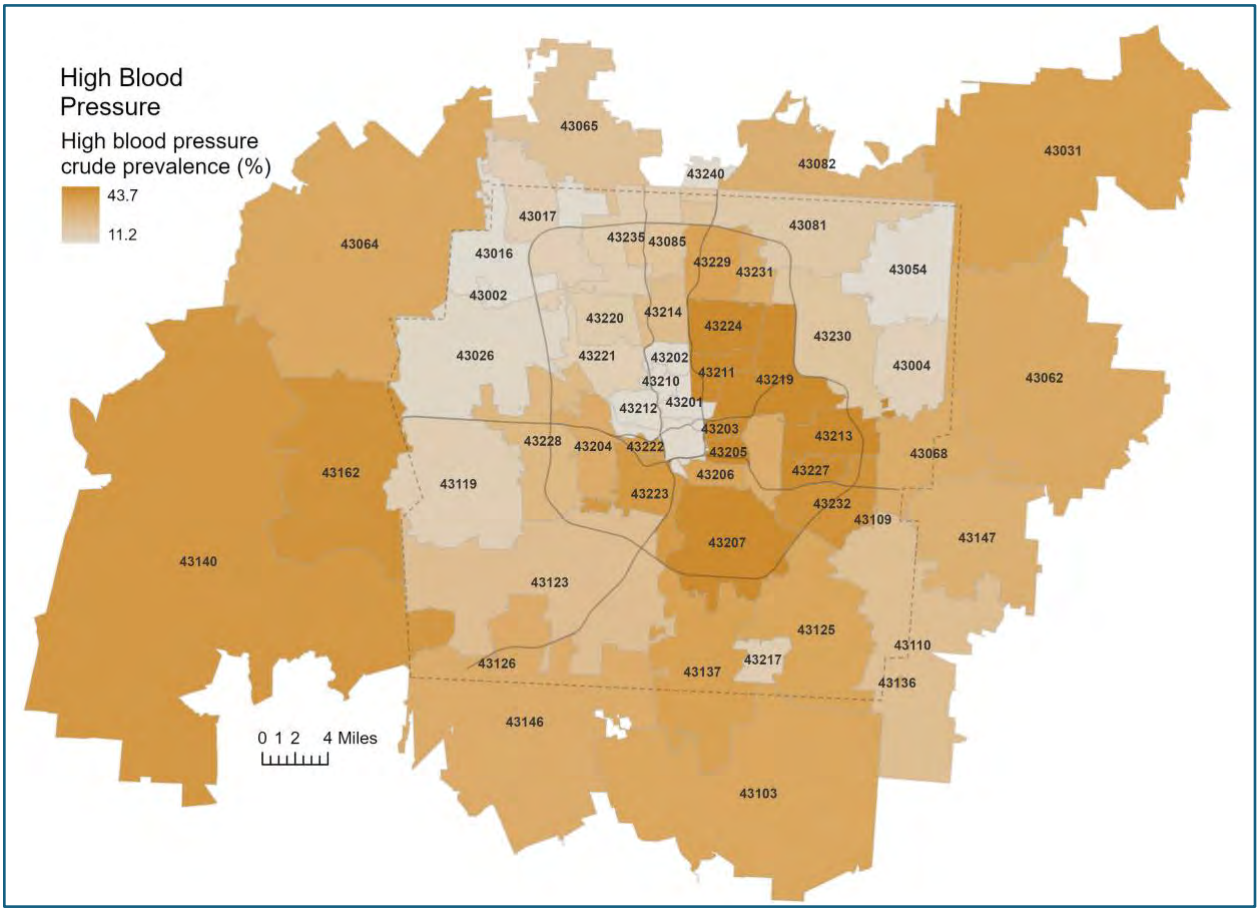
HIGH BLOOD PRESSURE

Older adults, black (non-Hispanic) residents, and individuals with a disability are more likely to report this health condition.

Fortunately, recent data suggest that among those Franklin County residents who have been diagnosed with high blood pressure, most (73%) are taking medicine to address/manage this health condition.

High blood pressure prevalence is higher in east-central Franklin County, especially 43224, 43211, 43219, 43203, 43205, 43213, 43227, and in 43207

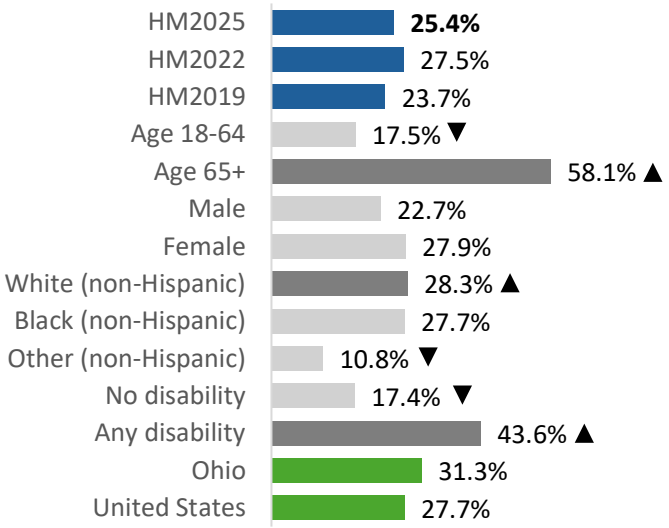


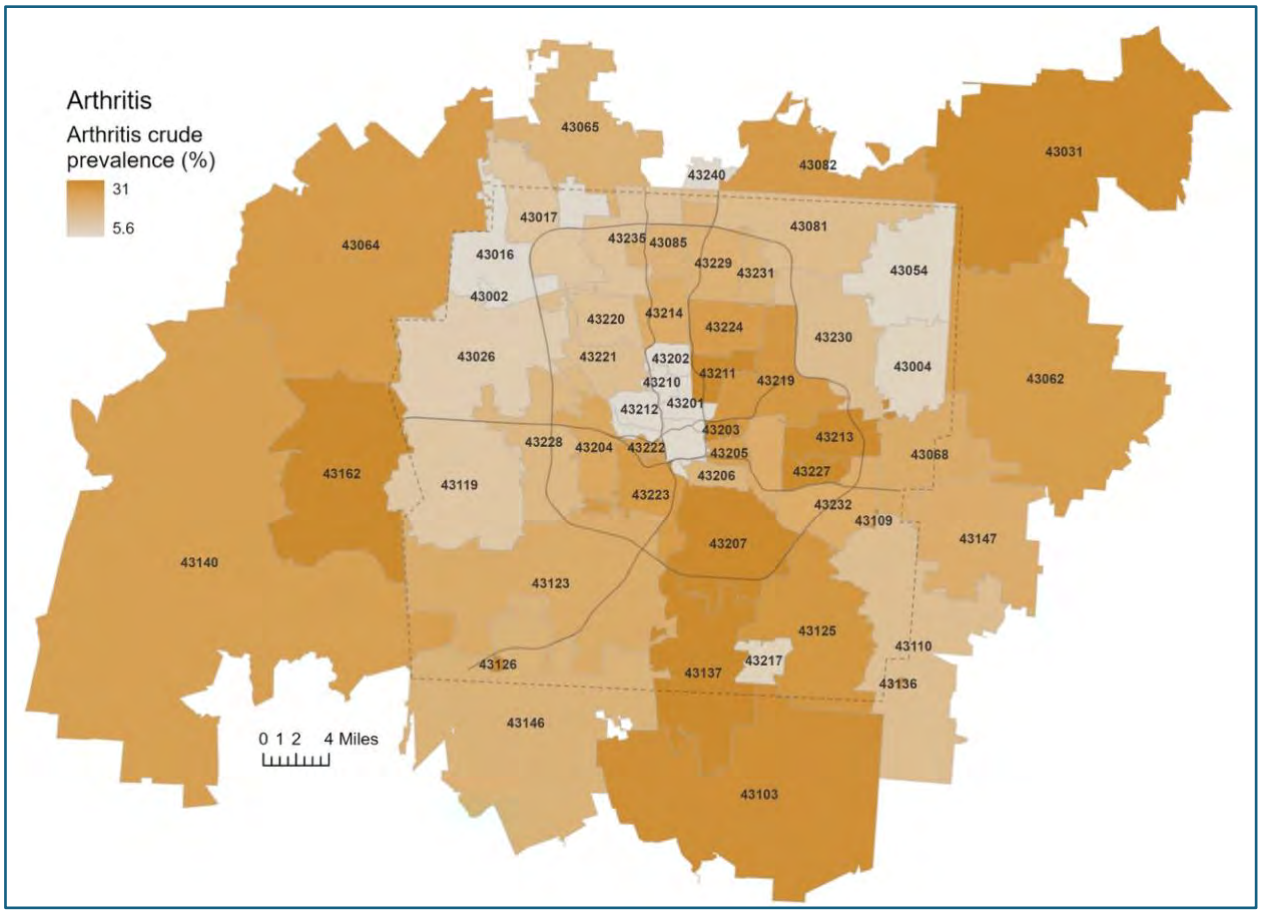


ARTHRITIS

As expected, older adults have a far higher prevalence of arthritis than younger adults, and individuals with a disability are also more likely to report this chronic health condition. Interestingly, individuals with an other (non-Hispanic) racial background had a significantly lower rate of arthritis than either the white or black (non-Hispanic) populations.

Arthritis prevalence is higher in Franklin County zip codes that are east of I-71 and west of I-270, and is especially high in 43211, 43213, 43227, and 43207.

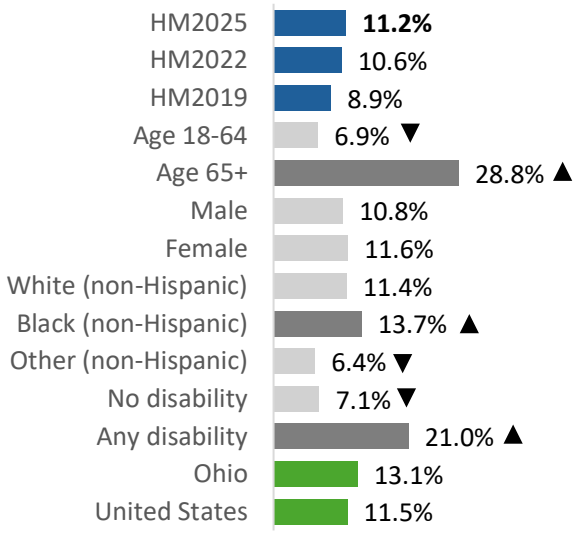


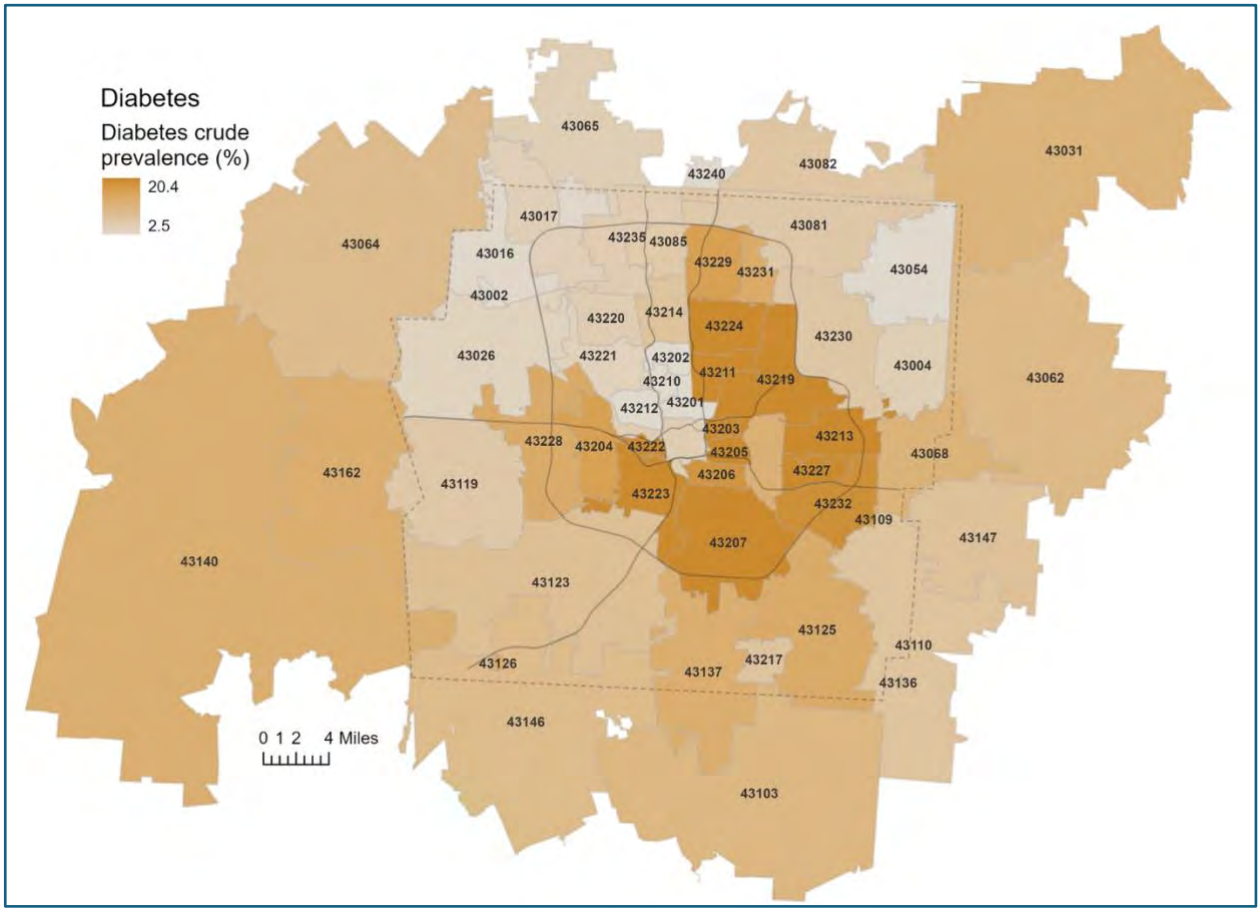


DIABETES

Diabetes is more common among older adults than younger adults. Note that this analysis does not distinguish between type 1 and type 2 diabetes. As was the case with arthritis prevalence, individuals with an other (non-Hispanic) racial background were significantly less likely than those in other groups to have been diagnosed with diabetes.

Diabetes prevalence is higher in most Franklin County zip codes that are within I-270, except for those zip codes in the northwestern quadrant.





Community Voices: Diabetes

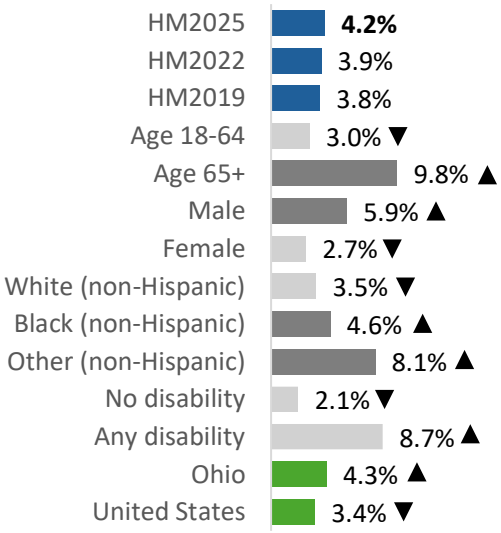
For community members, diabetes is at the forefront of their chronic condition concerns in the community. They perceive this condition to be increasing among the community's youth, and also noted how this condition co-occurs with other chronic conditions.

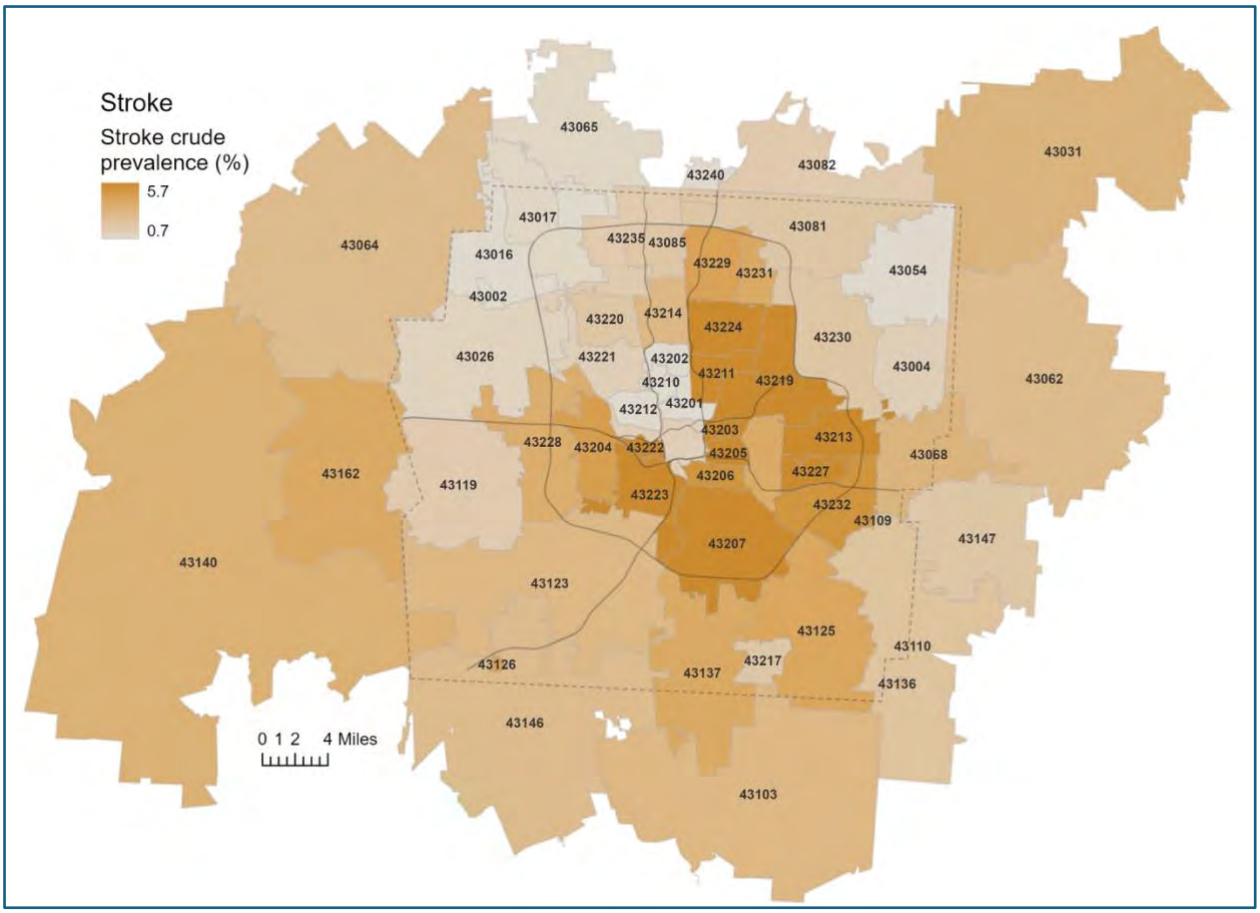
> *"Type two diabetes has become more prevalent than before…And insulin resistance can start younger. Even if type two is not there, we can have the metabolic syndrome. The hypertension strokes are even happening younger, and it seems that doctors will focus on an older population. A lot of kids won't be heard."*
>
> *"A lot of kids I see have juvenile diabetes, probably more than what I even remember. And if you have a disability, you tend to have those kind of issues."*

STROKE

Lifetime experience of stroke is more common among older adults. Disparities between gender and racial groups are likely due in part to disparities in risk factors such as heart disease.

Stroke prevalence is higher in most Franklin County zip codes that are within I-270, except for those zip codes in the central and northwestern quadrants.

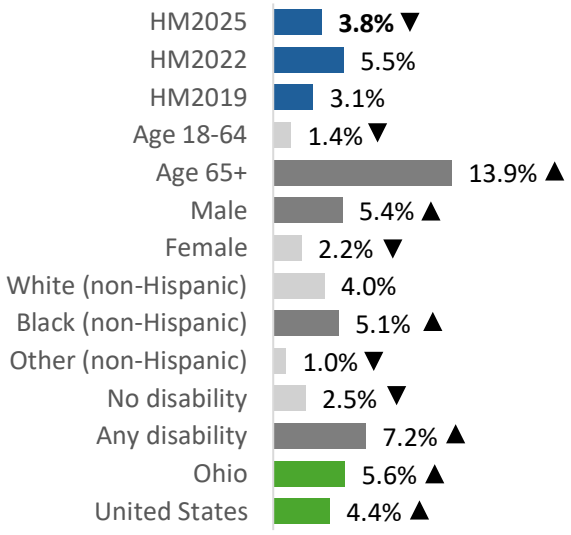


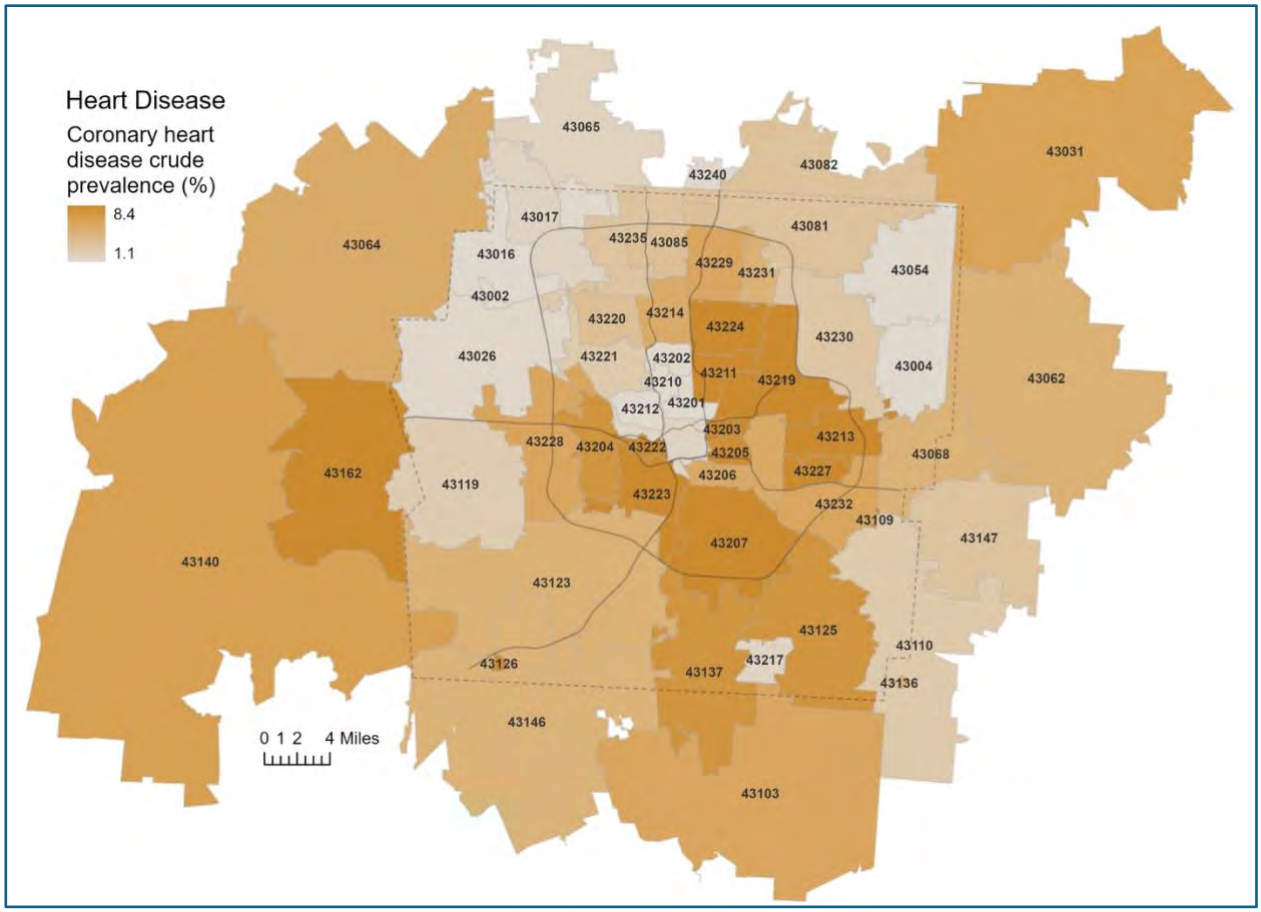


HEART DISEASE

Within Franklin County, the prevalence of heart disease is highest among older adults. Heart disease prevalence is also higher among males, which is consistent with national research on this topic. Lastly, the prevalence of heart disease is also higher among the black (non-Hispanic) population than among the white (non-Hispanic) population.

Heart disease prevalence is higher in most Franklin County zip codes that are within I-270, except for those zip codes in the northwestern quadrant.





Community Voices: Other Chronic Conditions

Community members also spoke about other chronic conditions that affect the black community disproportionately, including sickle cell traits, HIV, and fibroids.

> *"There's a lot of people in the black community who don't realize the difference between sickle cell traits, sickle cell, or that they even have sickle cell. They don't have the educational component. So they're just out there, trying to figure out what's best. And with sickle cell, you can actually die. And a lot of people don't know that. If one parent has it and the other one doesn't, it doesn't necessarily mean you're going to get it versus two parents having it. And so a lot of people have unnecessary worry."*
>
> *"I've experienced family members with sickle cell, and when they go into hospitals, they're looked at as drug seekers. It's because they're not educated on what exactly they are supposed to be doing. So when they're having a crisis and they are in pain and really do need those medications, it's like, 'Well, the only time we see you is when you're in pain.'"*
>
> *"There are a lot of healthcare disparities with race, specifically with African Americans. I would say HIV is one, too."*
>
> *"A big one that affects African American women is fibroids. And they often get overlooked or mistreated when they are going to the doctor."*

Additional Information & References

Readers should note that data focusing on another chronic condition – asthma – is presented in the environmental health chapter of *HealthMap2025* (see page 166).

To assess the prevalence of these chronic conditions, *HealthMap2025* obtained recent data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS), which completes structured survey interviews with residents via telephone.[3] In most cases, survey respondents were asked if a doctor, nurse, or other health professional ever told them that they had a specific chronic health condition.

To enable comparisons by demographic subgroups (e.g., age, sex, race), Columbus Public Health staff analyzed BRFSS data using the most recent year or two available (typically 2021 & 2022). To map the prevalence of these indicators at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the CDC's PLACES[4] resource, which uses BRFSS data (2021 or 2022), Census Bureau data (either the 2020 decennial census or 2022 annual population estimates), and American Community Survey data (2018-2022 estimates).

[1] Centers for Disease Control and Prevention. (n.d.) About Chronic Disease. https://www.cdc.gov/chronic-disease/about/index.html

[2] Nelson K, Norris K, Mangione CM. Disparities in the Diagnosis and Pharmacologic Treatment of High Serum Cholesterol by Race and Ethnicity: Data from the Third National Health and Nutrition Examination Survey. Arch Intern Med. 2002;162(8):929–935. doi:10.1001/archinte.162.8.929

[3] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data, 2022 (HM2025), 2018 (HM2022), 2016 (HM2019). [Note: For high blood pressure prevalence, HM2025 data were collected in 2021 and HM2022 data were collected in 2019.]

[4] Centers for Disease Control and Prevention, PLACES: Local Data for Better Health. (n.d.). https://www.cdc.gov/places/index.html

Disability Status

Disability is a significant public health concern. As the mean age of the United States population increases, older adults who have a disproportionately higher likelihood of disability become a greater proportion of the population. Individuals with disabilities face a variety of increased costs of living, barriers to engaging in work and the community, and additional health disparities than the rest of the population.[1,2]

12.2% of Franklin County residents reported **any disability**.

≈ Similar to HM2022 (11.1%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
65+ more likely	None observed	None observed	Observed (see map)

Community Voices

Members of the disability community think how others in the broader community perceive and react to disability causes their overall wellbeing to be unconsidered or ignored.

> *"Our wellbeing as people with disabilities is grossly ignored. Grossly overlooked and never considered. Whether it's the mental wellbeing, or the physical wellbeing, or the emotional wellbeing, or the economic wellbeing, we're not considered."*

Community members spoke to the specific challenges faced by individuals who identify as DeafBlind or have multiple disabilities.

> *"DeafBlind people suffer the most in my experience, in my community. They do not have a lot of the training. For example, they do not have access to braille training."*
>
> *"Developmental disability services here in Ohio, they are not accessible to DeafBlind people, not friendly to them at all. Takes a long time to get services. People who are deaf and have additional disabilities are very isolated. They haven't been able to find the place where they feel that they belong."*
>
> *"I fit into the DeafBlind community. And I will agree there's not a lot of acknowledgement of those who have dual disabilities, whether it's deaf and blind or any other combination of one or more disabilities. And there's not enough acknowledgement of, even though one disability may be the dominant disability, that doesn't mean you should ignore the other ones."*

Community members spoke about how there are some conditions that are not classified as a disability, even though they affect people's lives in similar ways.

> *"Ehlers Danlos syndrome. It's a connective tissue disorder, and most people will think of it as hypermobile. But the connective tissue is with the heart, with the brain, with the eyes, the spine, everything. [She has] a list of like ten different mini diagnoses that don't count as a developmental disability. So she's in bed a lot, wearing an eye mask or unable to function in a normal life, and then people are telling me, she doesn't have a developmental disability because she doesn't fit in that umbrella."*

Members of the wider Franklin County community also mentioned how caretaking responsibilities for family members who are disabled impact them.

> *"My mother has dementia. I know an awful lot of folks who are in their late sixties, mid-seventies, and older with that. Her husband is caring for her now, but when the day comes, he can't do that, she'll be moving in with me, and I will not be able to really leave her. She can be left home a little bit at home now, but that won't last for long, and I'll be her primary caretaker. So it's something I have to plan for because it's coming down the road."*
>
> *"I would say as a caregiver, that impacts me, my health. I constantly worry about my mom. Back in March, she had a fall. I was in the house, she got dizzy, she fell, and we had to take her to the hospital. It was really scary. So as a caregiver, I've experienced a lot of mental health issues through that, and I think through that, a lot of physical health issues have bubbled up."*

Community Voices: Issues related to accessing health care

Disabled individuals face difficulty filling out paperwork and accessing information about their health due to the high reliance on technology that many medical providers have. When it comes to having interpreters for health appointments, disabled individuals say lack of resources prevents best practices of using co-interpreters to ensure patient understanding.

> *"One issue when it comes to accessing care is accessing information. So, for example, if you go to the doctor and they want to give you a summary of your doctor's visit, a lot of times doctors just want to hand you paperwork and they're not always explaining things with you or to you."*
>
> *"A lot of systems such as computer systems at doctor's offices and things are not digitally accessible. Medicare professionals still don't know a lot of times how to help you as far as filling out paperwork. They don't see the value of doing certain things over the phone. There's always this thing that if one person with a disability can get it...There's no looking at each patient on a case-by-case basis."*

> *"So many doctors are moving to putting things on an iPad, but still, that's just as bad as traditional paperwork. If you're blind and you can't fill that out on your own, you got to have somebody to help you. And some doctors, they always think you come with a caregiver. They don't understand, that's really your job as the nurse. Your job is to take down the health information and help the patient out."*
>
> *"We encourage having co-interpreters. One hearing interpreter who signs to a deaf interpreter, and that deaf interpreter would sign to the deaf individual. And it's very effective, and it makes communication so much easier. It can be expensive, you know, having those two interpreters, but it will save you time in terms of effective communication and the [medical] provider being able to make that connection with their patients and make sure that their language needs are met. It's focusing on respect for that patient, and it's very effective, and that's something that providers need to accept more and provide."*

Finding providers who are competent and respectful when providing care for disabled individuals can be difficult.

> *"My problem is I've been with established care people for 14 years, and what happened was I just had some retire, and I'm having a problem finding doctors that take my insurance, let alone help with my medical needs."*
>
> *"I've even been turned away from a local hospital, because they said that none of the doctors here understand disability at all, and we should not be seeing that in 2024. And most of the things that I go in for are not even related to my disability. They're just normal things…I even left the medical space for 20 years because of the difficulty I was having. I didn't see doctors until I turned 40 again…A lot of times, people with disabilities have to search and search before we find a doctor that will, in fact, listen to us and realize that we know more about our own bodies than they might."*
>
> *"I just changed my primary care doctor because she started making me feel like I was a problem for her."*
>
> *"We become so afraid to even seek help sometimes."*

Disabled individuals face a number of other specific issues with health care, including providers' unwillingness to provide telehealth appointments, misdiagnosis and lack of understanding of complex care needs, difficulty getting health screenings, and difficulty providing feedback on health care surveys about their experiences.

> *"If you're an established patient and staff changes, there's no real training or continuity kind of training that teaches them that not everybody that's coming here may come here in person. Some people are using telehealth*

> *for various reasons. I've been almost threatened that I got to come into the office. And I've been told to my face that, well, another client with a disability is able to make it in, but that client may live in the Dublin area, and I don't. And I don't have the money all the time to travel across town."*
>
> *"People who perhaps have low language within the deaf community, meaning they are a deaf child raised within a hearing family and that family does not provide access to American Sign Language, they face language deprivation...that leads to mental health issues. So counselors then are saying he has a diagnosis of learning disabilities. Well, really, it's not the learning disability. The problem is the language deprivation, the exposure that they never had. And so that diagnosis doesn't really fit the situation in and of itself. There is a lack of advocacy and the resources that are needed for individuals to learn about the diverse community."*
>
> *"I think there needs to be doctors out there, individuals who understand complex care. My daughter has multiple disabilities. She has seven specialists. And when I went from trying to move her from pediatric care to adult care, I'm going through doctors like water because they can't handle the complexity of her needs…We need to have adult hospitals with complex care units that are willing to provide healthcare for these individuals."*
>
> *"We are still so behind the times when it comes to treating people with disabilities, any disability, really, with the machinery that they use. I mean, I'm 55 and have only had half of a mammogram done because the machines are still not accessible. And when you go there and you ask for them to help position you, they yell at you and ask if you've brought a caregiver with you to be able to do that. That's just one experience. But they are not trained to understand disability. They get a very short training period to learn about disability."*
>
> *"When we try to take the surveys that speak to our experience, if you're blind and depend on screen readers, you have to get your PIN number from your discharge papers first by using app to read that or have someone come over and do it for you. Then you have to enter that online. And then the online surveys are not accessible with the voiceover screen readers that we're using. The only other alternative is to bother someone, have them take the survey for us. Well, that violates our own privacy."*

Community Voices: Stigmas related to disabilities and/or mental health

Disabled individuals say that mental health issues like anxiety and depression are common due to the misperceptions people have about them.

> *"There's a big myth when you're dealing with the medical professional or people in general, that because we're blind, we're also dumb. Like our brain*

> *doesn't work. And that's not a fair assumption. Just because someone is blind doesn't mean they have a cognitive disability as well."*
>
> *"Anxiety and depression are two big ones [we suffer with]. I suffer from clinical depression and clinical anxiety. And that comes from the way that we are isolated, left out and beaten up for things that we don't have any control over, whether it's our economic status, our employment status, our housing status, or just the fact that we simply are asking for help and people make us feel bad for wanting help…the perception and assumptions are just wrong and rude."*
>
> *"Anxiety is a huge problem. And then in our culture, disability is too often seen as inferior or frightening, and the wellbeing of a disabled person is sometimes seen as not all that important."*
>
> *"Medical providers, in particular, live with that same fear and fright of people with disabilities. And when they focus on the, 'You must need home health services. There must be someone who has to do for you and speak for you.' At times it's very distressing when you're already not feeling good about yourself and you're there to get help, to have that magnified by other people's fears and perceptions, because they can't imagine how they would live with our disabilities, but they're directly not understanding how we adapt."*

These misperceptions also influence the ability of disabled individuals to find employment, even though they have valuable experience and skills to offer.

> *"We have to deal with employer perception all the time. They'll put us through trial periods. They'll ask us if we can find the restrooms and things that someone equal to us without obvious disabilities doesn't have to go through. All these excuses will be made about why we're not interviewed or why we're not contacted after the interview. Hospitality, caregiving and advocacy, independent living help. I'm good at all these things, especially environments that I'm familiar with. And I started getting experience around 16 years old, and I cannot prove that because so many people think that I need things done for me."*

Community Voices: Issues accessing social services/resources

Lack of knowledge about available resources are an issue, not only among disabled individuals but among case managers meant to help them access these resources. Some individuals also perceive there is an unwillingness to provide pathways to these resources.

> *"I think lack of resources is an issue, but also knowledge about the resources available to people is an issue."*

> *"It's knowing what programs are out there, whether it's for finding a job, whether it's for getting food, whether it's for getting help with paying for medical costs, just knowing those resources and where they are and how to apply for them, and people giving you the honest answer about how to apply for them, that's one of the biggest challenges."*
>
> *"When I'm advocating for others, people think I'm wonderful, I am knowledgeable, I'm skillful. When I advocate for myself, there's always this push because, no, we can't do that. But at my office, I get calls from other case managers asking me to do the things I'm wanting and they are doing for other people, but they don't want to do for me because I'm intimidating. And when I say, 'You can do this,' I get a very negative pushback and the dragging of the feet and the, 'Oh, I'm sorry, I'm busy. I've had too many crises to deal with.' I don't regret doing the work to get an MSW, but it doesn't necessarily help you as an individual get your services."*

Community members with disabilities also pointed out that many available resources have restrictions about who can qualify. They believe income-based programs effectively keep them in poverty and from making life changes like moving in with others or obtaining better employment that could improve their quality of life.

> *"People assume because you have a disability, that you're qualified for all of these things in the community that you're not. People assume because I had SSI when I had that, and then I eventually got SSDI, that I should get section eight housing, I should get a whole bunch of food stamps. I should be able to have all these things."*
>
> *"There is a program called iCanConnect, but that is federally funded and that's income based, which is really ridiculous because there are a lot of people that are suffering that can't hear, can't see, and they have a lack of services."*
>
> *"If our legislators got ill, they would never go through the same thing that a lot of us do because they have the money to hire the best doctors and providers so they could never thoroughly understand disability like us that really are in the poverty level and are kept in the poverty level because of rules governing SSI and SSDI. And the other programs like Medicaid, you can only have so much money to be able to qualify. People who have a disability and are fortunate to get a job and have a good job and good insurance, they can afford the money [for good care]."*
>
> *"The way SSI is set up now is if you want to make more money, you're scared to take that because you know they're going to take all your benefits versus there's not any program that allows for people to gradually grow away from the SSI to SSDI because they now have a job and they're starting to make more money. They just snatch the whole check away instead of*

> *taking away a dollar or two at a time as your income grows, so you have a chance to grow into that and save and be able to take care of your needs."*
>
> *"Right now, I have a friend who is terminal who has 28+ additional conditions besides blindness. We're both having the issue of Social Security and perception and all this keeping us from moving together and combining resources. Maybe we could make it if we had each other. We could both save each other's lives because we've experienced a lot of the same systemic troubles and find commonality."*

Individuals with disabilities also say they are prevented from accessing helpful resources due to where they live, and some see evidence that race impacts who receive resources.

> *"Some of the programs that are out there, whether they're for people with disabilities or for people who are on lower income, if you don't live in that area, you can't get those services. Just because I live in the suburbs doesn't mean I don't need them."*
>
> *"We get less of the resources that somebody in our same condition [gets] who happens to be white or maybe of another nationality or race. I have a friend that's in the same situation as me, but he's getting things that I can't get. We're both blind, we both have SSDI, but he's white and I'm black."*

Community Voices: Resources needed for the disabled community

Access to food and affordable housing are specific areas of need for the disability community. For example, they need people who can help them access healthy food more easily, and more accessible housing options.

> *"Food stamps doesn't buy you much, especially when you only get less than $100 a month because they assume, based on your bills, that as one person that you don't need a lot of money for food. If you don't cook that food fast enough, it's going to spoil in two days…I don't eat food as fast as probably maybe I should, because I'm blind and I'm teaching myself how to cook…there's no food service that if you need to go to the pantry [as a blind person], that somebody can get you there or that the food can be delivered only. The delivered food is frozen with all the sodium in it…And that's not always a healthy option for everybody either."*
>
> *"The DeafBlind community does not have access to someone who could go food shopping with the individual or perhaps read something to them if necessary, so on and so forth. We want to be able to bring that to the attention of the Ohio legislation within this year. And our goal is to convince legislation really to wake up to the needs, provide that funding, provide those outreach services in the near future."*

> *"Affordable housing. That's what I have a problem with. [For] people with special needs or people with low income families."*
>
> *"I find sometimes that it's hard to get a wheelchair around anywhere…they built new apartments about seven years ago in downtown, and there's no elevator. How is that fair to anyone with a disability who can't physically walk downstairs? It seems like we've been pushed aside…we're not seeing the things that should be in place to allow people like my daughter to go and live a full life and go to the places that we'd like to go."*

Individuals with disabilities had specific advice about how to improve their experiences in Franklin County: better training for all medical professionals about working with the disability community, connecting individuals with people who can advocate for them, providing better pathways to existing resources, and providing more help accessing the wider community for those with limited mobility options.

> *"Public health departments, to me, need to work with the disability community to start creating educational things for doctors. Whether you're a nurse, whether you're a nurse practitioner, whether you're a surgeon, whether you're a medical tech assistant. The whole medical community, from the bottom to the top of it, needs some serious long-term disability training. To me, public health department needs to even push, if they can, for it to be stuck in the medical school curriculum…They need to come to our community and hear from us the things people need to know, not make up your own disability training for doctors and medical professionals in your own head."*
>
> *"I think they need to provide advocators for those who don't have family or friends that can help advocate for them."*
>
> *"If doctors or PCPs have an individual who has several complex issues, the health department [could] create a database that the doctor. With the patient's permission, can put that person in the database, and then there's a case manager or someone there that reaches out to them and helps them find the services and the things that are available to them…I find a lot of the service coordinators just aren't educated on what's out there…Advocation, and maybe a database that doctors can refer people to the health department, and they can help.*
>
> *"Collaborate with the local centers of independent living. Independent living, housing for people with disabilities is often nowhere near resources like transportation and bus stops, communities, doctors. This is a physical divide between people with disabilities and non-disabled people."*

To assess the disability status of Franklin County, Ohio, and US residents, *HealthMap2025* obtained recent data from the American Community Survey.[3] The ACS estimates the prevalence of many different types of disabilities:

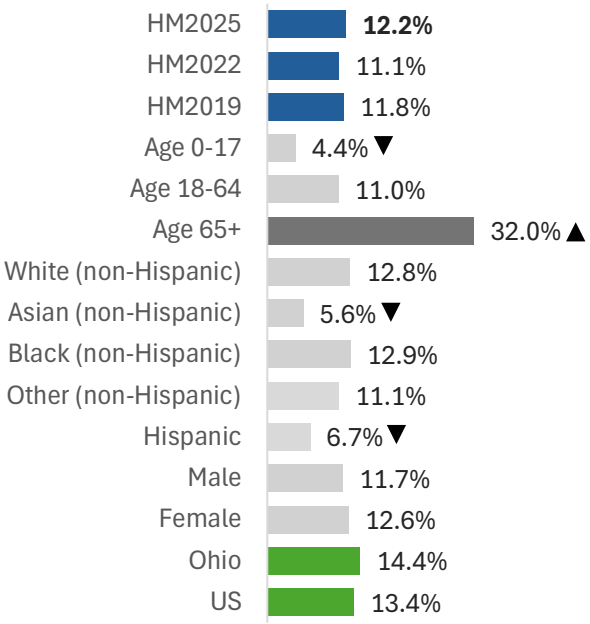
- *Hearing difficulty*, which is defined as "deaf or [having] serious hearing difficulty") and is measured among people of all ages;
- *Vision difficulty*, which is defined as "blind or [having] serious difficulty seeing even while wearing glasses" and is measured among people of all ages;
- *Cognitive difficulty*, which is defined as having "serious difficulty concentrating, remembering, or making decisions") and is measured among people aged 5 years or older;
- *Ambulatory difficulty*, which is defined as having "serious difficulty walking or climbing stairs" and is measured among people aged 5 years or older;
- *Self-care difficulty*, which is defined as having "difficulty dressing or bathing" and is measured among people aged 5 years or older;
- *Independent living difficulty*, which is defined as having "difficulty doing errands alone such as visiting a doctor's office or shopping" and is measured among people aged 15 years or older (but only reported for those aged 18 years and older).

Franklin County has a slightly lower rate of disabled individuals as compared to Ohio or the United States.

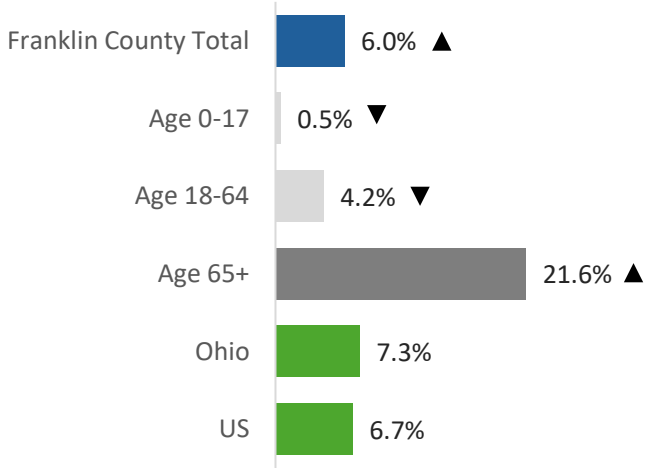
Those aged 65 or over have the highest percentage of residents with at least one disability, with ambulatory difficulties and independent living difficulties being most prevalent. Among children and younger adults, cognitive difficulties are more prevalent.

Of note, Asian (non-Hispanic) individuals and Hispanic individuals have less than half the disability rate as the general population and multiple subgroups.

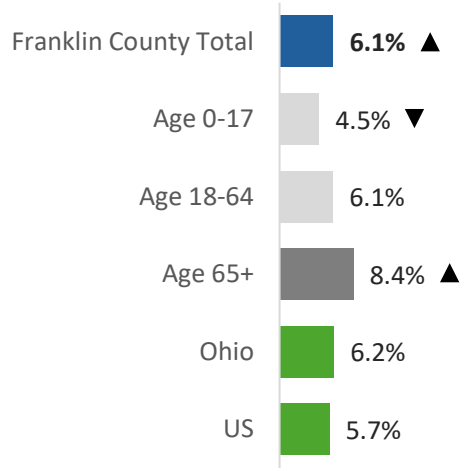
Disability Status Prevalence



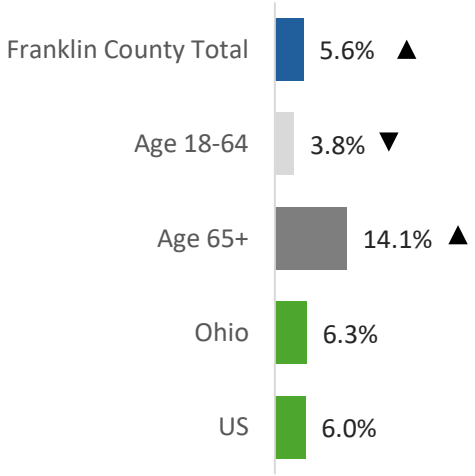
Ambulatory Difficulty



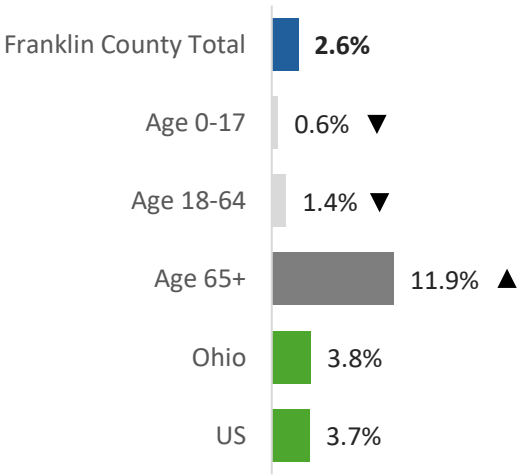
Cognitive Difficulty



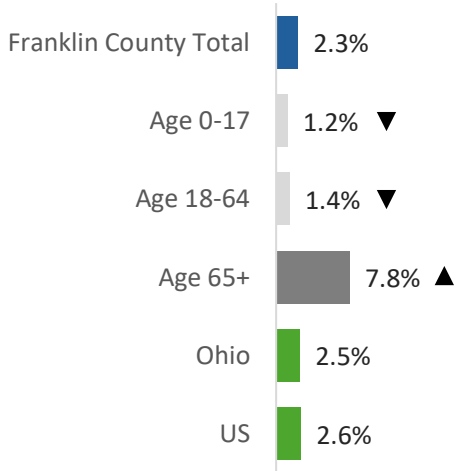
Independent Living Difficulty Age 18+



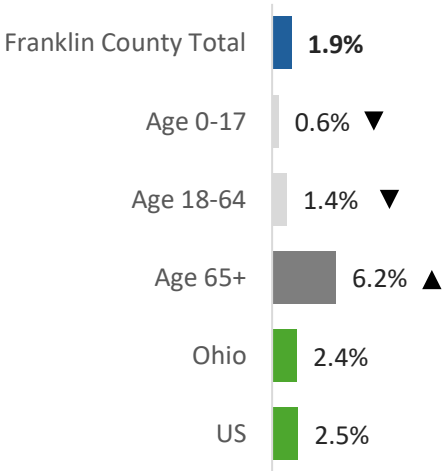
Hearing Difficulty



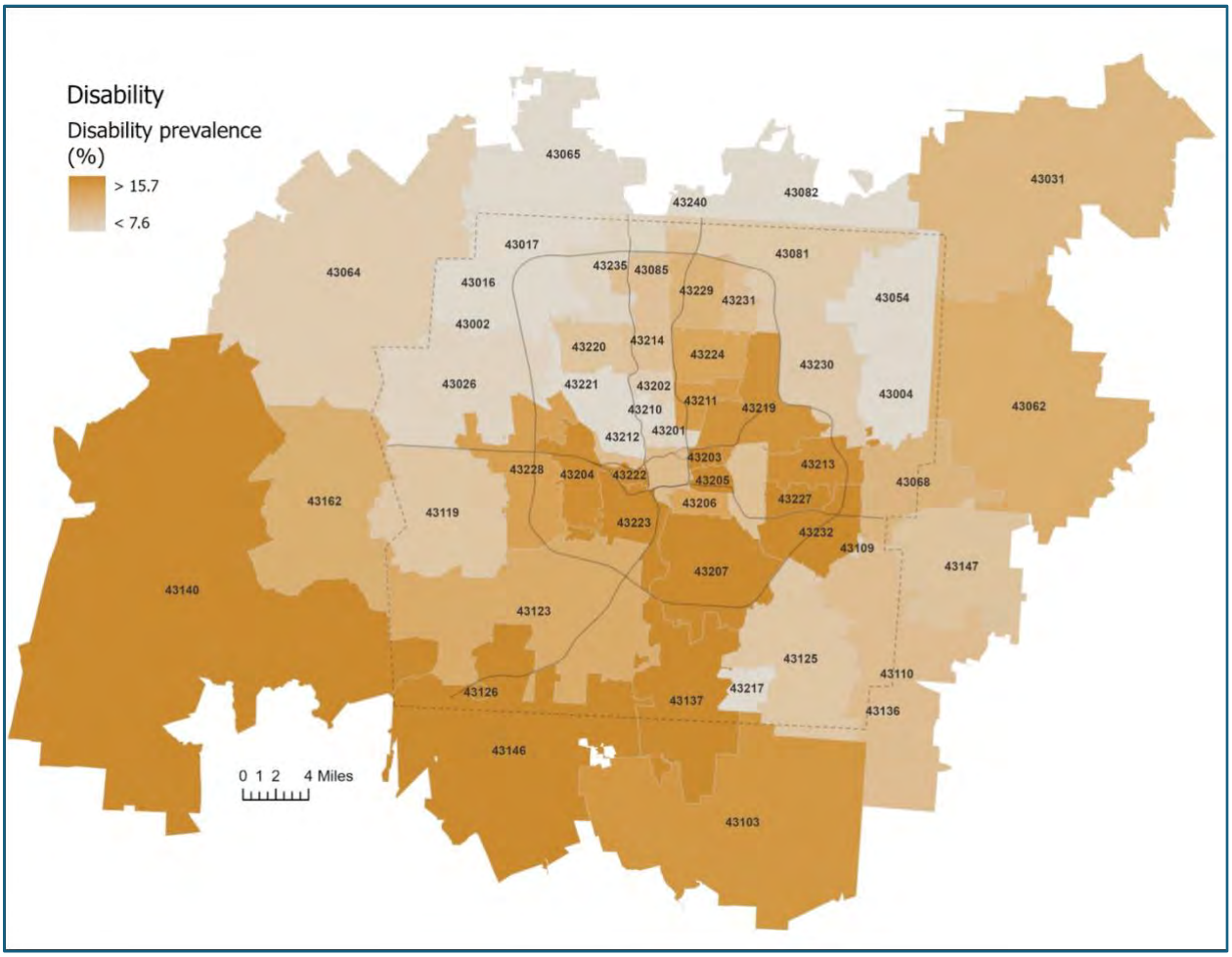
Self-Care Difficulty



Vision Difficulty)



As shown in the map below, disability prevalence is greater in eastern zip codes within I-270, western zip codes within I-270, and in southern / southwestern zip codes.



Additional Information & References

To map the prevalence of this indicator at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the Census Bureau's American Community Survey.[3]

[1] Carrie L Shandra, Disability as Inequality: Social Disparities, Health Disparities, and Participation in Daily Activities, Social Forces, Volume 97, Issue 1, September 2018, Pages 157–192, https://doi.org/10.1093/sf/soy031

[2] Mitra, S., Palmer, M., Kim, H., Mont, D., & Groce, N. (2017). Extra costs of living with a disability: A review and agenda for research. *Disability and health journal*, *10*(4), 475–484. https://doi.org/10.1016/j.dhjo.2017.04.007

[3] U.S. Census Bureau. (2022). Disability Characteristics. American Community Survey, ACS 1-Year Estimates Subject Tables, Table S1810. Retrieved May 29, 2024, from https://data.census.gov/table/ACSST1Y2022.S1810?q=disability&g=010XX00US_040XX00US39_050XX00US39049.

HEALTH BEHAVIORS

Cancer Screening

Breast cancer and colorectal cancer are among the leading causes of cancer death in the United States.[1,2] Regular and timely screening are among the most powerful tools for prevention and early detection of both breast and colorectal cancers.

61% of Franklin County adults aged 45-75 reported having a **colonoscopy** in the last 10 years.

Metric changed since HM2022

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Unavailable	Unavailable	None identified	Observed (see map)

69.7% of Franklin County women age 40+ reported having a **mammogram** in the last 2 years.

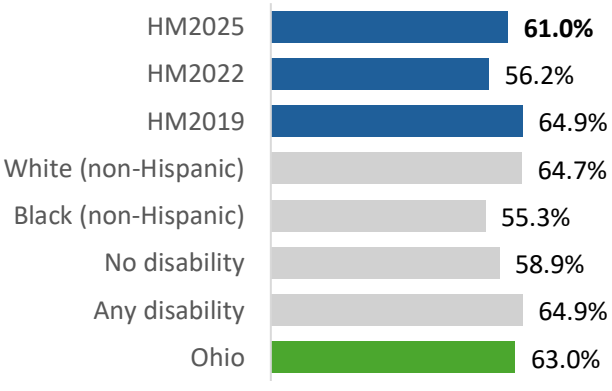
≈ Similar to HM2022 (74%)

Disparities by selected social determinants of health

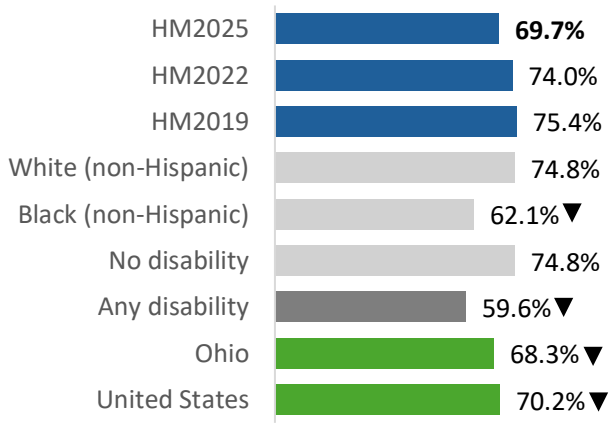
Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Unavailable	N/A	Black less likely	Observed (see map)

For both types of cancer screening, black (non-Hispanic) residents were less likely than white (non-Hispanic) residents to have completed the recommended screening. Franklin County's screening rates were fairly similar to the screening rates for Ohio and the United States.

Colorectal Cancer Screening



Breast Cancer Screening



Healthy People 2030

The Healthy People 2030 objectives for both colorectal cancer screening and breast cancer screening are designated as the number of adults who are meeting the current guidelines for cancer screening.[3,4]

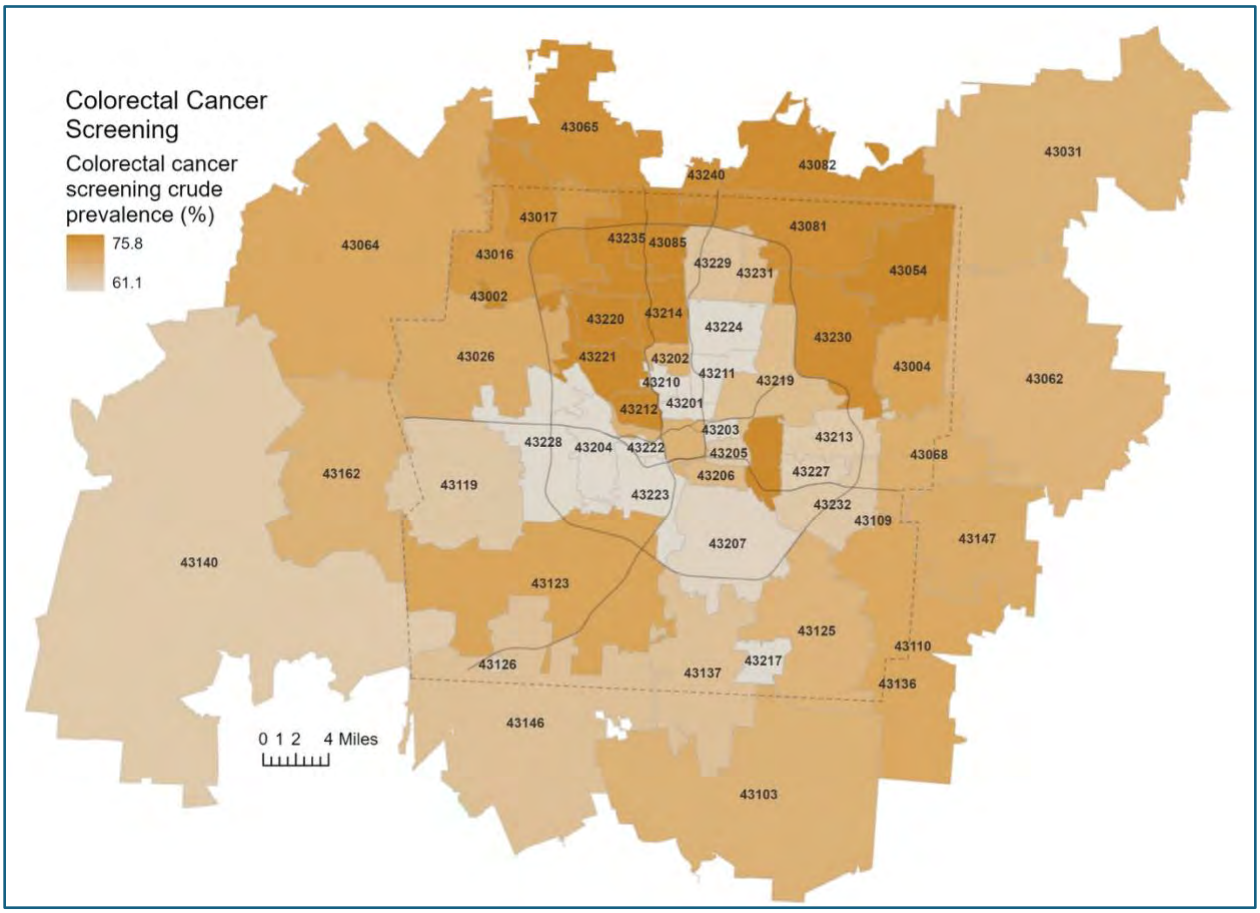
HP2030 objective for Colorectal Cancer Screening: Not met (but improving)

Healthy People Objective:	Most recent Franklin County data (HM2025)
68.3%	**61%**

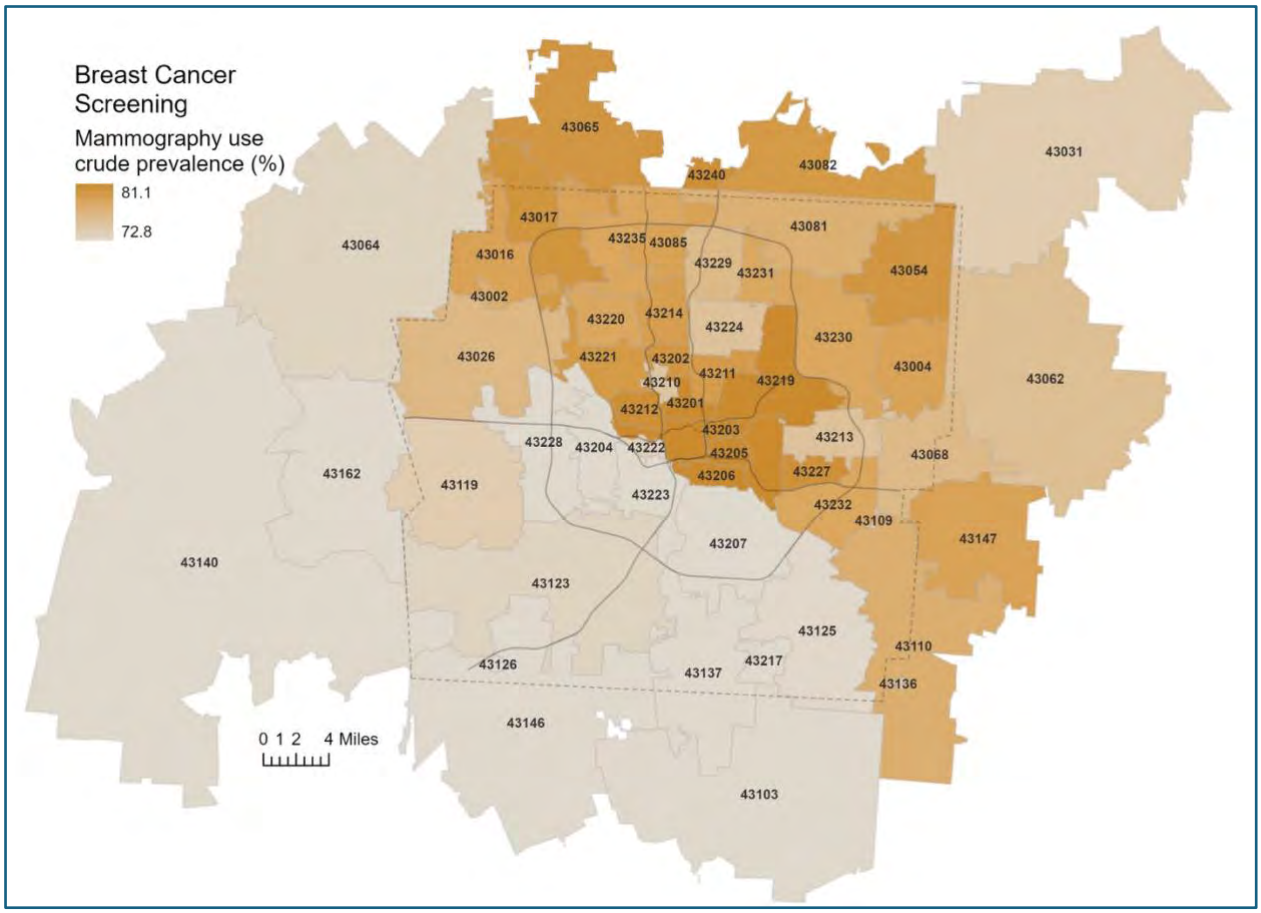
HP2030 objective for Breast Cancer Screening: Not met

Healthy People Objective:	Most recent Franklin County data (HM2025)
80.3%	**69.7%**

Colorectal cancer screening rates are lowest in Franklin County's north-central zip codes (e.g., 43211, 43224), western zip codes (e.g., 43222, 43223, 43204, 43228), and some southern zip codes (e.g., 43207, 43217).



Breast cancer screening rates are lower in nearly all of Franklin County's southern and southwestern zip codes.



Additional Information & References

To assess the prevalence of this health behavior, *HealthMap2025* obtained recent data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS), which completes structured survey interviews with residents via telephone.[5] For colorectal cancer screening, survey respondents were asked if they had ever received either a colonoscopy or sigmoidoscopy, and how long it had been since their last colonoscopy. Survey respondents aged 45-75 and who had received a colonoscopy within the last 10 years were considered up to date. For breast cancer screening, women were asked whether they had received a mammogram, and how long it had been since their last mammogram. Survey respondents aged 40+ and who had received a mammogram in the last 2 years were considered up to date.

In 2021, the United States Preventative Services Task Force (USPSTF) recommended changing the screening age for colorectal cancer from 50-75 to 45-75. Because the HM2022

indicator reflected a narrower age range, it would be misleading to compare that estimate to the one for HM2025, which reflects a wider age range.[2]

Over the last 10 years, breast cancer screening recommendations for individuals aged 40-50 have changed multiple times. Previously, the USPSTF recommended that women aged 50-75 receive mammograms every 2 years and that women aged 40-49 receive mammograms based on their personal health history and status.[1] This was updated in 2024 to recommend mammograms every 2 years for all women aged 40+, and the data for HM2022 and for HM2025 reflect that recent recommendation. These guidelines are also intended for generally healthy adults with no prior cancer history or family cancer history. There are separate guidelines for those at higher risk due to their individual medical and family history, which may involve screening earlier or more frequently.

To enable comparisons by demographic subgroups (e.g., age, sex, race), Columbus Public Health staff analyzed BRFSS data using the most recent year or two available (typically 2021 & 2022). Due to small sample sizes, only white (non-Hispanic) and black (non-Hispanic) residents of Franklin County could be compared to one another.

To map the prevalence of these indicators at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the CDC's PLACES[6] resource, which uses BRFSS data (2021 or 2022), Census Bureau data (either the 2020 decennial census or 2022 annual population estimates), and American Community Survey data (2018-2022 estimates).

[1] US Preventive Services Task Force. Screening for Breast Cancer: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2024;331(22):1918–1930. doi:10.1001/jama.2024.5534

[2] US Preventive Services Task Force. Screening for Colorectal Cancer: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2021;325(19):1965–1977. doi:10.1001/jama.2021.6238

[3] Healthy People 2030 objective C-07, U.S. Department of Health and Human Services

[4] Healthy People 2030 objective C-05, U.S. Department of Health and Human Services.

[5] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data, 2022 (HM2025), 2018 (HM2022), 2016 (HM2019)

[6] Centers for Disease Control and Prevention, PLACES: Local Data for Better Health. (n.d.) https://www.cdc.gov/places/index.html

Alcohol Use

Excessive alcohol use – which includes binge drinking – can lead to several chronic diseases and other serious health problems, including heart disease, liver disease, stroke, mental health problems, and alcohol use disorders, among others. Excessive alcohol use has been associated with 178,000 deaths in the United States each year.[1]

17.8% of Franklin County adults reported **binge drinking**.

≈ Similar to HM2022 (18.5%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
18-64 more likely	None identified	White more likely	Observed (see map)

Community Voices

Members of the community perceive alcohol to be too easy to access in their communities. They see its broad acceptance as a socializing activity to be a barrier to healthier consumption.

> *"There's a liquor store in every corner. You don't have to go far to find liquor or beer or cheap alcohol."*
>
> *"Even our events truly are centered around alcohol. We have wine and arts, tequila and tacos…There's this conception of family and hometown, and all I see personally is people walking around with their kids in strollers and getting drunk."*
>
> *"It feels like no matter what you're doing with your friends, there's people drinking. And I know if I'm ever like, 'Oh, I'm just like, not gonna drink tonight.' Like, people will start asking me if I'm pregnant…the pressure is so intense and ridiculous."*

Community members also believe that overconsumption of alcohol stems from using it as a coping method for stress.

> *"Life is so stressful, people just drink. I definitely think that a lot of us are functionally alcoholics. And I'm speaking for 20 to 30 [year-olds].".*
>
> *"People overindulge. Some people drink because they can't cope with things that are going on, it's a comfort thing to them. I see a lot of people who come back from the military and just can't cope. And that's a coping skill. It's not a healthy coping skill, but it's a coping skill a lot of people use."*

> *"I know that this affects people of all financial statuses, situations. I met somebody who I look up to a lot, and [asked] a question about how he manages stress, and he said he was really good at managing stress, but in the times of his life where he really had a lot of stress at work and stuff, he just leaned really heavily on the alcohol. And I think that a lot of people don't realize that they are coping with whatever is going on in their life. It's like the easiest way to numb it."*

COVID-19 is perceived to have resulted in an increase of alcohol overconsumption at home.

> *"I think especially with in the house drinking, people used to be a little more responsible. So they were going out, maybe having a drink or two. Once COVID came, bars closed. It went to, I'm gonna go to the liquor store and grab me a pint or a fifth. So now you're sitting at home and instead of having one or two that you would usually have at happy hour, you're drinking a whole bottle."*

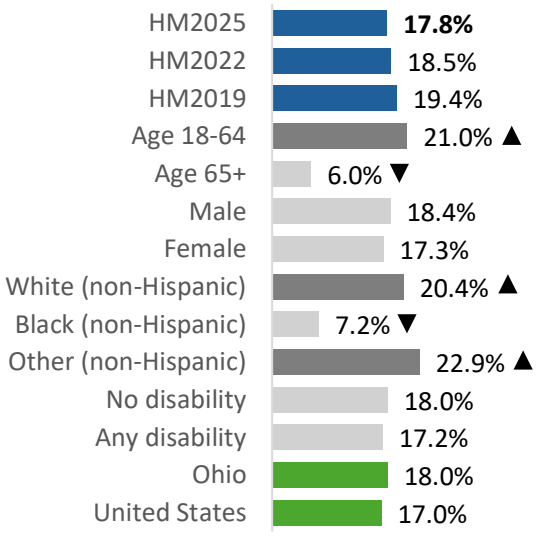
The negative effects of overconsuming alcohol mentioned by community members included worsened mental health and violence in the community.

> *"So I think people don't know the consequences yet of the type of drinking we're doing now. I was one of those weekend people with the fifth, but I stopped. And before I stopped, I started experiencing depression, anxiety, and not being able to focus and no motivation. All that changed, my life changed dramatically just from cutting that weekend use."*
>
> *"No good can come from too much alcohol. And you can see all the violence downtown when places are closing. People lose all sense of reason."*

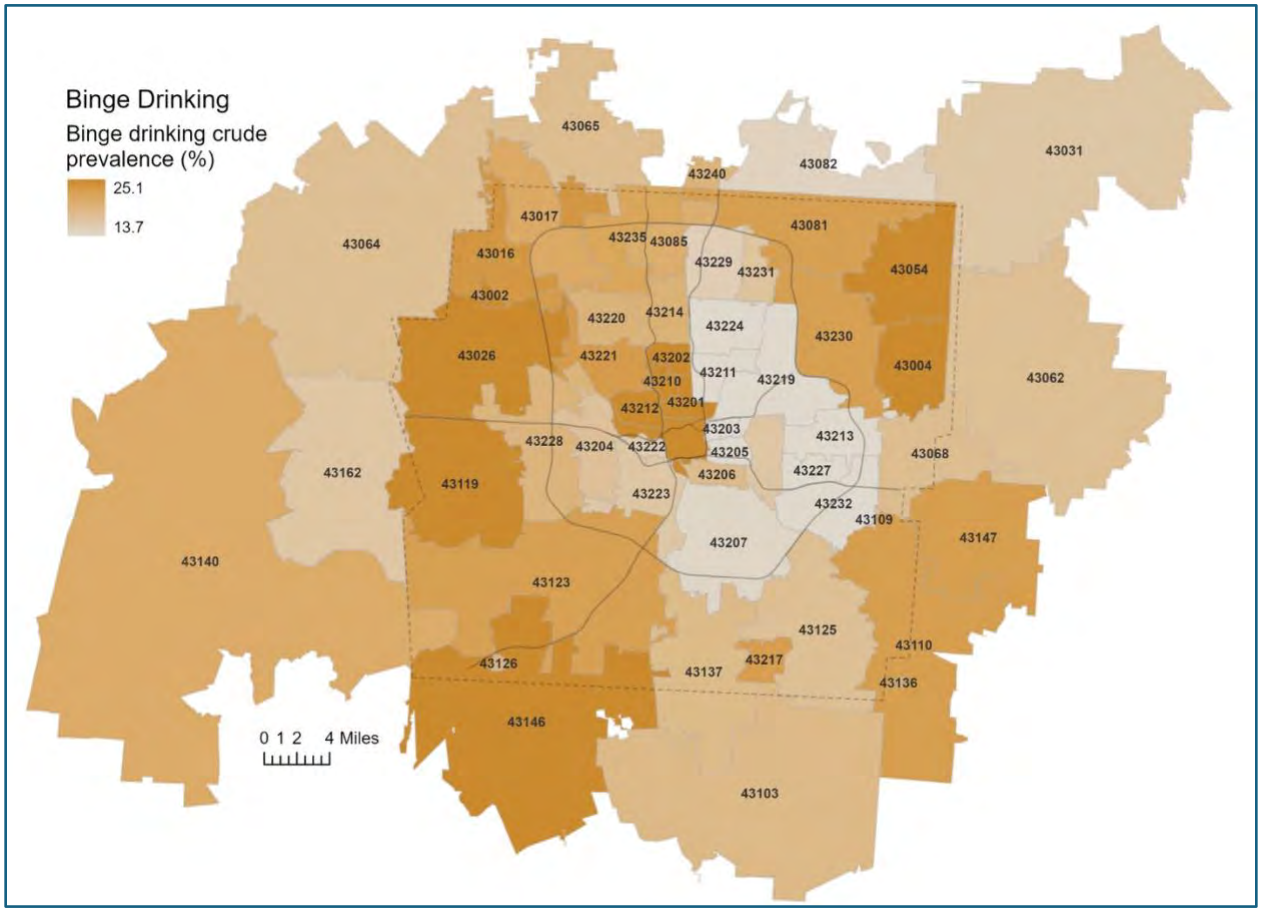
The prevalence of self-reported binge drinking has decreased slightly over time as compared to previous *HealthMaps*.

People aged 18-64 are more likely than those aged 65+ to report binge drinking, as are those who identify as white (non-Hispanic).

Binge Drinking Prevalence



Binge drinking prevalence is higher in Franklin County's far western zip codes, in the zip codes that span the Grandview, Upper Arlington, OSU, and Clintonville areas, and in the county's far northeastern zip codes.



Additional Information & References

To assess the prevalence of this health behavior, *HealthMap2025* obtained recent data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS), which completes structured survey interviews with residents via telephone.[2] For men, binge drinking is defined as having five or more drinks on one occasion in the past 30 days; for women, binge drinking is defined as having four or more drinks on one occasion in the past 30 days.

To enable comparisons by demographic subgroups (e.g., age, sex, race), Columbus Public Health staff analyzed BRFSS data using the most recent year or two available (typically 2021 & 2022). To map the prevalence of this indicator at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the CDC's PLACES[3] resource, which uses BRFSS data (2021 or 2022), Census Bureau data (either the 2020 decennial census or 2022 annual population estimates), and American Community Survey data (2018-2022 estimates).

Data Gap: Because the BRFSS uses telephone interviewing methods to collect this information, it is likely that these statistics *underestimate* the amount of binge drinking occurring in the community. This is because some people might wish to be viewed favorably by the person interviewing them, and therefore not accurately report the full extent to which they engage in a socially unacceptable behavior (e.g., a social desirability bias).

Data Gap: The Community Health Needs Assessment Steering Committee requested recent data about the rates of binge drinking, cigarette use, and e-cigarette use among Franklin County's youth (e.g., those between the ages of 11 and 17). Unfortunately, Ohio's Youth Risk Behavior Survey does not calculate statistical estimates at the county level.

[1] Centers for Disease Control and Prevention, *What is Excessive Drinking?* https://www.cdc.gov/drinklessbeyourbest/excessivedrinking.html

[2] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data, 2022 (HM2025), 2019 (HM2022), 2016 (HM2019),

[3] Centers for Disease Control and Prevention, PLACES: Local Data for Better Health. (n.d.) https://www.cdc.gov/places/index.html

Tobacco Use

Cigarette use is one of the highest contributors to mortality, disease, disability, and overall health status worldwide and in the United States.[1] Aside from the approximately 480,000 smoking-attributable deaths in smokers every year, there are also approximately 41,000 deaths from secondhand smoke exposure. Although decades of intervention have successfully decreased cigarette smoking rates, there is still progress to be made.

Originally marketed as a smoking cessation tool with fewer risks than traditional cigarettes, e-cigarettes increased in popularity over the past 10-15 years, especially among youth and young adults. Early evidence already suggests that there may be significant long and short term risks to e-cigarette use, particularly for the respiratory system.[2]

15.2% of Franklin County adults reported currently **smoking cigarettes**.

Down from HM2022 (22.7%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
18-64 more likely	Male more likely	Other races (non-Hispanic) more likely	Observed (see map)

9.1% of Franklin County adults reported currently **using e-cigarettes**.

Up from HM2022 (6.8%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
18-64 more likely	Female more likely	Other races (non-Hispanic) more likely	Observed (see map)

Community Voices

Community members worry less about traditional cigarette use in their communities, and more about e-cigarette use, which they perceive as overwhelmingly common among ex-smokers and people who have never smoked. They are highly concerned about misconceptions surrounding the healthiness of vaping.

> *"Some people are trying to go to vaping to quit smoking, but it's having the exact opposite effect. They're more addicted to it. They are using it more often. They're having to go to higher nicotine levels. It's doing the exact opposite."*

> *"I see a lot of people giving up tobacco think that the e-cigarettes are going to are safer. That to me is the big problem. They really aren't. But people really have that belief that, well, I don't really smoke."*
>
> *"And a lot of people who weren't smoking in any capacity, over time, have gotten hooked on vapes because it's like, you have a drink, you're at a party, and this isn't a cigarette. This thing tastes like candy, and you smell the cloud of it. And you're like, this is harmless. This is vapor."*
>
> *"That's really troubling to somebody my age to see young people vaping, when so much information has not come out or been made available. The oils and how that goes into your lungs and stuff. That really concerns me for young people."*

Ease of access, misconceptions about the safety of vaping, and its use as a coping mechanism for stress and anxiety contribute to the pervasiveness of vaping amount the county's youth.

> *"I used to do substance use prevention in middle schools, and that was a big thing…so many kids knew about vapes and have them. Not even be able to make it through class without needing a vape. Like, going to the bathroom and taking a vape."*
>
> *"For my daughter, she never, we never smoked or drank or anything growing up. And then when she went to college 2 hours away, she ended up starting smoking. And she said it calms her nerves."*

While encouraging residents and businesses to follow laws around vape sales and spreading accurate information about the health risks is necessary to decrease this behavior, efforts must also contend with how appealing vapes are compared to traditional cigarettes, and the difficulty of regulating the industry.

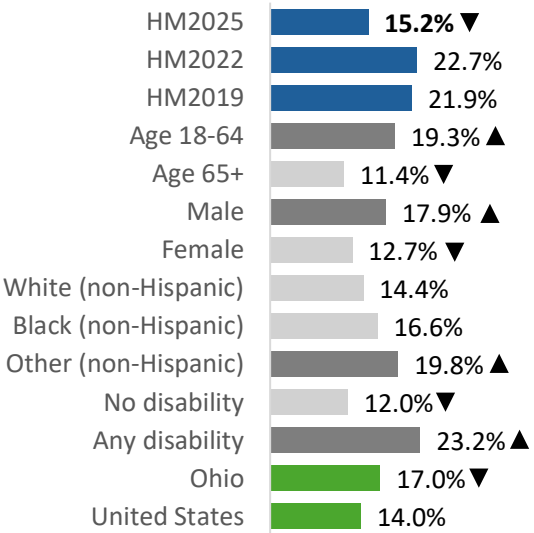
> *"It's the taste, you know, they don't feel as bad. It doesn't taste like a regular cigarette."*
>
> *"There's no social drawback of just vaping a mango kiwi."*
>
> *"I think the oversight is the piece that's slow. Technology is moving fast. The amount of nicotine that you're getting, the size of the e-cigarettes…the vaping and the nicotine is moving faster than the government can say, 'Hey, let's regulate this. Hey, let's put a study on this, or let's try to stop this.'"*
>
> *"They banned that brand. But then there's so many other brands. And the reason why they banned that brand is because you had a lot of people, like, getting stuff wrong with their esophagus…but it's like, why would you ban the brand and then there's 20 other brands? People still have access."*

Some community members perceive attempts to curb smoking and vaping as futile, ineffective solutions that impose unreasonable burdens.

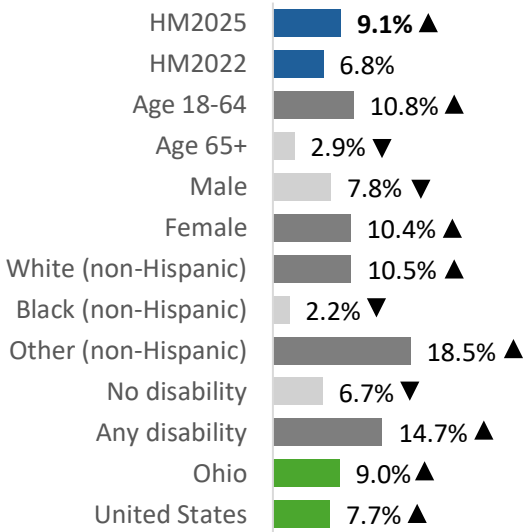
> *"It makes me so mad that our legislators are trying to deal with these issues by banning certain things or by dealing with the symptoms or the superficial. Like, they're gonna ban menthol cigarettes, but you're not really dealing with tobacco use. You're not taking on the big tobacco companies. You're not doing anything except making it harder for me to get a new pack…And you're not stopping anything. You're just putting more stress and making it harder on communities that are already vulnerable, already at risk, already stressed out…"*
>
> *"My community just made everything nonsmoking. You can't smoke in your house. You can't smoke out on the premises anywhere. And I'm like, you're paying almost $2,000 to live in these so-called luxury apartments, and you telling me I can't smoke a cigarette, that just blows my mind."*

As shown below, current cigarette use has dropped significantly since *HealthMap2022*. However, although the Franklin County adult smoking rate is lower than that for Ohio, it is still above the US average. Furthermore, e-cigarette use among Franklin County adults has increased since *HealthMap2022*.

Cigarette Smoking



E-Cigarette Use



The demographic patterns are stark: individuals with an other (non-Hispanic) racial background use e-cigarettes as often as cigarettes. Additionally, males are more likely than females to smoke cigarettes, while females are more likely than males to use e-cigarettes. Black (non-Hispanic) individuals were distinctly unlikely to use e-cigarettes, which is an

interesting trend given that cigarette use among black (non-Hispanic) adults was higher than the average. As expected, e-cigarette use among older adults was very low.

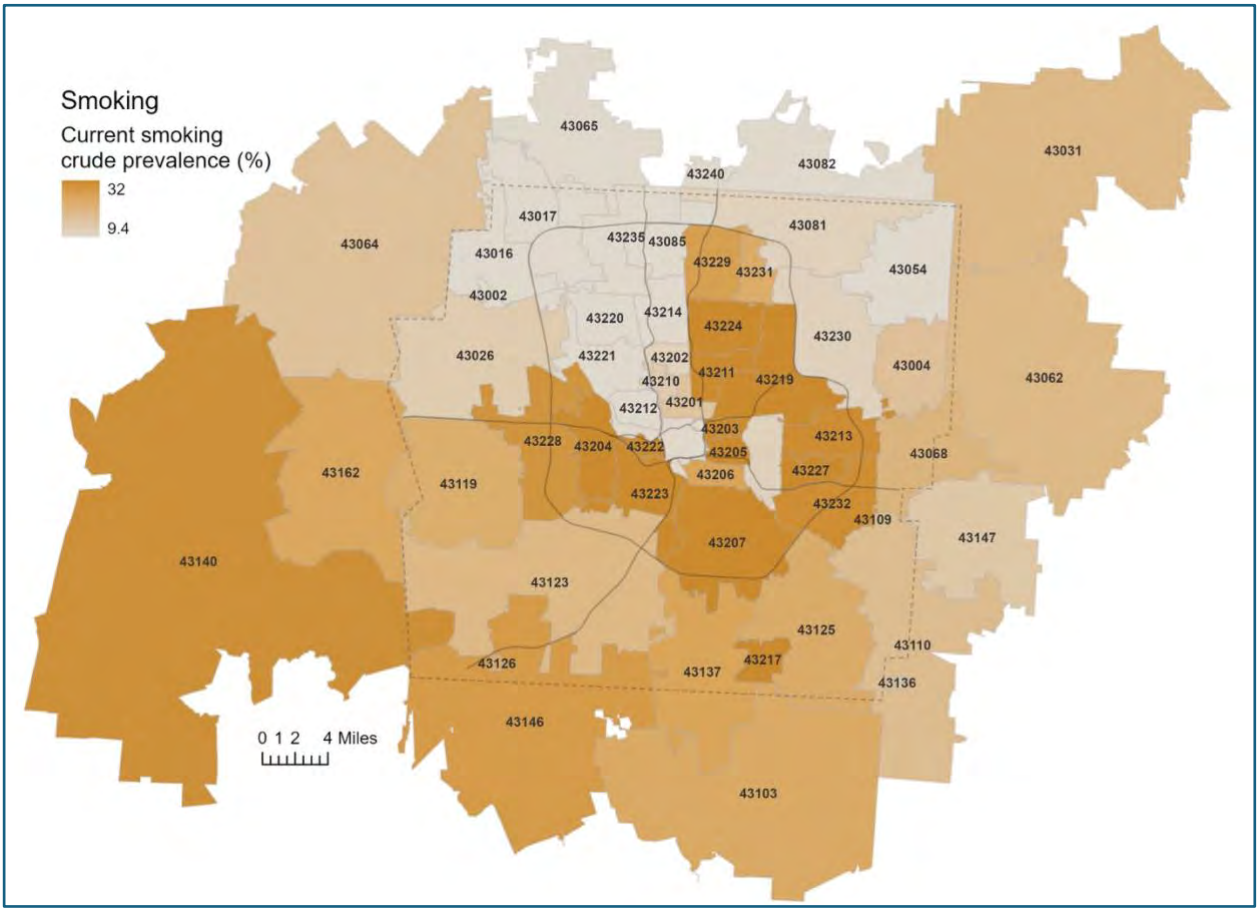
Healthy People 2030

While Franklin County does not meet the Healthy People 2030 standard, there has been significant improvement from HM2022, which estimated that 22.7% of Franklin County adults were current smokers.[3] Unfortunately, there is no HP2030 goal for e-cigarette use among adults.

HP2030 objective for Adults Currently Smoking Cigarettes: Not met (but improving)

Healthy People Objective:	Most recent Franklin County data (HM2025)
6.1%	**15.2%**

Smoking prevalence is higher in most Franklin County zip codes that are within I-270, except for those zip codes in the northwestern quadrant. Prevalence rates are also higher in many of the county's southern zip codes.



Additional Information & References

To assess the prevalence of this health behavior, *HealthMap2025* obtained recent data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS), which completes structured survey interviews with residents via telephone.[4] To assess cigarette use, adults were asked whether they smoke cigarettes every day, some days, or not at all. To assess e-cigarette use, adults were asked whether they have never used e-cigarettes, use every day, use some days, or used them in the past but not now. Participants were classified as current users if they used the product some days or every day.

Note that the question on e-cigarette use changed slightly in BRFSS' 2022 version of the survey questionnaire. In 2021, the question read "Do you now use e-cigarettes or other electronic vaping products every day, some days or not at all?" and in 2022 became "Would you say you have never used e-cigarettes or other electronic vaping products in your entire life or now use them every day, use them some days, or used them in the past but do not currently use them at all?" Both questions result in the same group being categorized as current users (every day or some days), however the new question allows further clarification of "never users" compared to "past users".[4] Still, considering there was a change in question wording, readers should be cautious when drawing conclusions about changes over time.

It is also important to note that multiple cities in Franklin County (e.g., Columbus, Bexley, Dublin, Grandview Heights) instituted a ban on the sale of all flavored nicotine products as of January 1, 2024. This measure has faced several legal challenges, and it is unclear whether it will withstand scrutiny from higher courts.[5] There is not yet data to discern whether this measure has or will have any effect on tobacco use in Franklin County, but this will be a critical issue in future *HealthMap* assessments.

To enable comparisons by demographic subgroups (e.g., age, sex, race), Columbus Public Health staff analyzed BRFSS data using the most recent year or two available (typically 2021 & 2022). To map the prevalence of these indicators at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the CDC's PLACES[6] resource, which uses BRFSS data (2021 or 2022), Census Bureau data (either the 2020 decennial census or 2022 annual population estimates), and American Community Survey data (2018-2022 estimates).

[1] National Center for Chronic Disease Prevention and Health Promotion (US) Office on Smoking and Health. (2014). *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General*. Centers for Disease Control and Prevention (US).

[2] Marques, P., Piqueras, L., & Sanz, M. J. (2021). An updated overview of e-cigarette impact on human health. *Respiratory research*, *22*(1), 151. https://doi.org/10.1186/s12931-021-01737-5

[3] Healthy People 2030 objective TU-02, U.S. Department of Health and Human Services

[4] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data, 2022 (HM2025), 2019 (HM2022), 2016 (HM2019)

[5] Shipkowski, Bruce. (2024, May 20). *Judge rules Ohio law that keeps cities from banning flavored tobacco is unconstitutional*. Associated Press. https://apnews.com/article/ohio-tobacco-regulations-local-vaping-bans-41396258b60c26798ec128e85851dfac

[6] Centers for Disease Control and Prevention, PLACES: Local Data for Better Health. (n.d.) https://www.cdc.gov/places/index.html

Weight Status

Weight is an important health indicator for mortality, chronic health conditions, and quality of life. Individuals at a higher weight are at greater risk for conditions such as cancer, heart disease, and diabetes. In 2015, high body mass index (BMI) contributed to 7.1% of deaths and 4.9% of disability-adjusted life years globally.[1]

29% of Franklin County adults reported **being overweight**.

≈ Similar to HM2022 (30.6%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
65+ more likely	Male more likely	White more likely	Observed (see map)

37% of Franklin County adults reported **being obese**.

≈ Similar to HM2022 (35.7%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
None observed	Female more likely	Black more likely	Observed (see map)

Community Voices

Community members noted that weight status contributes to many other physical health issues, and that achieving a healthier weight status becomes even more difficult due to the compounded issues.

> *"I think that obesity led to issues in my knees. So now I have arthritis in my knees. They would always say, if you lose some of that weight, it'll take less off of your knees and your ankles and that kind of thing…Diabetes and blood pressure can also lead to swelling and inflammation. But to [lose weight], you got to have the ability to. Like, I would never go anywhere because I would be out of breath in ten minutes. I couldn't walk up that hill, so I wasn't going there."*

Community members cited difficulty achieving adequate physical activity as a primary contributor to overweight status. Contributors to inadequate physical activity mentioned included the lack of affordable places to exercise, work schedules, work environments, and a culture that prioritizes cars, among others.

"Health wise, weight gain and things like that, there's not many other things except for expensive gyms to go to. I get off late at night. I'm not gonna go walk around at 10:00 at night and get my exercise."

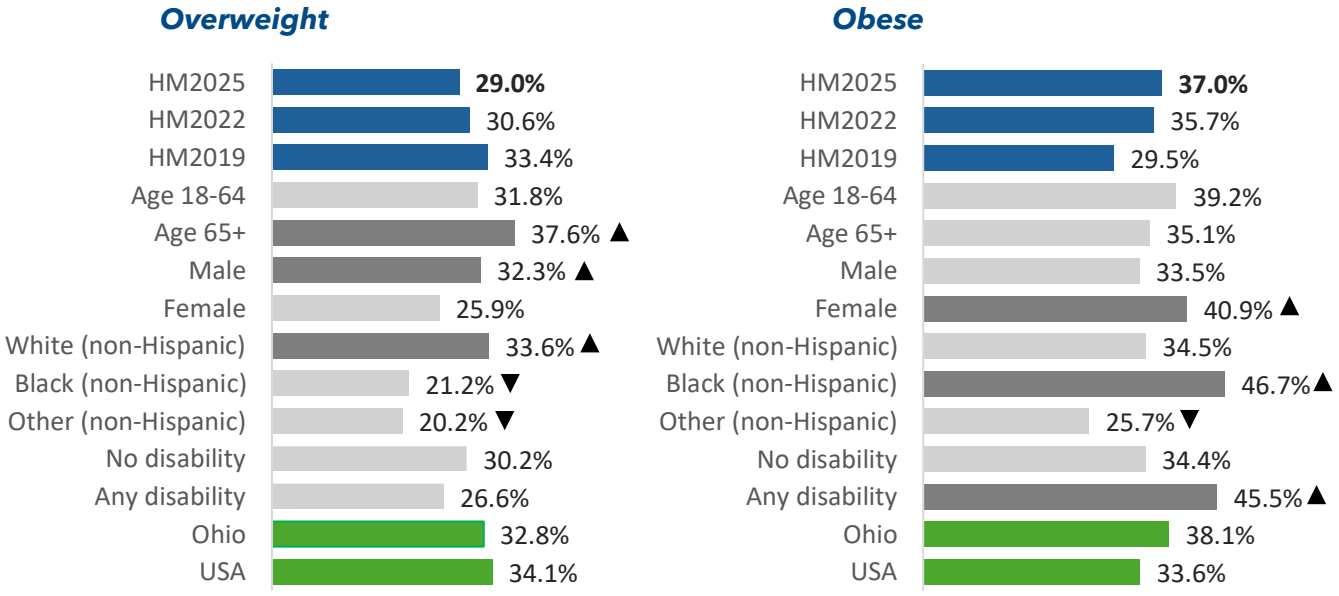
"My neighborhood stays quiet. There's a lot of kids, but I think most of the time they're either on their phones or in the house, playing video games…so it's creating a lazier, more unhealthier child that's [creating a cycle]…they'll have kids, and they just see their parents doing nothing."

"I work in an office environment…. [A lot of us are] sitting all day and possibly not getting the exercise or the movement that we might need…we have little stand up desks, but we're not moving around all day. We're literally just sitting there."

"Our country, our nation is gearing towards driving to get to places. Bikes are actually fading away. We barely see people biking around. Walking is not safe anymore. So people barely walk and stuff. So I think that lack of mobility is causing the obesity and overweight."

"The cost, yeah, Silver Sneakers is free. But then you get into knowing that our high schools uses that pool for their swimming…if you want a lap lane, you have to now reserve it. So it's like you have the initiative to go do something, but you kind of get detoured."

In Franklin County, black (non-Hispanic) individuals are more likely to be obese than overweight, indicating that there may be unmet needs for intervention for this population. Women are also more likely to be obese than overweight compared to men. Hispanic individuals were excluded from this analysis due to low sample size.



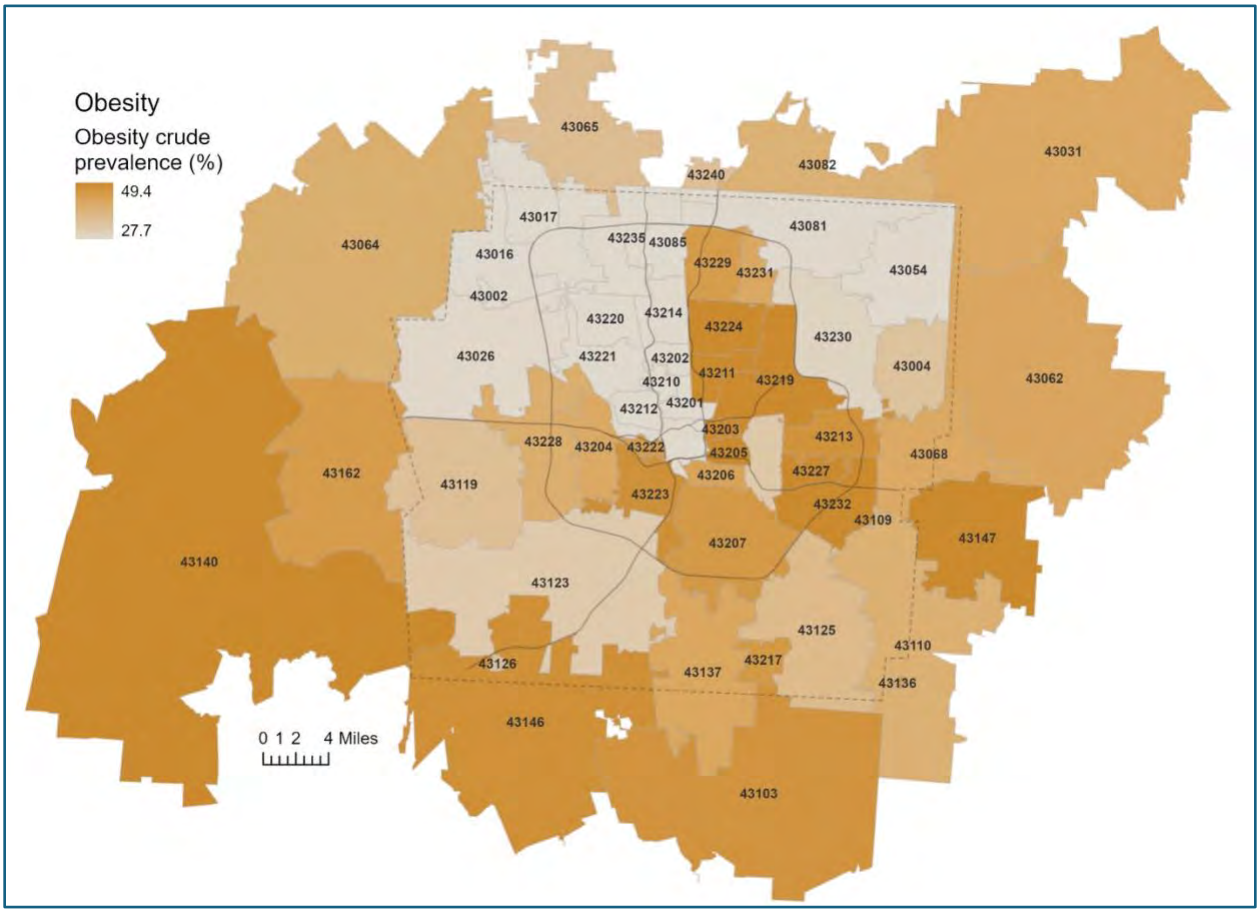
Healthy People 2030

Healthy People 2030 uses data from the National Health and Nutrition Examination Survey, which estimated that 38.6% of US adults were obese from 2013-2016. The BRFSS data used in HM2025 has a more conservative US estimate of 33.6% from 2021-2022. On either measure, the rate of obesity is rising locally and nationwide. There is no Healthy People 2030 goal for overweight status.

HP2030 objective for Obesity: Not met

Healthy People Objective:	Most recent Franklin County data (HM2025)
36%	**37%**

Obesity prevalence is higher in many Franklin County zip codes that are within I-270, except for those zip codes in the northwestern quadrant and the far northeastern areas. Prevalence rates are also higher in some of the county's southern zip codes.



Additional Information & References

To assess the prevalence of this health status, *HealthMap2025* obtained recent data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS), which completes structured survey interviews with residents via telephone.[3] A body mass index (BMI) of less than 18.5 is considered underweight, 18.5-24.9 is considered normal, 25-29.9 is considered overweight, and 30+ is considered obese.[4]

Although BMI is a commonly used measure of overweight/obesity status, it has been criticized as an outdated and discriminatory marker of health. This measure was developed in the 1800s and based primarily on male bodies, which are not the standard for all humans. Because BMI is a ratio of height to weight, the measure cannot differentiate between lean (muscle) mass and fat mass. Therefore, an elite athlete may be classified as overweight or obese despite being very fit and healthy. However, there are no other standardized measures of body composition that are as widely known and used.[5]

To enable comparisons by demographic subgroups (e.g., age, sex, race), Columbus Public Health staff analyzed BRFSS data using the most recent year or two available (typically 2021 & 2022). To map the prevalence of this indicator at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the CDC's PLACES[6] resource, which uses BRFSS data (2021 or 2022), Census Bureau data (either the 2020 decennial census or 2022 annual population estimates), and American Community Survey data (2018-2022 estimates).

Data Gap: The Community Health Needs Assessment Steering Committee requested recent data about the proportion of adult residents who meet physical activity guidelines. Unfortunately, the BRFSS stopped measuring this metric in 2019.

[1] GBD 2015 Obesity Collaborators, Afshin, A., Forouzanfar, M. H., Reitsma, M. B., Sur, P., Estep, K., Lee, A., Marczak, L., Mokdad, A. H., Moradi-Lakeh, M., Naghavi, M., Salama, J. S., Vos, T., Abate, K. H., Abbafati, C., Ahmed, M. B., Al-Aly, Z., Alkerwi, A., Al-Raddadi, R., Amare, A. T., … Murray, C. J. L. (2017). Health Effects of Overweight and Obesity in 195 Countries over 25 Years. *The New England journal of medicine*, *377*(1), 13–27. https://doi.org/10.1056/NEJMoa1614362

[2] Healthy People 2030 objective NWS-03, U.S. Department of Health and Human Services.

[3] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data, 2022 (HM2025), 2019 (HM2022), 2016 (HM2019)

[4] Weir, C. B., & Jan, A. (2023). BMI Classification Percentile And Cut Off Points. In *StatPearls*. StatPearls Publishing.

[5] Nuttall F. Q. (2015). Body Mass Index: Obesity, BMI, and Health: A Critical Review. *Nutrition today*, *50*(3), 117–128. https://doi.org/10.1097/NT.0000000000000092

[6] Centers for Disease Control and Prevention, PLACES: Local Data for Better Health. (n.d.) https://www.cdc.gov/places/index.html

MATERNAL AND INFANT HEALTH

Pre-pregnancy And Pregnancy Health

The health of pregnant individuals before and during their pregnancy is a significant opportunity for meaningful intervention. Pregnant individuals with medical comorbidities are at significantly increased risk for complications for both parent and child, including severe morbidity such as placental abruption, eclampsia, and neonatal intensive care unit (NICU) admission.[1]

43.7% of women who had a live birth had a **chronic health condition**.

≈ Similar to HM2022 (42.8%)

Disparities by selected social determinants of health: *White more likely*

44.9% of women who had a live birth were not taking **vitamins** before pregnancy.

≈ Similar to HM2022 (48.8%)

Disparities by selected social determinants of health: *Hispanic, Black more likely*

18.4% of women who had a live birth had pre-pregnancy **depression**.

≈ Similar to HM2022 (17.7%)

Disparities by selected social determinants of health: *White more likely*

6.1% of women who had a live birth had pre-pregnancy **hypertension**.

↑ Up from HM2022 (5.4%)

Disparities by selected social determinants of health: *Black more likely*

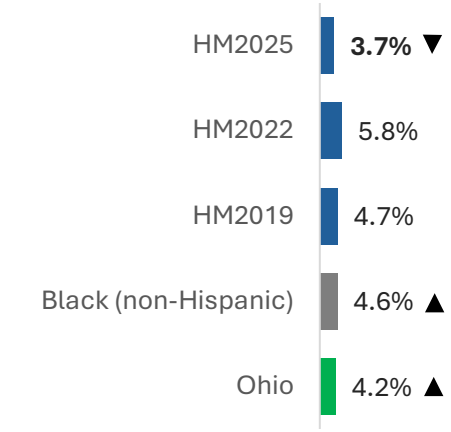
24.9% of live births were from **unintended pregnancies**.

≈ Similar to HM2022 (23.9%)

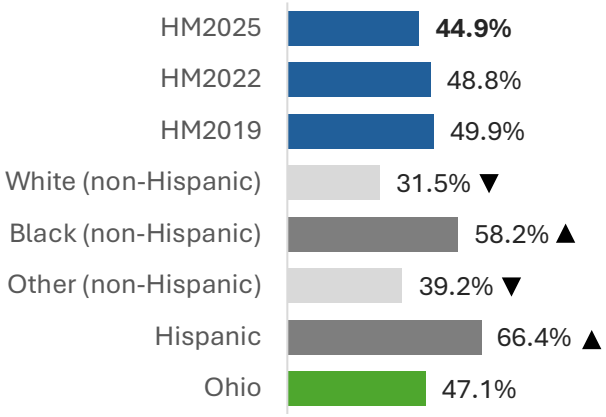
Disparities by selected social determinants of health: *Black, Hispanic more likely*

Although pre-pregnancy diabetes has decreased in recent years, black (non-Hispanic) residents are at increased risk for that health condition. Both black (non-Hispanic) and Hispanic residents were more likely to report not taking vitamins prior to pregnancy, as compared to white (non-Hispanic) residents or individuals who have an other (non-Hispanic) racial background.

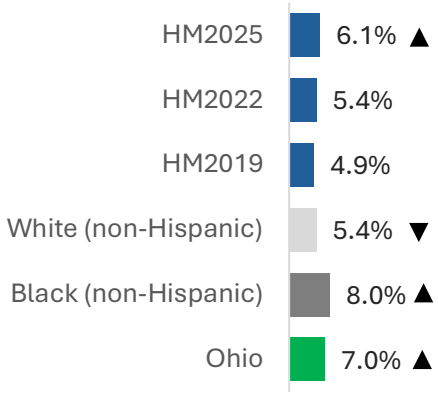
Pre-pregnancy Diabetes



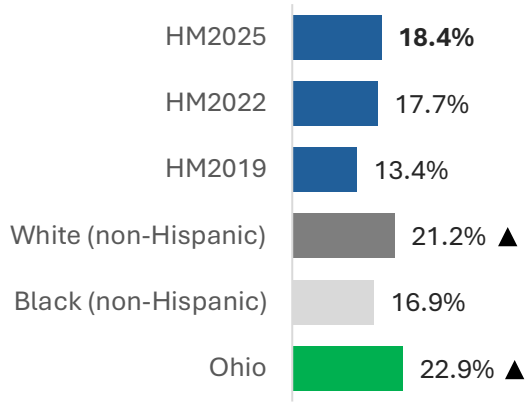
No Vitamins Pre-pregnancy



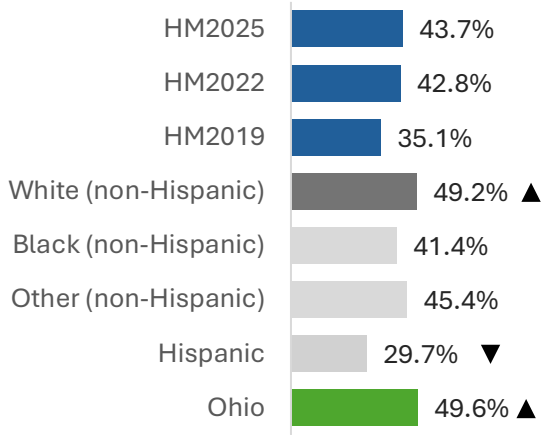
Pre-pregnancy Hypertension



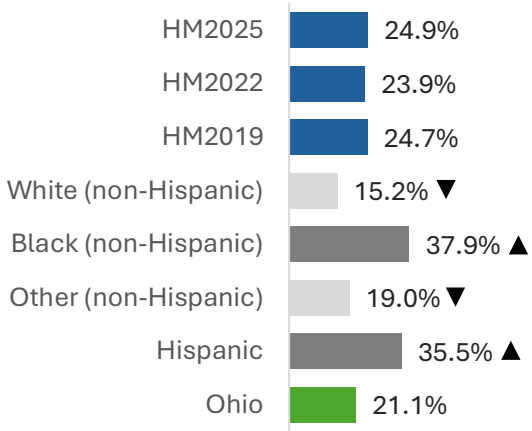
Pre-pregnancy Depression



Prenatal Chronic Conditions



Unintended Pregnancy



Additional Information & References

Data for this section were sourced from the Ohio Pregnancy Assessment Survey (OPAS), which asks questions of women who had a live birth.[2] Pre-conception vitamin usage was defined as taking multivitamins, prenatal vitamins, or other folic acid vitamins in the month before conception. Pre-pregnancy diabetes was defined as type 1 or 2 diabetes in the past 3 months before conception. Similarly, pre-pregnancy hypertension and depression were measured in the 3 months before conception. Prenatal chronic health conditions were defined as one or more conditions of anxiety, depression, gestational diabetes, or pregnancy-onset hypertension. Finally, unintended pregnancy was defined as either wanting to be pregnant later or not wanting to be pregnant at all prior to conception.

Readers might notice that pre-pregnancy overweight and obesity status was reported in *HealthMap2022* but not in *HealthMap2025*. This is because these data are no longer publicly reported by OPAS. This may be due in part to the increasing normalization of pregnancy at a higher BMI.

Data Gap: Future HealthMaps should consider obtaining data about pregnancy-related / maternal mortality.

[1] Tanner, M. S., Malhotra, A., Davey, M. A., Wallace, E. M., Mol, B. W., & Palmer, K. R. (2022). Maternal and neonatal complications in women with medical comorbidities and preeclampsia. *Pregnancy hypertension*, *27*, 62–68. https://doi.org/10.1016/j.preghy.2021.12.006

[2] Ohio Department of Health. *Ohio Pregnancy Assessment Survey* [Interactive Dashboard]. Retrieved from https://grcapps.osu.edu/app/opas, 2022 (HM2025), 2019 (HM2022), 2016 (HM2019)

Prenatal Racial Bias

Health disparities by race have been increasingly highlighted as a contributor to the maternal-child health crisis in the United States.[1] One proposed mechanism for why certain groups experience greater risks is bias or discrimination in healthcare. This may result in patients receiving substandard medical care or avoiding prenatal care altogether.[1]

9.9% of **pregnant individuals** reported **experiencing racial bias** from a healthcare provider.

Up from HM2022 (6.4%)

Disparities by selected social determinants of health: *Black, Hispanic more likely*

Community Voices

Community members spoke about the issue of maternal mortality, and how inadequate treatment by health care professionals contributes to higher rates for black mothers.

> *"The maternal death rates. If you're white middle class, your average chance of survival [in pregnancy and childbirth] is much greater than ours. I think it's like twice. The difference is pretty high. And that's just egregious. We have needs, we have the ability, we're just not putting the resources in."*
>
> *"Moms are going into hospitals and they're not believing in their pain. My aunt's friend went into the hospital, and she had her baby. She kept telling there was something wrong, and they left her for 4 hours…She passed away. She had an aneurysm. And she has been telling them all this time…the migraine, the headache she was having, it was so bad. They just told her, 'It's from the epidural.' And that's probably true…I'm pretty sure she would have been a great advocate for herself, but she was just in so much pain, she couldn't do it."*

Community members also gave other specific examples of how they have seen racial bias within the health care system, including health care professionals not listening to their wishes for labor and delivery, inadequate treatment of health issues resulting from pregnancy, and unfair assumptions that young black women are sexually promiscuous.

> *"I just had a baby eight months ago. And if it wasn't for the doula putting a birth plan and being an advocate for me, things could have went left several times during the delivery process. So you just think that not everyone has access to someone who can advocate for you in that process. They were trying to push a lot of stuff. I was very much like, I don't want any medication unless medically necessary…They'll go out the room and have those*

> *conversations, come back and try to still push it. And so it was frustrating at times…"*
>
> *"I had gallstones for the whole time I was pregnant. Found out that they were gallstones after I had my son. And then I'm still complaining of pain. It's like up to a year and a half later, maybe two years, and I was in the hospital four or five times. Then guess what? I had pancreatitis, because they never cleaned out my bioduct from the gallstones when I was 16. They never listened to me. And I really do think it's because I'm half black, half Hispanic."*
>
> *"The first time I had sex, I got pregnant, and I had my exam at the hospital. The first thing that they did was check me for STD's and ask me, how many people have I been with, and I have had other friends say, 'that's never happened to us.' I just wonder if the same thing would have happened if I had walked in white."*

Community members suspect that they experience racial bias in the health care system due to historical myths that black women feel less pain, as well as assumptions by health care professionals that their health issues are due to inherent genetic differences.

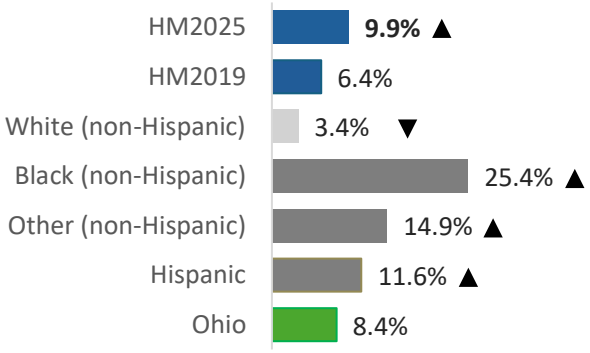
> *"It's obviously not true, but for the longest time in doula training, when you read the books, they were told that black women can accept more pain than a woman that's not black."*
>
> *"I've gone to a doctor and I've actually had them say, 'With you being an African American female, this is probably hereditary, you're probably having diabetes or it's high blood pressure' or something…they're making that assumption without doing the testing. They didn't afford me the opportunity to be tested…'It's probably just this. I don't think you have anything to worry about.' When I tell you I've heard that so many times, and then it develops into something."*

Lastly, a black community member highlighted how the historical treatment of people of color by the health care system and their preclusion from knowledge about their health still impacts the ability of healthcare to be equitable today:

> *"Knowledge is power. I mean, you can advocate better for yourself and for others when you know better. And I think it can be a class issue, it could be a socioeconomic issue. But if we consider racial discrimination or any of those factors…Even if I have access today, the reality is that two, three, four generations ago, it was withheld. Or even if my ancestors had the knowledge, they couldn't do anything with it because they were barred from being able to do so…We're behind. We have to try to play catch up as it pertains to a lot of things that can speak to our physical health, our mental health."*

As would be expected, experiences of racial bias are most common among racial and ethnic minorities. This was particularly prominent for black (non-Hispanic) patients, even compared to other racially minoritized groups. Concerningly, these experiences increased since the last *HealthMap*.

Prenatal Racial Bias Prevalence



Additional Information & References

To assess the experience of racial bias in prenatal care, data from the Ohio Pregnancy Assessment Survey (OPAS) were used.[2] Participants were asked "During your most recent pregnancy, did you experience discrimination or were you made to feel inferior while getting any type of health or medical care because of the things listed below", where one of the options was "My race, ethnicity, or culture". This measure is only reported periodically, with the most recent publicly available data collected in 2020.

[1] ACOG Committee Statement No. 10: Racial and Ethnic Inequities in Obstetrics and Gynecology. (2024). *Obstetrics and gynecology*, *144*(3), e62–e74. https://doi.org/10.1097/AOG.0000000000005678

[2] Ohio Department of Health. *Ohio Pregnancy Assessment Survey* [Interactive Dashboard]. Retrieved from https://grcapps.osu.edu/app/opas, 2020 (HM2025), 2016 (HM2019)

Maternal Healthcare

Pre-pregnancy healthcare visits offer expectant mothers and their doctors an opportunity to discuss healthy diet choices, folic acid supplementation, and other interventions that help to build the foundation for a healthy pregnancy.[1] Postpartum visits allow mothers who recently delivered a baby to be screened for postpartum depression, to have their overall health examined, and to discuss possible pregnancy complications such as gestational diabetes.[2]

72.3% of pregnant individuals had a **healthcare visit** in the year before their pregnancy.

≈ Similar to HM2022 (67.6%)

Disparities by selected social determinants of health: *Hispanic less likely*

90.2% of postpartum individuals had a **postpartum healthcare visit**.

≈ Similar to HM2022 (93.2%)

Disparities by selected social determinants of health: *Hispanic less likely*

Community Voices

Community members are aware that pregnant and postpartum individuals may not seek out health care when they should. They also drew attention to how specific health issues like preeclampsia and postpartum depression can worsen if not addressed by a health care professional.

> *"I hear that they don't get the prenatal [checks], they don't see the doctor like they should."*
>
> *"Postpartum preeclampsia, not knowing that they even have it until after they have the baby and then they're home for like a few days and then they're nearly about to die. But it wasn't caught during pregnancy."*
>
> *"I know I was almost psychotic after I had my child many years ago, and they're all safely grown now. But it was bad. I mean, I literally shudder when I think of the thoughts that would go through your mind. You had no control. And there was just nothing. There was no resources. If you go tell your doctor that, they're going to lock you up, take your kid away. I don't want to lose my child. But there was no help."*

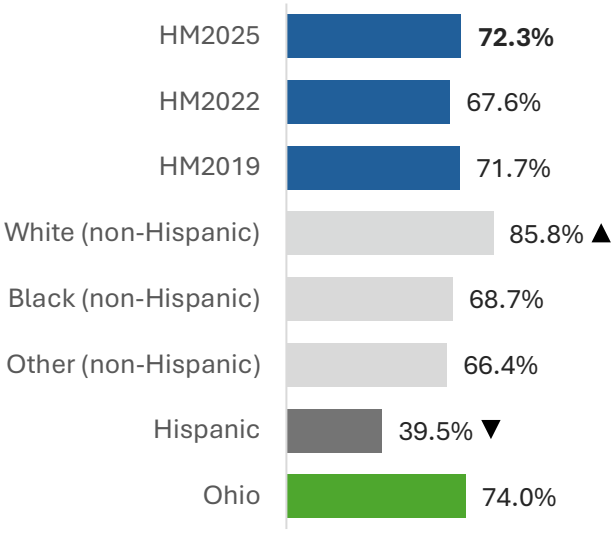
Community members mentioned that one of the reasons pregnant individuals don't seek health care is out of fear they will not receive adequate care. These fears appear to be especially prevalent in black communities.

"A lot of us were scared of doctors because of situations in the past. We really don't trust doctors. It's hard to even find one that we can really bond with…so many black women are dying during childbirth because they're not getting adequate care. They say we were better off back when we caught them ourselves than going to the hospital."

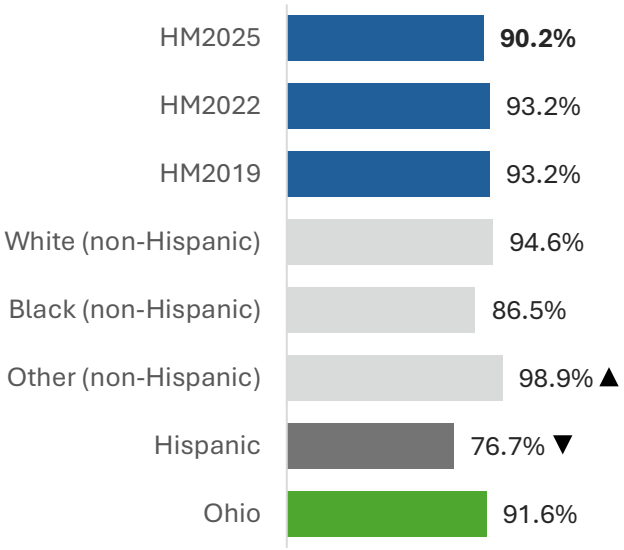
"There's just a lot of stories that you hear out here, where mostly black women are telling horror stories of how they're just not getting the proper care."

Pre-pregnancy healthcare visits were higher among white (non-Hispanic) individuals than all other racial groups and were particularly low among Hispanic individuals. Postpartum healthcare visits are high for all groups but are similarly lowest for Hispanic individuals. This could indicate a cultural or language barrier that can be further addressed.

Pre-pregnancy Healthcare visit



Postpartum Healthcare Visit



Additional Information & References

To assess the healthcare visit status of Franklin County mothers with a recent live birth, *HealthMap2025* used data from the Ohio Pregnancy Assessment System (OPAS).[3] Pre-pregnancy healthcare visits were defined as any visit with a healthcare professional in the 12 months prior to conception. Postpartum healthcare visits were defined as a checkup for the postpartum individual that occurs around 4-6 weeks after delivery.

[1] Berghella, V., Buchanan, E., Pereira, L., & Baxter, J. K. (2010). Preconception care. *Obstetrical & gynecological survey*, *65*(2), 119–131. https://doi.org/10.1097/OGX.0b013e3181d0c358

[2] ACOG Committee Opinion No. 736: Optimizing Postpartum Care. (2018). *Obstetrics and gynecology*, *131*(5), e140–e150. https://doi.org/10.1097/AOG.0000000000002633

[3] Ohio Department of Health. (2022). *Ohio Pregnancy Assessment Survey* [Interactive Dashboard]. Retrieved from https://grcapps.osu.edu/app/opas, 2022 (HM2025), 2019 (HM2022), 2016 (HM2019)

Infant Health and Adolescent Pregnancy

Infant health and mortality is a global concern, even in high-income countries such as the United States. Worldwide, the leading cause of death among those under age 5 is preterm birth, with the third cause of death being intrapartum-related events.[1] Adolescent pregnancy, along with increasing the risk for adverse infant outcomes, is also associated with serious physical and social consequences for the mother.[2]

7.4 infants died per 1,000 live births.	≈ Similar to HM2022 (6.9)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Unavailable	N/A	Black more likely	Observed (see map)

9.4% of infants were **born with a low birthweight**.	≈ Similar to HM2022 (9.5%)
10.6% of infants were **born prematurely**.	≈ Similar to HM2022 (10.9%)
12.1 infants had **neonatal abstinence syndrome** per 1,000 live births.	≈ Similar to HM2022 (11.4)
The **teen birth rate** was **15.2** per 1000 adolescent females.	↓ Down from HM2022 (17.2)

Community Voices

Community members are concerned that the county's youth are unable to access reproductive health care like birth control or abortion. They emphasized the importance of options and choices for teens who become pregnant. Abstinence-only education is not sufficient in their minds to reduce the issue of teen pregnancy.

"What concerns me now is there is not the access to care for young women that there used to be when I was that age. I can remember in high school, driving down to campus to go to Planned Parenthood with friends so that they could get on the pill or do whatever…We always knew in the back of our mind that if something came up, there were options."

"So as far as options, I think that if my mom would have had those options back then, I probably wouldn't be here, but it was an option, and it was a choice. She just did not have that. And there was not even birth control, birth control was not an option for her. From what she told me, it's because she was taught abstinence [only]."

"In high school, they have to take health. The kids consider it a joke. But if the kids think it's a joke, whether it's a valid program or not, then they're not getting anything from it. You're a freshman and you are getting a pregnancy test. And it happens all the time, but I think that means that what we're teaching them, it's not enough."

Community members also think that perceptions that gynecologists should only be seen once a person becomes sexually active are contributing to youth not having enough knowledge or access when it comes to reproductive health.

"A lot of the OBs, they don't even want to see the kids until they're 21. I called her because my daughter had extremely heavy bleeding several days, I wanted to get her on something that could help reduce that. And she's like, 'Well, we don't normally see them until they're 21.' If the health providers in that world are even saying this isn't really the age that we start to see them at, then you reduce the number of places that you can get help."

"One of my friends said to her daughter, 'Now that you've got a boyfriend, we should go to the gynecologist.' And I was standing right there, 'No, no. You go to the gynecologist because you're a woman and you take care of yourself. The boyfriend has nothing to do with this.' And I don't know if that is the message that they're getting."

A lack of education about sex and reproductive health can ultimately result in young parents being unequipped to adequately care for children.

"Young moms don't have the knowledge that they need. Years ago, they would have classes so when you got pregnant, you had a class that taught you the things that you needed, just the stuff you would need to know. Now they have these kids having babies and they don't know anything…they don't have a formula for the baby. Like, she was feeding the baby actual 2% milk because she didn't have any formula. She didn't know she needed the formula. She didn't have a means to get the formula, and her and the baby is just out. They didn't have Pampers."

Relatedly, families' unwillingness to broach the subject of sex and reproduction with their children may prevent youth from accessing birth control when it could be helpful for them.

> *"They don't teach them about their bodies. We have 8, 9-year-old girls who have started their periods, and their parents don't tell them. I remember a little girl, when she was eight, she said, 'I need a pad.' I'm not thinking like a sanitary pad. I'm thinking she was talking about paper… Some of the parents are talking to them, but a lot of them, they're not teaching. And the boys too, they're not teaching them about puberty, how their body's changing, how it's normal to feel what you're feeling."*
>
> *"My family was very closed [off], 'don't talk [about it]'. I don't think we ever even talked about sex, honestly. And when I got to college, the doctor was recommending for my migraines the Depo shot, which is a birth control. And I didn't want to have to tell my parents I needed birth control because I didn't think they would believe me that it wasn't about sex. And so I went to Planned Parenthood, and I used the money I earned working in school, and I got the Depo for $65 every three months."*

The infant health indicators have not changed significantly in recent years; not only does infant mortality remain relatively high, and is especially high among black (non-Hispanic) babies. Franklin County's neonatal abstinence syndrome (NAS) rate is slightly higher than that for Ohio.

Infant Mortality Rate

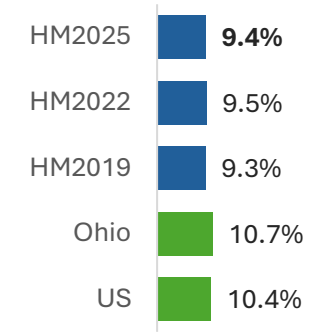
	Rate per 1,000 babies born
HM2025	**7.4**
HM2022	**6.9**
HM2019	**8.7**
White (non-Hispanic)	3.7 ▼
Black (non-Hispanic)	12.6 ▲
Hispanic	7.8
Ohio	**7.1**
US	**5.6**

Neonatal Abstinence Syndrome

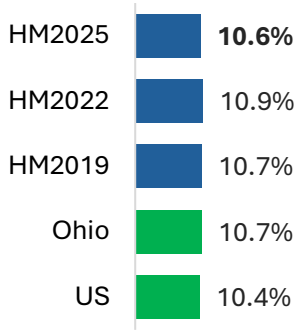
	Rate per 1,000 babies born
HM2025	**12.1**
HM2022	**11.4**
HM2019	**12.3**
Ohio	**10.1** ▼

Although Franklin County is similar to Ohio and the United States with regard to low birthweight and preterm birth rates, the teen birth rate has significantly declined across all geographies.

Low Birthweight



Preterm Birth



Teen Birth Rate

Rate per 1,000 girls age 15-19	
HM2025	**15.2** ▼
HM2022	**17.2**
HM2019	**23.4**
Ohio	**15.4** ▼
US	**13.6** ▼

Healthy People 2030

There is still progress to be made on infant mortality[3] and preterm births[4] in order to achieve the Healthy People 2030 goals. However, the adolescent pregnancy goal[5] has been exceeded and is currently less than half the target rate for that objective.

HP2030 objective for Infant Mortality: Not met

Healthy People Objective:
5.0 per 1000 live births

Most recent Franklin County data (HM2025)
7.4

HP2030 objective for Preterm Births: Not met

Healthy People Objective:
9.4%

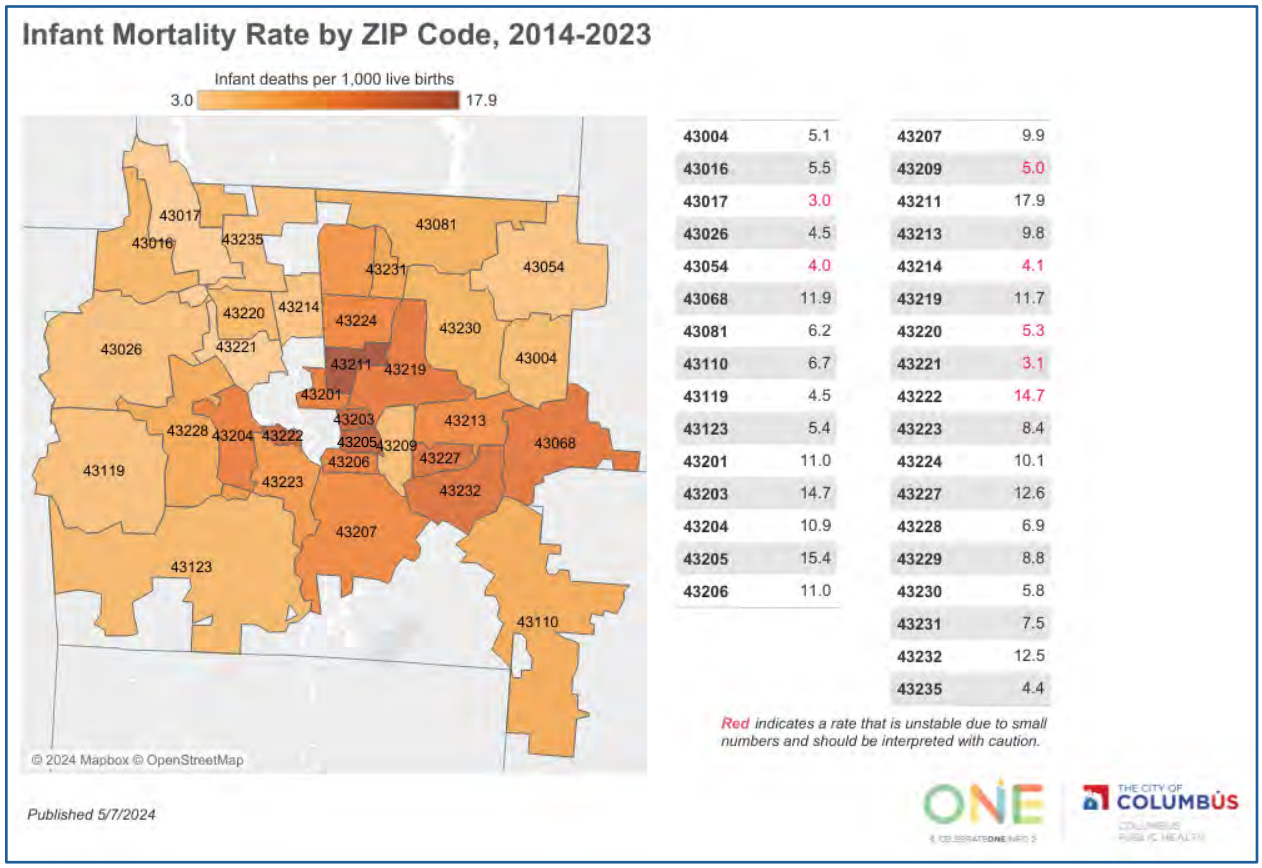
Most recent Franklin County data (HM2025)
10.6%

HP2030 objective for Adolescent Pregnancy: Met

Healthy People Objective:
31.4 per 1000 females aged 15-19

Most recent Franklin County data (HM2025)
15.2

The map below is a screenshot of the infant mortality rate across Franklin County's zip codes from 2014-2023, as mapped by Celebrate One and Columbus Public Health. The zip codes with the highest infant mortality rates are 43211, 43205, 43203, and 43222.[6] Readers who are interested in learning more about this topic are encouraged to visit Celebrate One and Columbus Public Health's interactive map, which can be accessed by **clicking here**.



Additional Information & References

Infant mortality refers to deaths that occur before someone is 1 year of age. Low birthweight is defined as less than 2500 grams (i.e., ~5.5 pounds) and preterm births are births that occur before 37 weeks gestation. NAS hospitalization rates were calculated from the number of reported NAS hospitalizations divided by the number of births in the same year. Adolescent fertility rates were defined as the birth rate of adolescent females aged 15-19 per 1000 in the same age range.

Adolescent pregnancy is challenging to measure both because there is no standard age when an individual becomes fertile and because abortions and miscarriages may be underreported. The most typical age range for reporting adolescent pregnancy and birth is

15-19; although pregnancies can and do occur under 15 years old, they constitute a very small number and are not frequently reported.

Franklin County infant mortality data were sourced from the City of Columbus' Infant Mortality Report for 2023, which in turn obtained data from Ohio Department of Health's Bureau of Vital Statistics about all births in which the mother was a resident of Franklin County.[7] Ohio and US infant mortality were sourced from the National Center for Health Statistics for 2022.[8] Low birthweight and preterm delivery for Franklin County and Ohio were sourced through the DataOhio Birth tool for 2023, while US statistics were again pulled from the National Center for Health Statistics for 2022.[9,10] Neonatal abstinence syndrome data were pulled from the Ohio Department of Health Violence and Injury Prevention division for 2022, 2020, and 2017.[11-14] Finally, adolescent pregnancy rates were sourced from the Centers for Disease Control and Prevention's WONDER database.[15]

[1] Perin, J., Mulick, A., Yeung, D., Villavicencio, F., Lopez, G., Strong, K. L., Prieto-Merino, D., Cousens, S., Black, R. E., & Liu, L. (2022). Global, regional, and national causes of under-5 mortality in 2000-19: an updated systematic analysis with implications for the Sustainable Development Goals. *The Lancet. Child & adolescent health*, *6*(2), 106–115.

[2] Maheshwari, M. V., Khalid, N., Patel, P. D., Alghareeb, R., & Hussain, A. (2022). Maternal and Neonatal Outcomes of Adolescent Pregnancy: A Narrative Review. *Cureus*, *14*(6), e25921. https://doi.org/10.7759/cureus.25921

[3] Healthy People 2030 objective MICH-02, U.S. Department of Health and Human Services

[4] Healthy People 2030 objective MICH-07, U.S. Department of Health and Human Services

[5] Healthy People 2030 objective FP-03, U.S. Department of Health and Human Services

[6] Celebrate One and Columbus Public Health (2023). Infant Mortality Report. https://public.tableau.com/app/profile/columbus/viz/InfantMortalityReport/P1Home

[7] City of Columbus. (2023). *Infant Mortality Report Franklin County, Ohio* [Interactive Dashboard]. Retrieved in 2024 from https://public.tableau.com/app/profile/columbus/viz/InfantMortalityReport/P1Home

[8] Ely DM, Driscoll AK. Infant mortality in the United States: Provisional data from the 2022 period linked birth/infant death file. National Center for Health Statistics. Vital Statistics Rapid Release; no 33. Hyattsville, MD: National Center for Health Statistics. 2023. DOI: https://doi.org/10.15620/cdc:133699

[9] DataOhio. (2023). *Birth* [Interactive Dashboard]. Ohio Department of Health, Bureau of Vital Statistics. Retrieved in 2024 from https://data.ohio.gov/wps/portal/gov/data/view/ohio_births

[10] Osterman MJK, Hamilton BE, Martin JA, Driscoll AK, Valenzuela CP. Births: Final data for 2022. National Vital Statistics Reports; vol 73, no 2. Hyattsville, MD: National Center for Health Statistics. 2024. DOI: https://dx.doi.org/10.15620/cdc:145588.

[11] Violence and Injury Prevention Section, Ohio Department of Health. (n.d.). *2022 Ohio Neonatal Abstinence Syndrome County Report*. https://odh.ohio.gov/wps/wcm/connect/gov/c9ba2f12-7d0a-4c4d-a7fd-ac9df2841c4a/Ohio+NAS+Data+by+County%2C+2018-2022.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_79GCH8013HMOA06A2E16IV2082-c9ba2f12-7d0a-4c4d-a7fd-ac9df2841c4a-oHsSMQB

[12] Violence and Injury Prevention Section, Ohio Department of Health. (n.d.). *2020 Ohio Neonatal Abstinence Syndrome County Report*. https://odh.ohio.gov/wps/wcm/connect/gov/7105d74d-7647-4dd6-83f9-9cbd0bba0d1c/Ohio+NAS+Data+by+County%2C+2016-2020.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-7105d74d-7647-4dd6-83f9-9cbd0bba0d1c-nNqG8oP

[13] Violence and Injury Prevention Section, Ohio Department of Health. (n.d.). *2017 Ohio Neonatal Abstinence Syndrome County Report*. https://odh.ohio.gov/wps/wcm/connect/gov/4cad708c-ba99-4b8b-b425-01cfef119c5d/2017+NAS+County+Table+12.3.2018.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-4cad708c-ba99-4b8b-b425-01cfef119c5d-oNFlFoC

[14] Violence and Injury Prevention Section, Ohio Department of Health. (n.d.). *2022 Ohio Neonatal Abstinence Syndrome Report*. https://odh.ohio.gov/wps/wcm/connect/gov/bb7407ed-f681-4ec0-b73e-572ffe05bb31/2022+NAS+Hospital+Discharge+Data+Summary+Table.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-bb7407ed-f681-4ec0-b73e-572ffe05bb31-oHsSFwF

[15] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER Online Database. Data are from the Natality Records 2016-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/natality-expanded-current.html

Celebrate One and Columbus Public Health's interactive map can be accessed at https://public.tableau.com/app/profile/columbus/viz/InfantMortalityReport/P1Home.

INFECTIOUS DISEASES

Common Infectious Diseases

Infectious diseases are among the leading causes of death worldwide, even in high income countries.[1] COVID-19, which emerged in 2019, has become the most commonly reported infectious disease, one that has long-term and severe health effects (including serious illness and/or death), especially among vulnerable members of the population. Community members continue to be at risk for COVID-19, and preventing the spread of this and other diseases continues to be a public health concern in Franklin County.

The most commonly reported **infectious diseases** for both adults and children were **COVID-19, Chlamydia,** and **Gonorrhea**

New metrics for HM2025

The most commonly reported infectious disease was COVID-19 for both adults and children/adolescents, followed by several sexually transmitted diseases and foodborne pathogens. Pertussis is a vaccine preventable disease, so the ongoing infection rate underscores the importance of continuing vaccination efforts. Interventions regarding sexually transmitted and foodborne illnesses continue to be important as well.

Adults (18+)

Disease	Rate per 1,000
COVID-19	**28.37**
Chlamydia	**9.16**
Gonorrhea	**3.99**
Syphilis (Primary and Secondary)	0.56
Campylobacter	0.27
Salmonella	0.15
Streptococcal disease, group a invasive (IGAS)	0.14
Streptococcus pneumoniae, invasive disease (ISP)	0.14
Legionella	0.08
Ecoli	0.08

Children (0-17)

Disease	Rate per 1,000
COVID-19	**14.45**
Chlamydia	**3.50**
Gonorrhea	**1.00**
Campylobacter	0.24
Giardia	0.19
Salmonella	0.17
Pertussis	0.13
Shigella	0.12
Ecoli	0.11
Lyme Disease	0.09

In *HealthMap2022*, infectious diseases were measured for the total population (instead for separately for adults and for children), resulting in a rate of 7.86 per 1,000 for chlamydia and 3.78 per 1,000 for gonorrhea. By recalculating these infectious diseases for the total

population in *HealthMap2025*, the rate of chlamydia is observed to be similar (7.84 per 1,000) while the rate of gonorrhea has decreased (3.30 per 1,000).

Additional Information & References

Using data from the Ohio Disease Reporting System, Columbus Public Health's Office of Epidemiology provided the total number of infectious disease cases in 2023 for each of the top 10 reported diseases among adults and children (separately). Case numbers were then converted into crude rates based on the age-specific population of Franklin County, using 2023 population estimates provided by Ohio's Department of Public Safety.[2]

The data in this report are based on counts of infectious diseases that were reported to the Ohio Department of Health. Some illnesses, such as influenza, are not reportable unless there is a severe outbreak, novel infectious, or severe morbidity or mortality. Other diseases may not be reported if the individual is asymptomatic or manages symptoms at home without medical intervention. Influenza was excluded from these data, as the counts would only include hospitalizations or mortality and would be a misleading presentation of influenza rates.

Data Gap: Readers might be surprised to learn about the prevalence of sexually transmitted infections among youth aged 0-17. One possible data source that could potentially add context to this finding is the High School Youth Risk Behavior Survey (YRBS). Although 2023 YRBS data for Ohio were not available in time for inclusion in this report, they are now available online at https://youthsurveys.ohio.gov/reports-and-insights/yrbs-yts-reports. Those data could be analyzed to determine if there have been changes in the percentage of high school youth who reported ever having sexual intercourse, current sexual activity, or condom use.

[1] World Health Organization. (2024). *The Top 10 Causes of Death.* https://www.who.int/news-room/fact-sheets/detail/the-top-10-causes-of-death

[2] Ohio Division of Emergency Medical Services, Ohio Department of Public Safety. (2024). Personal communication.

Human Immunodeficiency Virus (HIV)

Human Immunodeficiency Virus (HIV) was first identified in 1981, exponentially rising to over 130,000 cases annually by 1984 in the United States before being controlled by greater surveillance and treatment.[1] Rapid advancements in prophylactic and antiretroviral therapies have both decreased transmission rates and extended the expected lifespan of HIV infected individuals to be close to non-HIV infected individuals.[2]

There were **14.8 new HIV diagnoses** per 100,000 Franklin County residents.

≈ Similar to HM2022 (16.3)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Unavailable	Male more likely	Black more likely	Unavailable

Although Franklin County's overall HIV incidence rate has not changed significantly in recent years, it remains higher than the rates for Ohio and the United States.

Within Franklin County, there are vast disparities by both race and sex: individuals who do not have a white racial background and males are much more likely to have been diagnosed with HIV.

HIV Incidence	**Rate per 100,000**
HM2025	**14.8**
HM2022	**16.3**
White	6.7 ▼
Black/African American	34.5 ▲
Multi-Race	20.7 ▲
Hispanic	24.8 ▲
Male	22.6 ▲
Female	7.3 ▼
Ohio	**7.4**
US	**13.3**

Healthy People 2030

The Healthy People 2030 goal for HIV is a total of 3000 new infections per year nationally, which is equivalent to a rate of 0.9 per 100,000 population.[3] Franklin County (indeed, the United States as a whole) still has much progress that needs to be made toward this objective.

HP2030 objective for New HIV Infection: Not met

Healthy People Objective:	Most recent Franklin County data (HM2025)
0.9	**14.8**

Additional Information & References

To assess HIV incidence in Franklin County and Ohio, *HealthMap2025* sourced data about new infections from the Ohio Department of Health HIV/AIDS Surveillance Program for 2022 and 2019.[4,5] For the United States rates, data were obtained from the Centers for Disease Control and Prevention HIV Surveillance Report for the same years.[6]

Data Gap: Future *HealthMaps* should explore the possibility of calculating HIV incidence within each Franklin County zip code (or other sub-county geography).

[1] Bosh, K. A., Hall, H. I., Eastham, L., Daskalakis, D. C., & Mermin, J. H. (2021). Estimated Annual Number of HIV Infections — United States, 1981-2019. *MMWR. Morbidity and mortality weekly report*, *70*(22), 801–806. https://doi.org/10.15585/mmwr.mm7022a1

[2] Samji, H., Cescon, A., Hogg, R. S., Modur, S. P., Althoff, K. N., Buchacz, K., Burchell, A. N., Cohen, M., Gebo, K. A., Gill, M. J., Justice, A., Kirk, G., Klein, M. B., Korthuis, P. T., Martin, J., Napravnik, S., Rourke, S. B., Sterling, T. R., Silverberg, M. J., Deeks, S., … North American AIDS Cohort Collaboration on Research and Design (NA-ACCORD) of IeDEA (2013). Closing the gap: increases in life expectancy among treated HIV-positive individuals in the United States and Canada. *PloS one*, *8*(12), e81355. https://doi.org/10.1371/journal.pone.0081355

[3] Healthy People 2030 objective HIV-01, U.S. Department of Health and Human Services

[4] HIV Surveillance Program, Ohio Department of Health. (2023). *New Diagnoses of HIV Infection Reported in Franklin County*. https://odh.ohio.gov/wps/wcm/connect/gov/cac882ed-d27b-42ff-9d14-2e60a4c7e366/Franklin2022.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_79GCH8013HMOA06A2E16IV2082-cac882ed-d27b-42ff-9d14-2e60a4c7e366-oFCnYED

[5] HIV Surveillance Program, Ohio Department of Health. (2023). *New Diagnoses of HIV Infection Reported in Ohio*. https://odh.ohio.gov/wps/wcm/connect/gov/6ceaf279-cee6-4254-b899-386b585f0e5a/Ohio2022.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_79GCH8013HMOA06A2E16IV2082-6ceaf279-cee6-4254-b899-386b585f0e5a-oFCmzk1

[6] Centers for Disease Control and Prevention. (2024). *Diagnoses, deaths, and prevalence of HIV in the United States and 6 territories and freely associated states, 2022*. http://www.cdc.gov/hiv-data/nhss/hiv-diagnoses-deaths-prevalence.html

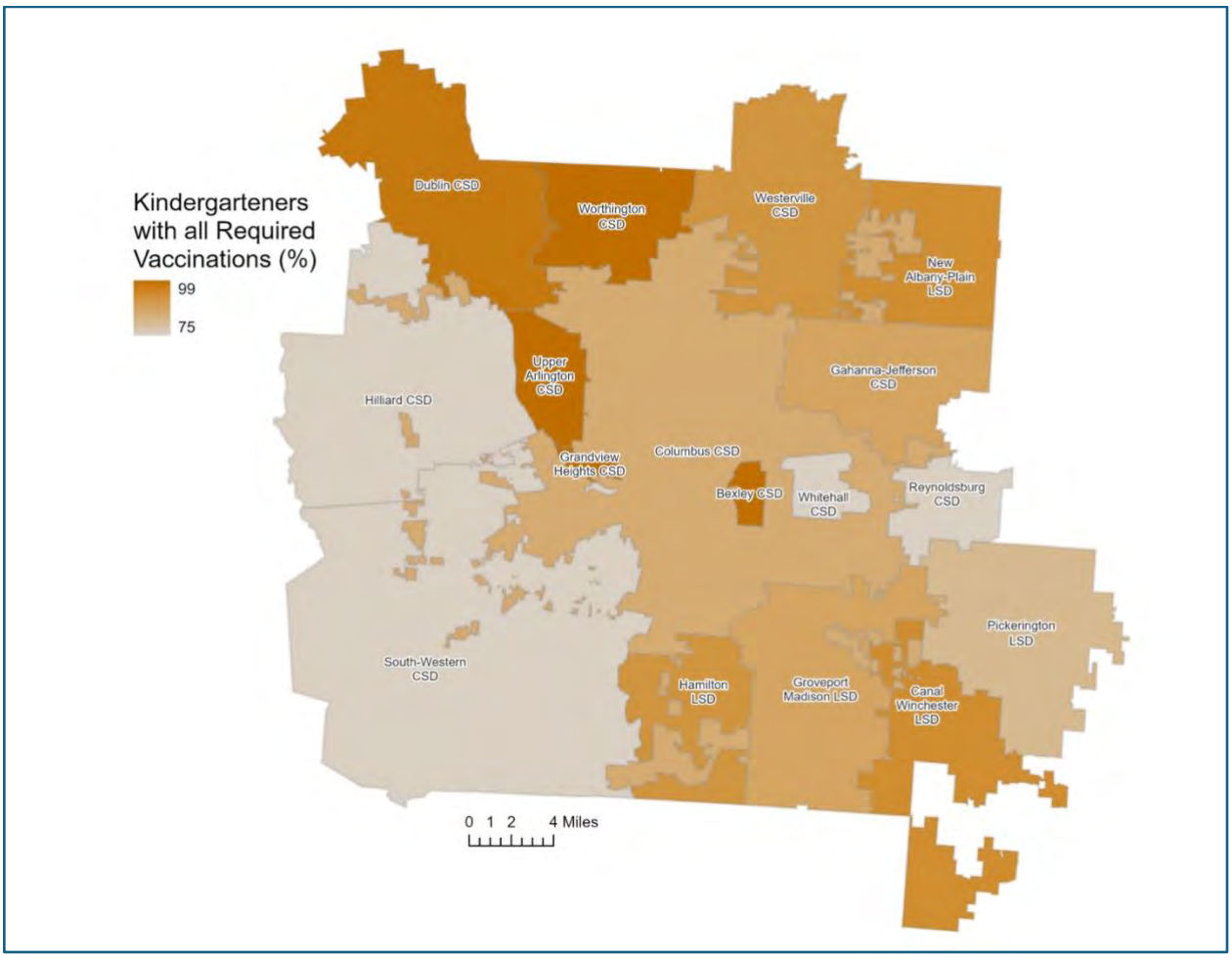
Kindergarten Vaccinations

Vaccinations are one of the most powerful, lifesaving health innovations of the 20th century. Globally, an estimated 154 million lives have been saved in the past 50 years due to vaccination, 146 million of which were children younger than 5.[1]

86.6% of Franklin County kindergarteners received all required **vaccines**.

New metric for HM2025

The Grandview Heights, Upper Arlington, Bexley, Worthington, and Dublin school districts reported that ≥95% of their kindergarteners entered school with all required vaccinations complete. The Columbus, Pickerington, Reynoldsburg, Hilliard, South-Western, and Whitehall school districts reported that ≤89% of their kindergarteners entered school with all required vaccinations complete.



Additional Information & References

The required vaccinations for a kindergarten student in Ohio includes 4+ doses of Diphtheria, Tetanus, and Pertussis (DTaP); 3+ doses of Hepatitis B; 2 doses of Measles, Mumps, and Rubella (MMR); 3+ doses of Polio; and 2 doses of Varicella.[2] More doses than the minimum may be required depending on the age of the child and when the child received their vaccines.

For this metric, Columbus Public Health's Office of Epidemiology requested data from Ohio Department of Health's Immunization Program. These data are a composite measure of kindergarteners in Franklin County public and private schools who had received all required vaccines for the 2022-2023 school year. Columbus Public Health staff then aggregated the data to calculate an estimate for each school district. Franklin County Public Health staff then mapped the prevalence of this indicator across the various school districts.

[1] Shattock, A. J., Johnson, H. C., Sim, S. Y., Carter, A., Lambach, P., Hutubessy, R. C. W., Thompson, K. M., Badizadegan, K., Lambert, B., Ferrari, M. J., Jit, M., Fu, H., Silal, S. P., Hounsell, R. A., White, R. G., Mosser, J. F., Gaythorpe, K. A. M., Trotter, C. L., Lindstrand, A., O'Brien, K. L., … Bar-Zeev, N. (2024). Contribution of vaccination to improved survival and health: modelling 50 years of the Expanded Programme on Immunization. *Lancet (London, England)*, *403*(10441), 2307–2316. https://doi.org/10.1016/S0140-6736(24)00850-X

[2] Vanderhoff, B. (2023). *In Re: Approved Means of Immunization Pursuant to Sections 3701.13 and 3313.671 of the Ohio Revised Code Director's Journal Entry*. Ohio Department of Health. https://odh.ohio.gov/wps/wcm/connect/gov/8e6d4c5d-7b45-4a0a-80cb-a1d8d00f4073/%28JE%29+%28131628%29+10-23-23+Directors-Journal-School-Requirements+10.16.2023+CERTIF.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_79GCH8013HMOA06A2E16IV2082-8e6d4c5d-7b45-4a0a-80cb-a1d8d00f4073-oJII3Hj

HEALTH CARE ACCESS

Emergency Department Utilization

Emergency department (ED) volume is an important metric for allocating appropriate resources and preventing overcrowding.[1] Frequent use of the emergency department is more common among women, patients with Medicare/Medicaid, black, and those who abuse prescriptions drugs.[2] Many patients report visiting the emergency department multiple times for the same condition, indicating that there may be a gap in either inpatient or follow-up care that drives frequent ED visits.[2]

There were **470.6 total emergency department visits** per 1,000 residents.	≈ Similar to HM2022 (511.3)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Older more likely	Female more likely	Black more likely	Observed (see maps)

There were **410.5 treated-and-released emergency department visits** per 1,000 residents.	≈ Similar to HM2022 (449.7)
There were **60.2 hospital admissions from an emergency department** per 1,000 residents.	≈ Similar to HM2022 (61.6)

Community Voices

Community members spoke about how difficulties finding providers who accept their insurance and long waitlists for appointments can lead individuals to use the emergency room for issues that could have been treated more affordably elsewhere. Additionally, many community members may not know about Federally Qualified Health Centers where they can get more affordable care if they are uninsured.

> *"So [the insurance companies] give you a list of who will take you. Well, then when you call them, they don't want to take you. Then I looked at [medical center] for what they offered, and they don't do it during the summer and then they're backed up forever. So I actually made a complaint to my insurance company and I said, 'I have this benefit, but no one will take me.' So they refer me to online counseling. So that finally came through. Don't know how long it's going to last, but I can see where, especially young people who need someone immediately, they end up in the hospital so*

> *many times."*
> *"There is availability for access to healthcare for people that do not have insurance that is affordable. I just think that it's not advertised enough. I know that it's not advertised enough. I went eleven years with no health care until I found out about FQHCs. I could have been going, because I was that person that only went to the emergency room when it was absolutely necessary. People don't know that they're available and they can help with 340b access to medications and PAPs through pharmaceutical companies. They're just not advertised enough."*

Community members also pointed out that a general lack of education about the medical system can lead individuals to use the ER for minor issues, and that more education is needed to ensure people seek the appropriate level of care for their health issues.

> *"I remember I sprained my ankle and I made the mistake of going to the emergency room at [medical center]. I think I got billed $4,000 and that's with health insurance."*
>
> *"I couldn't get insurance because I was working and it was so expensive. I was working two jobs and I would go to the ER all the time. Now every year when I get my taxes, I have to pay the emergency room for all this stuff that I was doing when I was 18, 19, 20, and I didn't know anything about the medical system. I just know I'm sick and I need to go to the doctor. So I just don't think they educate people enough and they aren't helping people enough with the medical assistance."*

The overall rates of total emergency department visits, treated and released visits, and admissions to the hospital from the emergency department have not significantly changed in Franklin County or Ohio since HM2022 (see tables on this page and the next page).

Children had a lower rate of all visit types, whereas older adults had higher rates of total ED visits and ED visits that resulted in hospital admission. Additionally, black (non-Hispanic) individuals had higher rates for all visit types, whereas white (non-Hispanic) individuals had lower rates of total ED visits and treated/released ED visits.

Lastly, males had lower rates of total ED visits and treated/released ED visits whereas females had higher rates for those types of visits.

Total ED Visits

	Rate per 1,000
HM2025	**470.6**
HM2022	**511.3**
HM2019	**608.8**
Age 0-17	299.1 ▼
Age 18-64	499.1
Age 65+	630.9 ▲
White (non-Hispanic)	371.4 ▼
Black (non-Hispanic)	683.9 ▲
Other (non-Hispanic)	541.5
Hispanic	464.2
Male	410.8 ▼
Female	528.2 ▲
Ohio	**492.3**

Treated and Released ED visits

	Rate per 1,000
HM2025	**410.5**
HM2022	**449.7**
HM2019	**546.3**
Age 0-17	280.4▼
Age 18-64	450.9
Age 65+	443.6
White (non-Hispanic)	312.1▼
Black (non-Hispanic)	609.2▲
Other (non-Hispanic)	492.9▲
Hispanic	430.0
Male	352.3▼
Female	466.5▲
Ohio	**423.4**

Hospital Admissions from ED Visits

	Rate per 1,000
HM2025	**60.2**
HM2022	**61.6**
HM2019	**62.4**
Age 0-17	18.8▼
Age 18-64	48.2▼
Age 65+	187.3▲
White (non-Hispanic)	59.3
Black (non-Hispanic)	74.7▲
Other (non-Hispanic)	48.6▼
Hispanic	34.2▼
Male	58.6
Female	61.7
Ohio	**69.0**

The rate of minor severity (level 1) visits to the emergency department has increased among Franklin County residents while the rate of high severity (level 4) visits has decreased since HM2022. Elsewhere in Ohio, the rates of both low-moderate (level 2) and moderate severity (level 3) visits have decreased since HM2022.

Severity of ED Visits (per 1,000 patients treated)

	HM2025	HM2022	HM2019	Ohio
Level 1 (minor severity)	**10.0▲**	**8.0**	**10.1**	**7.1**
Level 2 (low to moderate severity)	**52.8**	**51.7**	**50.2**	**30.5▼**
Level 3 (moderate severity)	**161.3**	**162.0**	**149.9**	**140.5▼**
Level 4 (high severity, urgent evaluation required)	**142.7▼**	**134.9**	**121.1**	**136.2**
Level 5 (high severity, immediate threat to life or function)	**94.1▼**	**92.2**	**77.3**	**109.0**

The diagnoses associated with emergency department use are an important indicator of healthcare access in the community. For example, many concerns treated in the emergency department might have been treated by a primary care provider, but oftentimes patients report being unable to access that first line of treatment in a timely manner. Demographic

variables such as low socioeconomic status are also associated with non-urgent use of the emergency department.[3,4]

Overall, the leading cause of visits to an emergency department that resulted in patients being treated-and-released was acute upper respiratory infection (unspecified), which is a catch-all term for a nose/throat infection that does not have a known cause. This was followed by two different types of chest pain and COVID-19. The rates of these diagnoses among Franklin County residents who visited EDs were similar to Ohioans who visited EDs.

Top Diagnoses Among Those Who Were Treated & Released By An Emergency Department (Total Population; rate per 1,000)

	HM2025	HM2022	Ohio
1st	Nose/throat infection (acute upper respiratory infection; unspecified): 10.3▼	Nose/throat infection (acute upper respiratory infection; unspecified): 12.0	Other chest pain: 11.0
2nd	Other chest pain: 9.9	Chest pain (unspecified): 10.9	Nose/throat infection (acute upper respiratory infection; unspecified): 9.4
3rd	Chest pain (unspecified): 6.6▼	Other chest pain: 9.8	Chest pain (unspecified): 7.1
4th	COVID-19: 6.5	Headache: 8.7	COVID-19: 6.6
5th	Headache (unspecified): 5.7	Abdominal pain (unspecified): 8.1	Urinary tract infection: 6.0

Among youth, the leading cause of treated-and-released visits to an emergency department was also upper respiratory infections (unspecified), followed by other infectious diseases.

Top Diagnoses Among Those Who Were Treated & Released By An Emergency Department (Ages 0-17; rate per 1,000)

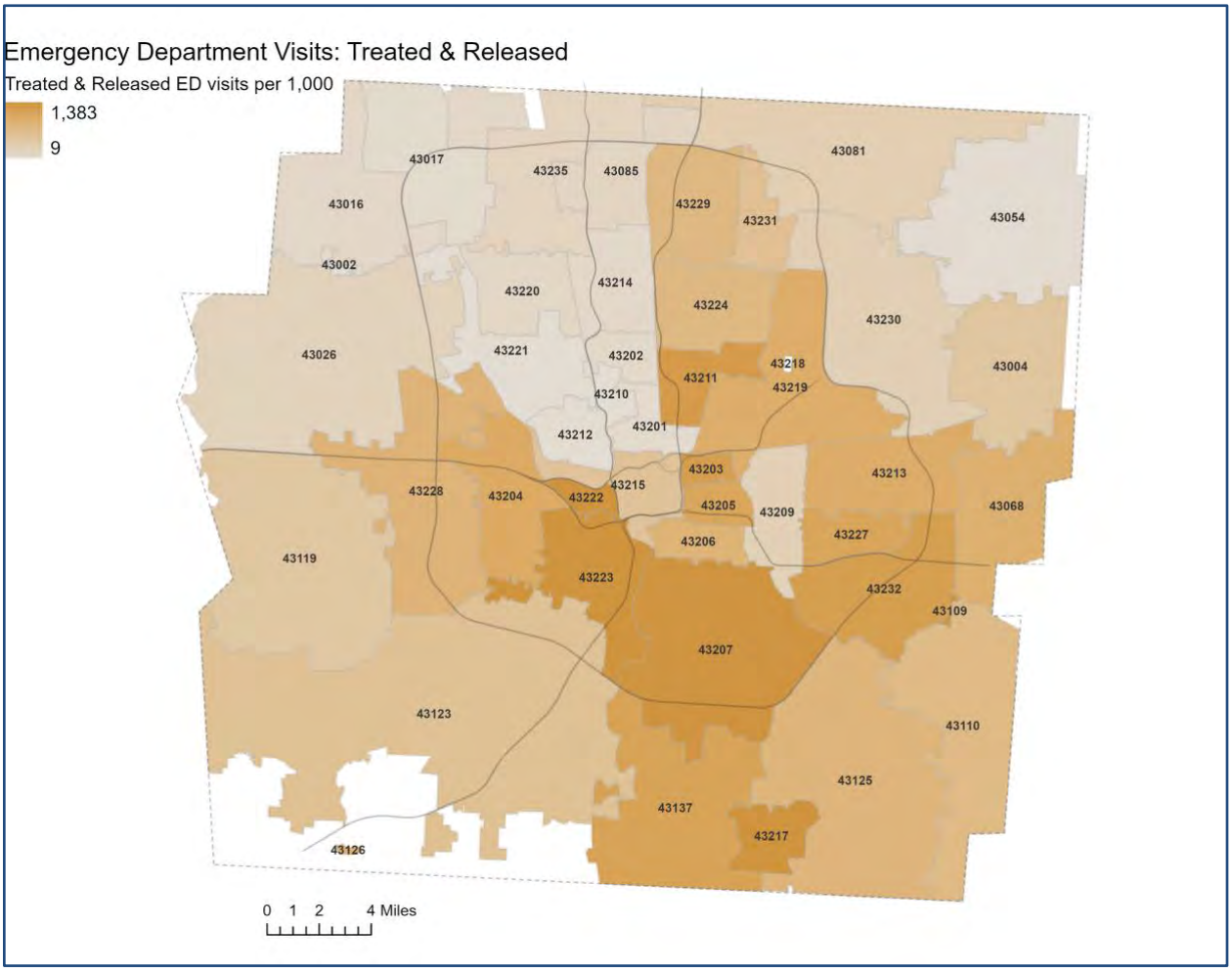
	HM2025	HM2022	Ohio
1st	Nose/throat infection (acute upper respiratory infection; unspecified): 19.1▼	Nose/throat infection (acute upper respiratory infection; unspecified): 24.7	Nose/throat infection (acute upper respiratory infection; unspecified): 21.7
2nd	Strep throat (streptococcal pharyngitis): 12.3	Fever (unspecified): 8.9	Strep throat (streptococcal pharyngitis): 11.7
3rd	Viral infection (unspecified): 8.9	Viral infection (unspecified): 8.9	Viral infection (unspecified): 9.0
4th	Vomiting (unspecified): 4.9▼	Vomiting (unspecified): 6.9	Fever (unspecified): 7.6
5th	Upper airway infection causing breathing difficulty (acute obstructive laryngitis; croup): 4.7	Influenza: 6.2	Injury to the head (unspecified): 6.6

Among older adults, the leading cause of treated-and-released visits to an emergency department was chest pain followed by urinary tract infection.

Top Diagnoses Among Those Who Were Treated & Released By An Emergency Department (Ages 65+; rate per 1,000)

	HM2025	Ohio
1st	Other chest pain: 11.9	Other chest pain: 13.1
2nd	Urinary tract infection: 11.2	Urinary tract infection: 12.3
3rd	COVID-19: 9.9	COVID-19: 10.7
4th	Chest pain (unspecified): 9.3	Chest pain (unspecified): 9.1
5th	Vertigo/light headedness (dizziness and giddiness): 9.1	Vertigo/light headedness (dizziness and giddiness): 8.9

As shown below, the rate of emergency department visits that led to patients being treated and released was highest in southern zip codes (43207, 43217, 43137), west-central zip codes (43222, 43223), and 43211.



Overall, the leading cause of visits to an emergency department that resulted in patients being admitted into a hospital was sepsis and hypertensive heart and chronic kidney disease (with heart failure) or chronic kidney disease, followed by hypertensive heart disease (with heart failure) and kidney failure. The rates of these diagnoses among Franklin County residents who visited EDs were similar to Ohioans who visited EDs.

Top Diagnoses Among Those Who Were Admitted Into A Hospital From An Emergency Department (Total Population; rate per 1,000)

	HM2025	HM2022	Ohio
1st	Sepsis (unspecified organism): 4.4▼	Sepsis (unspecified organism): 5.6	Sepsis (unspecified organism): 4.7
2nd	Hypertensive heart & chronic kidney disease with heart failure or chronic kidney disease (unspecified): 1.6▼	Hypertensive heart & chronic kidney disease with heart failure or chronic kidney disease (unspecified): 2.0	Hypertensive heart & chronic kidney disease with heart failure or chronic kidney disease (unspecified): 1.9
3rd	Hypertensive heart disease with heart failure: 1.4▼	Hypertensive heart disease with heart failure: 1.7	Hypertensive heart disease with heart failure: 1.7
4th	Acute kidney failure (unspecified): 1.2▼	Acute kidney failure (unspecified): 1.4	Acute kidney failure (unspecified): 1.5
5th	COPD (with acute exacerbation): 0.9	Heart attack (NSTEMI): 1.3	Pneumonia (unspecified organism): 1.4

Among youth, two of the top 5 leading causes of visits to an emergency department that resulted in a hospital admission were related to lung infections, and two of the other top 5 leading causes were related to major depression.

Top Diagnoses Among Those Who Were Admitted Into A Hospital From An Emergency Department (Ages 0-17; rate per 1,000)

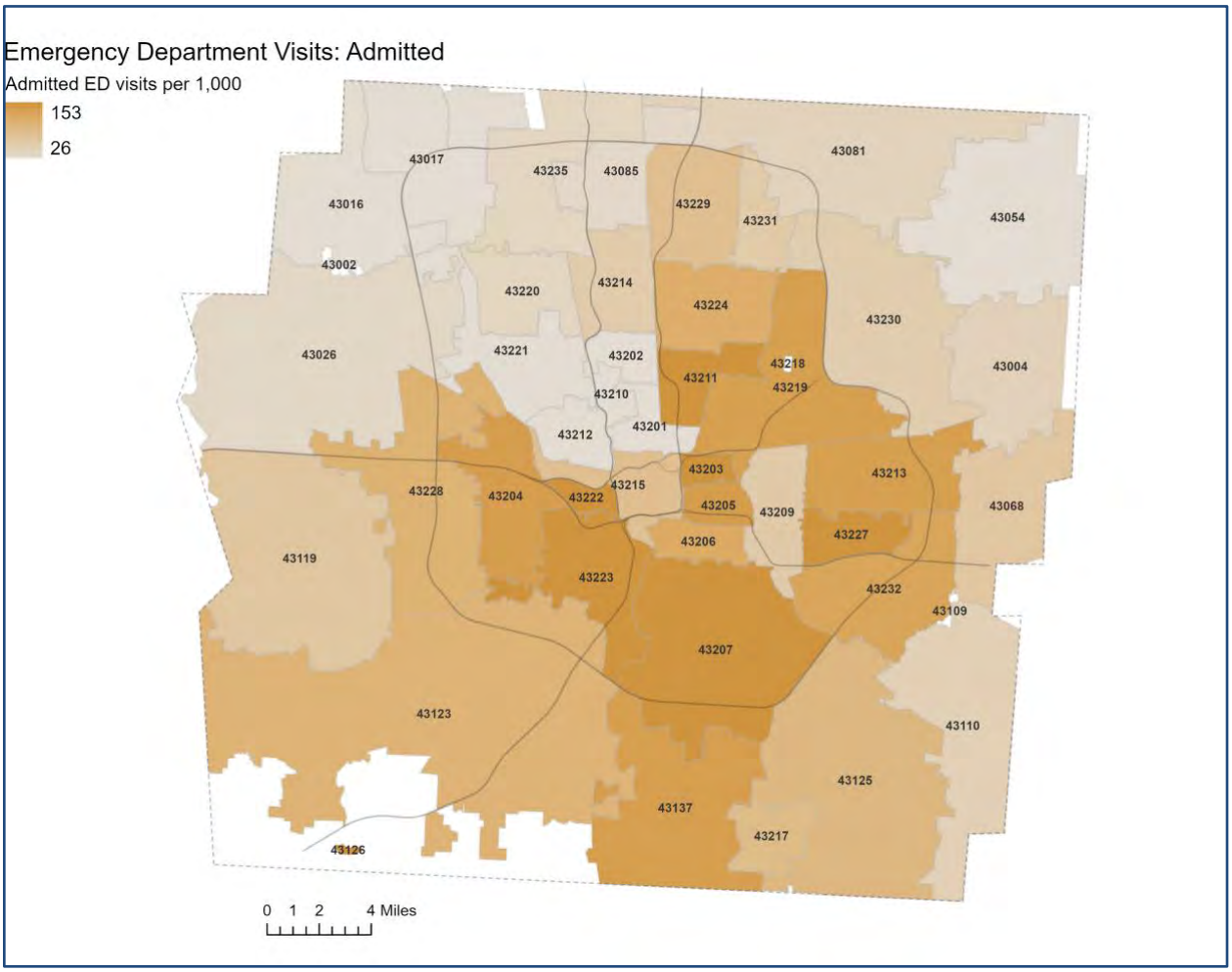
	HM2025	HM2022	Ohio
1st	Lung infection (acute bronchiolitis; RSV): 1.6	Lung infection (acute bronchiolitis; RSV): 1.5	Lung infection (acute bronchiolitis; RSV): 0.6
2nd	Recurrent major depression (without psychosis): 0.5	Dehydration: 1.4	Dehydration: 0.5
3rd	Lung infection (bronchiolitis; specified organism): 0.5▼	Lung infection (acute bronchiolitis;unspecified): 1.1	Recurrent major depression (without psychosis): 0.3
4th	Major depression (single episode): 0.4	Lung infection (bronchiolitis; specified organism): 1.0	Lung infection (acute bronchiolitis; unspecified):0.3
5th	Type 1 diabetic ketoacidosis (without coma): 0.4▼	Type 1 diabetic ketoacidosis (without coma): 0.7	Disruptive mood dysregulation: 0.3

Among older adults, the leading cause of visits to an emergency department that resulted in a hospital admission was sepsis, followed by hypertensive heart and chronic kidney disease, hypertensive heart disease (with heart failure), and kidney failure.

Top Diagnoses Among Those Who Were Admitted Into A Hospital From An Emergency Department (Ages 65+; rate per 1,000)

	HM2025	Ohio
1st	Sepsis (unspecified organism): 20.6▲	Sepsis (unspecified organism): 15.7
2nd	Hypertensive heart & chronic kidney disease with heart failure or chronic kidney disease (unspecified): 10.8▲	Hypertensive heart & chronic kidney disease with heart failure or chronic kidney disease (unspecified): 8.9
3rd	Hypertensive heart disease with heart failure: 7.8▲	Hypertensive heart disease with heart failure: 6.6
4th	Acute kidney failure (unspecified): 6.4	Acute kidney failure (unspecified): 6.1
5th	Heart attack (NSTEMI): 5.3	COVID-19: 5.2

As shown below, the rate of emergency department visits that led to patients being admitted to a hospital was highest in southern zip codes (43207, 43137), west-central zip codes (43222, 43223), 43203, and 43211.



Additional Information & References

Readers who are interested in learning more about this topic should also read the *HealthMap2025* section that focuses on individuals with disabilities (see page 65).

To measure emergency department utilization, *HealthMap2025* requested data from the Ohio Hospital Association for calendar year 2023.[5] Franklin County residents who visited any Ohio hospital's emergency department are counted in these data. The raw data from each category was divided by the total population for the appropriate year and geographic region, and then converted into a rate per 1,000. For sample size reasons, the "other (non-Hispanic)" racial category includes all racial/ethnic groups other than black (non-Hispanic), white (non-Hispanic), and Hispanic. Franklin County Public Health staff then mapped these data for each zip code in Franklin County.

The Ohio Hospital Association also provided data for the most frequent diagnoses (i.e., the primary ICD-10 codes) among Franklin County and Ohio residents who either (1) were treated and released from an emergency department (i.e., without being admitted to the hospital) in 2023 or (2) were admitted to a hospital from an emergency department in 2023.[5] The raw numbers that were provided were converted into crude rates for the appropriate geographic and age group.

Data Gap: The Community Health Needs Assessment Steering Committee requested recent data about patients who went to emergency departments for the same underlying health need(s) on multiple occasions over some duration of time (i.e., "emergency department readmissions"). Unfortunately, that type of data is unavailable.

[1] Kenny, J. F., Chang, B. C., & Hemmert, K. C. (2020). Factors Affecting Emergency Department Crowding. *Emergency medicine clinics of North America*, *38*(3), 573–587. https://doi.org/10.1016/j.emc.2020.04.001

[2] Behr, J. G., & Diaz, R. (2016). Emergency Department Frequent Utilization for Non-Emergent Presentments: Results from a Regional Urban Trauma Center Study. *PloS one*, *11*(1), e0147116. https://doi.org/10.1371/journal.pone.0147116

[3] Unwin, M., Kinsman, L., & Rigby, S. (2016). Why are we waiting? Patients' perspectives for accessing emergency department services with non-urgent complaints. *International emergency nursing*, *29*, 3–8. https://doi.org/10.1016/j.ienj.2016.09.003

[4] Montoro-Pérez, N., Richart-Martínez, M., & Montejano-Lozoya, R. (2023). Factors associated with the inappropriate use of the pediatric emergency department. A systematic review. *Journal of pediatric nursing*, *69*, 38–46. https://doi.org/10.1016/j.pedn.2022.12.027

[5] Ohio Hospital Association. (2023). *Ohio Hospital Association* [Dataset].

Dental Care Access

Oral health, which includes the mouth, teeth, and other maxillofacial elements, allows people to eat, breathe, and speak, granting it an important role in individuals' physical, mental, social, and economic well-being.[1,2] Poor oral health has been associated with a variety of health conditions, including cardiovascular disease, pregnancy and birth complications, and pneumonia.[3] Therefore, equitable access to dental care is critical to ensure optimal health.[4]

3.3% of children age 3-18 **needed dental care but could not secure it**.	↓ Down from HM2022 (3.9%)
12.8% of adults age 19-64 **needed dental care but could not secure it**.	↓ Down from HM2022 (16.1%)

Community Voices

Community members identified how fear and embarrassment can influence residents to avoid seeking dental care. Alternatively, people may not place a high priority on visiting a dentist if they have not experienced any teeth "problems."

> *"People are worried, if this goes wrong, my teeth are going to be gone."*
>
> *"To get dentures, you get an appointment, and they'll say you have to go get them pulled. Then come back here. Who wants to go eight weeks without teeth?…it needs to be more convenient."*
>
> *"I think another thing is embarrassment. So if you haven't gone to the dentist in a long time, it might feel sort of just scary to go into the dentist after a while because of fear of judgment from healthcare practitioners."*
>
> *"The fear of like not being treated well, being stigmatized, being seen as a drug addict, being seen as like we'll do all these procedures, we'll take out all your teeth, but we're not going to give you any pain medication because you struggle with addiction…"*
>
> *"I was one of those people that had good teeth anytime I went for cleaning. There were never any issues, so I held off for a really long time. And then I was finally like I need to go. And I got my first cavity…I was scared to go back again because you gotta get it fixed, right. And it's actually considered dental surgery…So I was really worried about pain. And then also this really weird thing, if I have easy teeth for such a long time, why do I need to go?"*

Dental care costs also play a large role in residents' willingness to see a dentist or orthodontist, whether they have insurance or not.

"But those [insurance] costs are not covering anything for the kids. The kids need braces. They're only covering $2,000 for the braces. But the average cost of braces was starting at $5,000."

"Even if you have insurance, it's outrageous. It really is. Like, if you need to have an implant, you might as well count on $5,000, and that's with insurance, though. They're just not covered."

"My husband just recently cracked a tooth about a month ago, and we don't have dental because he unfortunately lost his position where he was at. He went to a local dentist here. They told him what they could do, and then they started adding on different things and a health plan. 'This is what you can do, a yearly plan.' He goes, 'Wait a minute. Am I buying a condo, and I don't know about it?' That's exactly what he felt like. He left, and we went back to where I grew up in Galloway. They're working with us for him, just for a payment plan. Just for a broken molar, it's $3,000 to fix when you don't have any insurance."

"So for the past four years, I've been trying to get my mouth fixed affordably, which is impossible because I have no insurance. I don't have Medicaid anymore either, because I don't qualify. I can't afford the insurance either. I go to different places to check, and they want for one root canal, one crown; it was over $3,000…There could be a lot of work done in regard to affordability, dental care, especially for the self-pay."

"They want you to take that credit, that CareCredit, and the interest rates on those are outrageous. If you can't afford it to begin with, and you're saying you need to pay $3,000 back in two years. That's not going to happen. So you just don't do it at all, and you live with the pain."

Finding a dentist that will accept their insurance and being able to schedule appointments that do not conflict with work schedules are additional barriers to dental care.

"And then it's finding a dentist that will accept you. It's hard to find a dentist that will accept your insurance or if you don't have insurance, and it's just hard to find one and keep one."

"And the insurance changes whether you can stay with your dentist. I was with my dentist for almost 30 years, and then all of a sudden, they don't accept your insurance anymore. You already have a relationship, a rapport with them, and then you got to start all over again."

"Scheduling, too. It's hard to get into a dentist around a time that works for you, especially when you're working. A lot of places aren't open after five. I don't want to go on my lunch break because they always have me sitting there forever. And, after that, 'Oh, well, we can do your cleaning today but you have to schedule another appointment and miss work, use PTO to get your teeth pulled.'"

Franklin County residents also think there needs to be expanded emergency dental services in the community.

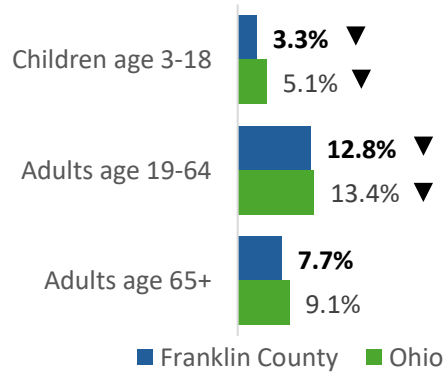
"[medical center] has emergency dental, but they only take the first ten people…So it's one of these, there is an emergency dental clinic, but again, if you're not right there when it first opens…"

"I don't understand why we've never had better emergency services for a dental situation. Because my mom had that and she had to run to a different one every Saturday. Now my particular dentist is pretty good. You call him at 7:00 in the morning and end up going, but it's not guaranteed the way Urgent Care is. "

"You go out with your friends and you get a tooth knocked out. Your dentist probably isn't going to answer either on a Friday or Saturday…where do you go?"

From HM2022 to HM2025, fewer children age 3-18 and adults age 19-64 needed dental care but could not secure it.

Needed Dental Care But Could Not Secure It



Additional Information & References

Data for this indicator were obtained from the Ohio Medicaid Assessment Survey.[5]

[1] World Health Organization. (n.d.) Oral health. https://www.who.int/health-topics/oral-health#tab=tab_1
[2] Peres MA, Macpherson LMD, Weyant RJ et al. Oral diseases: a global public health challenge. *The Lancet*. 2019;394(10194):249–60.
[3] Mayo Clinic. (n.d.) Oral health: A window to your overall health. https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475
[4] Hannan CJ, Ricks TL, Espinoza L, Weintraub JA. Addressing Oral Health Inequities, Access to Care, Knowledge, and Behaviors. Prev Chronic Dis 2021;18:210060. DOI: http://dx.doi.org/10.5888/pcd18.210060
[5] The Ohio Medicaid Assessment Survey Dashboard. https://grcapps.osu.edu/app/omas, 2021 (HM2025), 2019 (HM2022)

INJURY AND DEATH

Mental and Social Health

Mental and social health are increasingly recognized as both direct and indirect contributors to overall health. Experiencing violence or being exposed to violence in the home has long-term physical and mental health impacts.[1,2] In addition to the direct impact on an individual's mortality, suicide also has rippling negative effects among other community members, from family members to peers to first responders.[3]

13.8 per 100,000 residents died by **suicide**.

↑ Up from HM2022 (10.8)

26.4% of Franklin County residents reported feeling **lonely**.

New metric for HM2025

Disparities by selected social determinants of health

Age:	Sex:	Race/Ethnicity:	Geography:
None observed	Recently pregnant females more likely	Unavailable	Unavailable

23.7% of Franklin County adults reported ever having **depression**.

≈ Similar to HM2022 (23.1%)

Disparities by selected social determinants of health

Age:	Sex:	Race/Ethnicity:	Geography:
18-64 more likely	Female more likely	White more likely	Observed (see map)

14.7 per 100,000 residents died from **100% alcohol-attributable causes**.

↑ Up from HM2022 (12.9)

Disparities by selected social determinants of health

Age:	Sex:	Race/Ethnicity:	Geography:
60+ more likely	Male more likely	White more likely	Unavailable

5,729 children were victims of **child abuse**.

↓ Down from HM2022 (7,240)

5,495 residents were victims of **domestic violence**.

↓ Down from HM2022 (7,471)

Unfortunately, hospitalizations due to self-harm and deaths from suicide have both increased in Franklin County since the last *HealthMap*.

Self-Harm and Suicide

	Self-harm hospitalization (rate per 100,000)	Suicide death (rate per 100,000)
HM2025	7.6 ▲	13.8 ▲
HM2022	6.8	10.8
HM2019	4.9	12.5
Ohio	-	15.2
US	-	14.8

Healthy People 2030

Unfortunately, the suicide rate in Franklin County has risen above the Healthy People 2030 objective in recent years. Further research and interventions should examine what has caused this change.

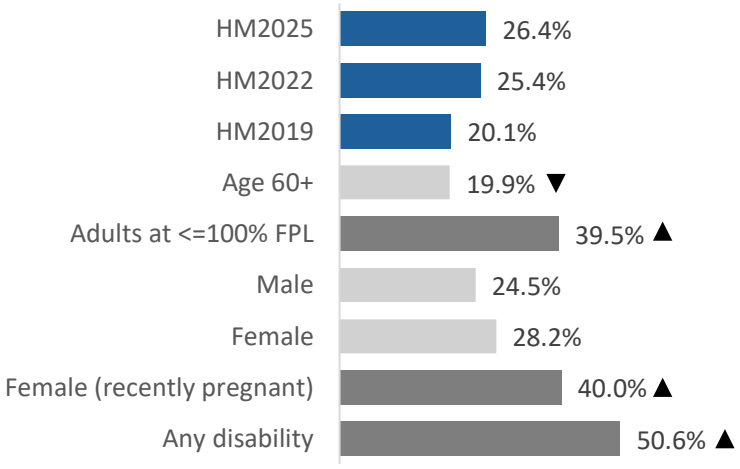
HP2030 objective for Suicide Deaths: Not met

Healthy People Objective:	Most recent Franklin County data (HM2025)
12.8	**13.8**

In 2023, the United States Surgeon General issued an advisory notice that warned Americans about an emerging public health crisis: the epidemic of loneliness, isolation, and lack of connection.[4]

Unfortunately, over a quarter of Franklin County adult (ages 19+) report feeling isolated from others (i.e., lonely). Those individuals who have a household income that places them at or under the 100% federal poverty level, recently pregnant females, and individuals with disabilities are most likely to report feeling lonely.

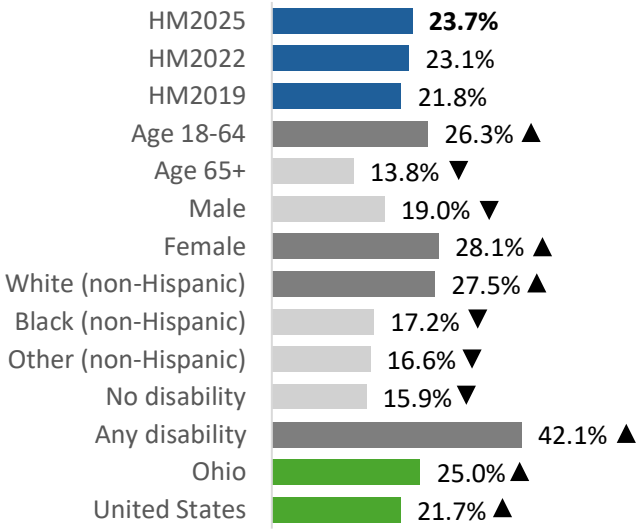
Loneliness

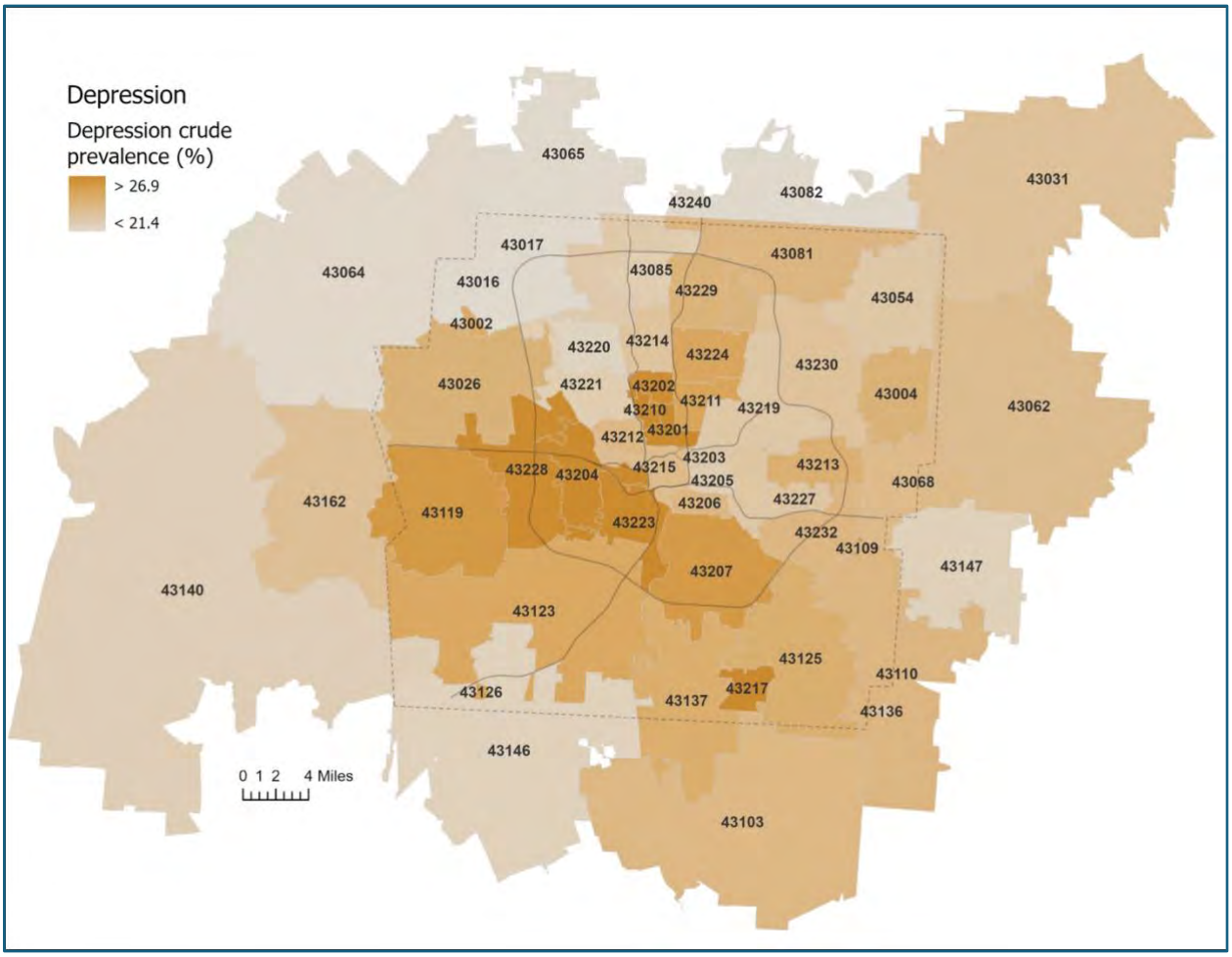


Females, white (non-Hispanic) individuals, adults under the age of 65, and individuals with a disability are more likely than other groups to report ever being told by a healthcare professional that they have a depressive disorder (e.g., depression).

Depression prevalence is higher in Franklin County's western and north-central zip codes.

Depression





Community Voices: Depression

Community members perceive that anyone can be vulnerable to depression, and that economic hardships contribute to depression in their community. They believe depression is hard to address because it is not easy to always tell when someone is suffering. Although residents say mental health issues seem to be losing some of the stigma they once held, depressed individuals are still met with perceptions that they just need to "get over it."

"The best-looking person is on the edge. [Mental health], it's so fragile and it has to be taken way more seriously. That commercial that says there's no way he's depressed, he's young, you know, those type of stigmas, it's terrible. And that's why we see a lot of people out on the street or a lot of people doing what they're doing because their mental health issues have not been addressed or they've been temporarily addressed."

"I see it with my job that I totally despise…does it affect my mental health? Absolutely. Can I pay the mortgage this month? Can I buy food this week? It's just a lot…I have a lot of breaking points."

"Mental health is something that you don't see a lot as well. It could be a neighbor that you think is okay, but they may get evicted or, you know, their property taxes went up too high and can't afford it. So those aren't physical things, you may not even be able to see [even with] neighbors that you probably thought you were close to."

"There's a lot of people who say 'mental health is so important to us and we're working on it.' But then if you do have some kind of issue with depression, there's still this like, 'Okay, well, I guess you better get over it.' You still have to keep going. And you're just kind of hopeless."

Meanwhile, community members also said that stigma around depression can prevent people from getting help they need. For example, it may still be perceived negatively to be medicated for depression, and generational attitudes around depression may prevent helpful conversations around mental health from happening.

"I could say in my community, I believe that it was always, 'don't get put on that medicine.' It was a bad thing if you got medicated. So some people have been diagnosed, but they're not being treated because they don't want to be on that medication."

"I have tried to talk with a lot of older people [in my community]…They have been through traumas, like they've been through wars, running from people and fleeing to a new country. That's a lot of trauma. But they don't agree that it's trauma. And I don't know how to tell [them] because I have not been in that place. I just came with them. And when I tried to tell them that, 'You

> *got to talk about this, so it gets out of your head.' They just don't want to talk about it."*
>
> *"Depression is big…And it's all ages. I live with my grandma. She doesn't believe in depression, and I'm sure she's been depressed for most of her life. But back in the day it was more like, you just gotta push through it and fight through it. You gotta be strong. 'Everybody's depressed.'"*
>
> *"The kids, they can't talk about mental health problems with their parents because the parents will think that it's a disease and that's not good. So they will try to do substances, which just goes down the wrong path. And the parents can't take control of the kids, and the kids are now alone in their [mind], and it's hard."*

Alcohol use disorder frequently co-occurs with other mental health disorders. Compared to the last *HealthMap*, Franklin County residents whose deaths were 100% alcohol-attributable have increased and are particularly high among males, white (non-Hispanic) individuals, and the elderly.

Alcohol Attributable Deaths

	Rate per 100,000
HM2025	**14.7** ▲
HM2022	**12.9**
HM2019	**9.1**
Age 20-59	13.6
Age 60+	38.1 ▲
White (non-Hispanic)	18.4 ▲
Black (non-Hispanic)	11.9
Male	21.4 ▼
Female	8.2 ▲
Ohio	**14.1** ▼
US	**14.4**

The number of child abuse victims and abuse reports have declined across all geographic groups; the number of domestic violence reports has remained stable while the number of domestic violence victims in Franklin County has dropped dramatically. A unique victim is only counted once but could be associated with multiple reports of violence in a year.

Family Violence

	Child maltreatment (unique victims)	Child maltreatment (substantiated reports)	Domestic violence (unique victims)	Domestic violence (substantiated reports)
HM2025	**5,729 ▼**	**16,784 ▼**	**5,495 ▼**	**3,505**
HM2022	**7,240**	**19,801**	**7,471**	**3,636**
HM2019	**6,243**	**18,060**	**11,224**	**3,157**
Ohio	**22,439 ▼**	**17,037 ▼**	**58,822 ▲**	**31,142 ▼**
US	**558,899 ▼**	**553,479 ▼**	**598,490 ▲**	**1,370,440 ▲**

Additional Information & References

Relatedly, who are interested in learning more about this topic are encouraged to read the Franklin County Suicide Prevention Coalition's 2023 Report, which can be accessed by **clicking here**. Additionally, readers who are interested in learning more about this topic should also read the *HealthMap2025* sections that focus on alcohol use (see page 81), overdose deaths (see page 163), and individuals with disabilities and their mental health experiences (see page 133).

For HealthMap2025, data on suicides and alcohol-attributable deaths were collected from the CDC WONDER database for 2023, 2020, and 2017, and self-harm hospitalizations were provided by the Ohio Department of Public Safety, which accessed the Trauma Acute Care Registry (TACR) system for 2022 and 2019.[5-7] Loneliness statistics were provided by Franklin County Public Health, which accessed the Ohio Medicaid Assessment Survey for 2023.

To assess the prevalence of depression, *HealthMap2025* obtained recent data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS), which completes structured survey interviews with residents via telephone.[8] In most cases, survey respondents were asked if a doctor, nurse, or other health professional ever told them that they had a specific chronic health condition (i.e., a depressive disorder). To enable comparisons by demographic subgroups (e.g., age, sex, race), Columbus Public Health staff analyzed BRFSS data using the most recent year or two available (typically 2021 & 2022). To map the prevalence of these indicators at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the CDC's PLACES[9] resource, which uses BRFSS data (2021 or 2022), Census Bureau data (either the 2020 decennial census or 2022 annual population estimates), and American Community Survey data (2018-2022 estimates).

Alcohol-attributable deaths were defined using the National Center for Health Statistics definition, which includes immediate deaths such as overdose as well as long-term chronic conditions such as alcoholic fatty liver.[5]

In both categories of violence, a "report" refers to a single instance where abuse or neglect was alleged to authorities. These reports are then investigated, and charges or action may be taken if there is enough evidence. A unique victim is counted only once in a calendar year, but they may be the subject of multiple reports if they experienced multiple acts of violence. Child maltreatment victims and reports were included if the abuse or neglect was classified as either "substantiated" or "indicated" in 2022, 2019, and 2016. Franklin County statistics were provided by the Ohio Department of Job and Family Services.[10] Statistics about child maltreatment from the United States and Ohio were sourced from the US Department of Health and Human Services annual Child Maltreatment report.[11]

Domestic violence statistics included all victim/perpetrator relationships, including married couples, life partners, and other eligible categories. Ohio and Franklin County statistics were sourced from an Ohio Bureau of Criminal Investigation report, where statistics were reported from all police agencies.[12,13] Reports were included if a charge was filed, and the included years were 2023, 2020, and 2017. For the United States, data were sourced from the Bureau of Justice Statistics for 2022.[14]

- Data Gap: The child maltreatment and domestic violence statistics reviewed here likely *underestimate* the full extent of those issues in the population, due to underreporting. Future HealthMaps should attempt to obtain different/more accurate data.
- Data Gap: The Community Health Needs Assessment Steering Committee requested recent data about the mental health of Franklin County's youth (e.g., those between the ages of 11 and 17). Unfortunately, Ohio's Youth Risk Behavior Survey does not calculate statistical estimates at the county level.
- Data Gap: The Community Health Needs Assessment Steering Committee requested recent data about resiliency. Unfortunately, this construct has not been measured quantitatively at the county level.
- Data Gap: Future *HealthMaps* should explore the possibility of calculating the percentage of adults who recently had an alcohol attributable death within each Franklin County zip code (or other sub-county geography).

[1] Potter, L. C., Morris, R., Hegarty, K., García-Moreno, C., & Feder, G. (2021). Categories and health impacts of intimate partner violence in the World Health Organization multi-country study on women's health and domestic violence. *International journal of epidemiology*, *50*(2), 652–662. https://doi.org/10.1093/ije/dyaa220

[2] Clarke, A., Olive, P., Akooji, N., & Whittaker, K. (2020). Violence exposure and young people's vulnerability, mental and physical health. *International journal of public health*, *65*(3), 357–366. https://doi.org/10.1007/s00038-020-01340-3

[3] Lyra, R. L., McKenzie, S. K., Every-Palmer, S., & Jenkin, G. (2021). Occupational exposure to suicide: A review of research on the experiences of mental health professionals and first responders. *PloS one*, *16*(4), e0251038. https://doi.org/10.1371/journal.pone.0251038

[4] U.S. Department of Health and Human Services. (2023). Our epidemic of loneliness and isolation. https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf

[5] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database. Data are from the final Multiple Cause of Death Files, 2018-2022, and from provisional data for years 2023-2024, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. http://wonder.cdc.gov/mcd-icd10-provisional.html

[6] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999-2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999-2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

[7] Ohio Division of Emergency Medical Services, Ohio Department of Public Safety. (2024). *Trauma Acute Care Agency* [Dataset].

[8] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data, 2022 (HM2025), 2019 (HM2022), 2015 (HM2019)

[9] Centers for Disease Control and Prevention, PLACES: Local Data for Better Health. (n.d.). https://www.cdc.gov/places/index.html

[10] Ohio Department of Job and Family Services, Ohio Department of Health. (2024). *Foster Care and Adult Protective Services* [Dataset].

[11] U.S. Department of Health & Human Services, A. for C., Families, Y., Administration on Children, & Families, C. B. (2023). Child Maltreatment 2022. https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2022.pdf

[12] Ohio Bureau of Criminal Investigation. (2024). *Victims of Domestic Violence by County and Agency*.

[13] Ohio Bureau of Criminal Investigation. (2024). *Domestic Violence Incidents by County and Agency*.

[14] Thompson, A., & Tapp, S. N. (2023). *Criminal Victimization, 2022*. Bureau of Justice Statistics, US Department of Justice. https://bjs.ojp.gov/document/cv22.pdf

Franklin County Suicide Prevention Coalition's 2023 Report can be accessed at https://franklincountyspc.org/wp-content/uploads/2024/04/2023-Franklin-County-Suicide-Report-Updated-4.22.24.pdf.

Mortality

With advances in medicine, technology, and sanitation, life expectancy at birth (i.e., the average number of years that a person can expect to live) has risen substantially over the last century.[1] However, significant disparities in life expectancy at birth and in mortality rates exist by sex, race, and geography, among others.[2]

The **life expectancy** at birth was **75.9 years** in Franklin County.

Down from HM2022 (77.1)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
n/a	Unavailable	None observed	Observed (see map)

The **mortality rate** (all causes) was **891.5 per 100,000 residents** in Franklin County.

New metric for HM2025

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Older adults highest	None observed	Black higher	Observed (see map)

As shown on the next page, Franklin County residents' life expectancy has decreased slightly since the last *HealthMap* and is similar to residents throughout Ohio and the United States. Asian and Hispanic individuals have a higher life expectancy than Franklin County overall, whereas black (non-Hispanic) individuals have the lowest life expectancy.

The next page also displays a table that presents data regarding the all-cause mortality rate (age-adjusted) among Franklin County residents. As expected, the mortality rate is lower among children and much higher among older adults. Black (non-Hispanic) individuals in Franklin County have an all-cause mortality rate that is substantially higher than the county as a whole; Asian (non-Hispanic) individuals have a mortality rate that is substantially lower than the county as a whole.

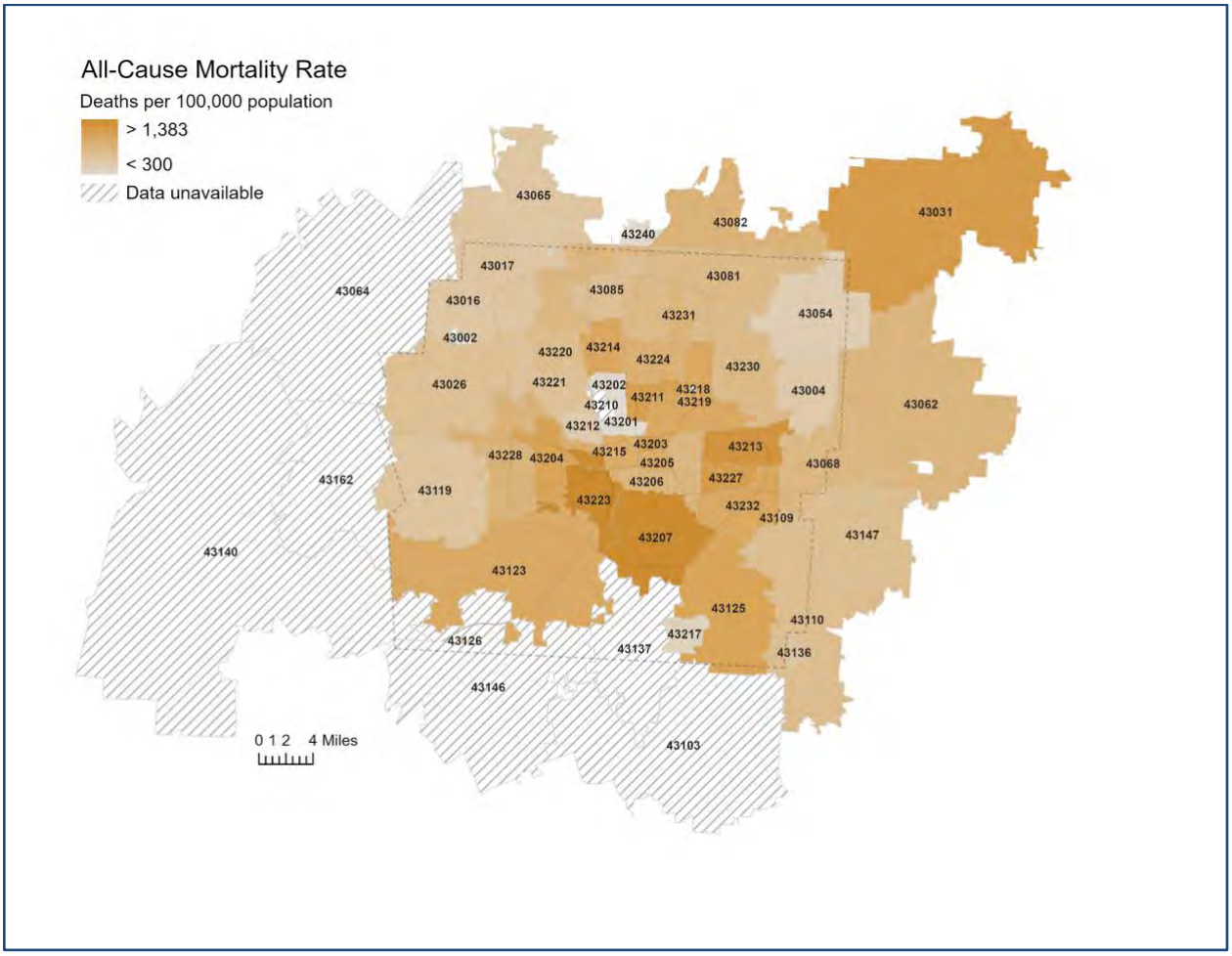
Life Expectancy at Birth

	Years
HM2025	**75.9**
HM2022	**77.1**
White (non-Hispanic)	76.6
Black (non-Hispanic)	72.9
Asian (non-Hispanic)	84.9 ▲
Hispanic	84.7 ▲
Ohio	**74.5**
US	**77.5**

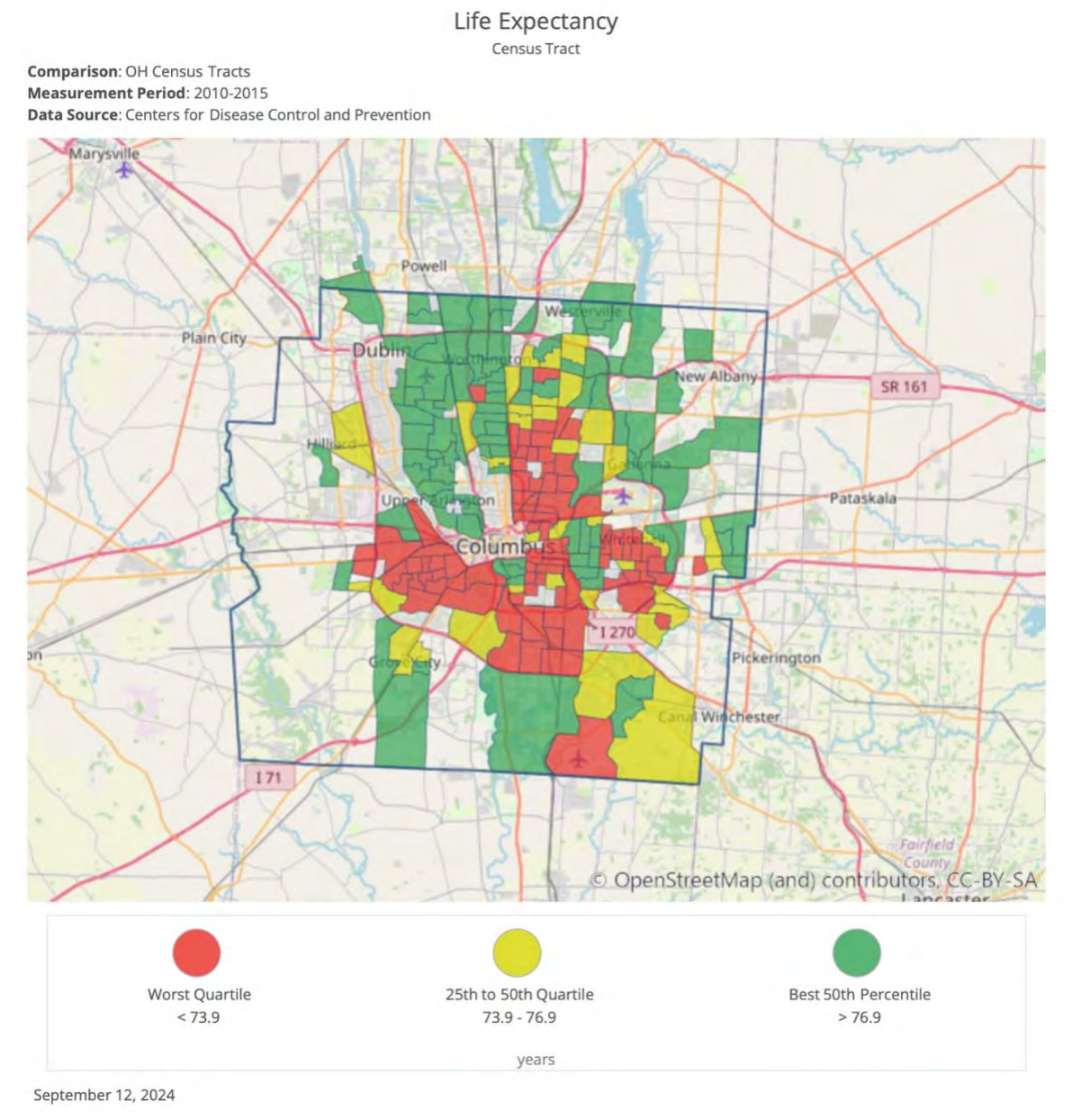
All-Cause Mortality Rate

	Age-adjusted rate per 100,000	
HM2025	**891.5**	
Ages 1-19	30.8	▼
Age 65+	4,969.0	▲
White (non-Hispanic)	880.8	
Black (non-Hispanic)	1,031.6	▲
Asian (non-Hispanic)	471.7	▼
Hispanic	486.6	▼
Male	1,067.6	▲
Female	750.3	▼
Ohio	**849.1**	▼
US	**753.3**	

The map below shows the all-cause mortality rate (crude) for those Franklin County zip codes that have data available for mapping. The all-cause mortality rate is highest in 43223 (Franklinton area), 43207 (southern Franklin County), and 43213 (Whitehall area).



The map below is a screenshot of residents' life expectancy across Franklin County's census tracts during the period from 2010-2015 (the most recent data available), as mapped by Franklin County CARES.[3] The census tracts with the lowest quartiles of life expectancy (e.g., less than 73.9 years) are concentrated in the Franklinton, Hilltop, South Side, Linden, and Whitehall areas of Franklin County. Readers who are interested in learning more about this topic are encouraged to visit Franklin County CARES' interactive map, which can be accessed by **clicking here**.



Additional Information & References

To report life expectancy in Franklin County, *HeathMap2025* referenced County Health Rankings reports from 2024 (data 2019-2021) and 2020 (data 2016-2018).[4] For Ohio and the

United States, we used data from the Centers for Disease Control and Prevention Mortality Reports in 2021 and 2022, respectively.[5,6] Note that the methodology for the County Health rankings has changed in recent years to reflect updated race categories.

The age-adjusted mortality rate for Franklin County was obtained from the National Institute on Minority Health and Health Disparities for the 2018-2022 period.[7] The mortality rates for Ohio and for the US relied on provisional data obtained from the CDC WONDER system for 2023.[8,9] Franklin County Public Health staff mapped the all-cause mortality rate for each zip code in Franklin County that had those data.

[1] Kinsella K. G. (1992). Changes in life expectancy 1900-1990. *The American journal of clinical nutrition*, *55*(6 Suppl), 1196S–1202S. https://doi.org/10.1093/ajcn/55.6.1196S

[2] Woolf, S. H., & Schoomaker, H. (2019). Life Expectancy and Mortality Rates in the United States, 1959-2017. *JAMA*, *322*(20), 1996–2016. https://doi.org/10.1001/jama.2019.16932

[3] Franklin County CARES. (n.d.) Life Expectancy (2010-2015). https://www.franklincocares.org/indicators/index/view?indicatorId=8195&localeTypeId=4&comparisonId=6807

[4] Population Health Institute, University of Wisconsin. (2023) County Health Rankings [Interactive Tool]. Retrieved in 2024 from https://www.countyhealthrankings.org/health-data/health-outcomes/length-of-life/life-expectancy?year=2024

[5] Kochanek, K. D., Murphy, S. L., Xu, J., & Arias, E. (2024). Mortality in the United States, 2022. NCHS data brief, (492), 1–8. https://www.cdc.gov/nchs/data/databriefs/db492.pdf

[6] Arias, E., Xu, J., Tejada-Vera, B., & Bastian, B. (2024). U.S. State Life Tables, 2021. National vital statistics reports : from the Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, 73(7), 1–18. https://www.cdc.gov/nchs/data/nvsr/nvsr73/nvsr73-07.pdf

[7] HDPulse: An Ecosystem of Minority Health and Health Disparities Resources. National Institute on Minority Health and Health Disparities. Data are from 2018-2022. Available from https://hdpulse.nimhd.nih.gov

[8] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database. Data are from the final Multiple Cause of Death Files, 2018-2022, and from provisional data for years 2023-2024, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. http://wonder.cdc.gov/mcd-icd10-provisional.html

[9] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999-2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999-2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

Franklin County CARES' interactive map can be accessed at https://www.franklincocares.org/indicators/index/view?indicatorId=8195&localeTypeId=4&comparisonId=6807.

Leading Causes of Death

Leading causes of death are an important metric for population health. These data can assist in identifying the impact of emerging health concerns such as COVID-19, provide an ecologic view of the outcomes of exposures such as environmental toxins, and illustrate health disparities by age and race.

The leading cause of death among those aged 0-17 was a **perinatal health condition** (**21.5** per 100,000).	↑ Up from HM2022 (19.2)
The leading cause of death among those aged 18-59 was an **accident** (**94.8** per 100,000).	↓ Down from HM2022 (114)
The leading cause of death among those aged 60+ was **heart disease** (**689.7** per 100,000).	↓ Down from HM2022 (743.1)

The leading causes of death among Franklin County children have remained consistent over time, with the most frequent cause of death being perinatal conditions, a label that includes deaths that occur after preterm births, birth complications, or birth defects, among others. Other leading causes of death for assault children include accidents, congenital conditions, and assault. Note: although the top two causes of death for black children were also perinatal conditions and accidents, those occurred at much higher rates (30.8 and 24.9, respectively) than the population averages reported below.

Leading Causes of Death – Children (age 0-17; rate per 100,000)

	HM2025	HM2022	Ohio	US
1st	Perinatal conditions: 21.5	Perinatal conditions: 19.2	Perinatal conditions: 18	Perinatal conditions: 13.7
2nd	Accidents: 9.8	Congenital Conditions: 10.9	Accidents: 10	Accidents: 8.5
3rd	Congenital conditions: 8.5	Assault: 8.3	Congenital conditions: 6.9	Congenital conditions: 6.8
4th	Assault: 5.5	Accidents: 7.6	Assault: 4.4	Assault: 3.1
5th			Cancer (malignant neoplasms): 2.5	Intentional self-harm: 2.2

	HM2025	HM2022	Ohio	US
6th			Intentional self-harm: 2.4	Cancer (malignant neoplasms): 2.2
7th			Heart diseases: 1.4	Heart diseases: 1.0
8th			Influenza & pneumonia: 0.9	Influenza & pneumonia: 0.6
9th				Sepsis (septicemia): 0.5
10th				Cerebrovascular diseases: 0.4

The leading cause of death among Franklin County adults aged 18-59 was accidents, followed by heart diseases, cancer, suicide, and assault.

Leading Causes of Death – Adults (age 18-59; rate per 100,000)

	HM2025	HM2022	Ohio	US
1st	Accidents: 94.8	Accidents: 113.98	Accidents: 82.7	Accidents: 67.4
2nd	Heart diseases: 40.6	Heart diseases: 51.03	Cancer (malignant neoplasms): 55.3	Cancer (malignant neoplasms): 47.3
3rd	Cancer (malignant neoplasms): 39.1	Cancer (malignant neoplasms): 46.5	Diseases of heart: 49.0	Diseases of heart: 42.2
4th	Intentional self-harm: 17.4	Assault: 20.21	Intentional self-harm: 19.3	Intentional self-harm: 18.0
5th	Assault: 16.7	COVID-19 : 14.77	Chronic liver disease and cirrhosis: 12.4	Chronic liver disease and cirrhosis: 12.2
6th	Chronic liver disease & cirrhosis: 9.4	Intentional self-harm: 13.86	Diabetes mellitus: 11.2	Diabetes mellitus: 9.4
7th	Diabetes mellitus: 8.6	Chronic liver disease & cirrhosis: 10.88	Assault: 10.6	Assault: 9.8
8th	Cerebrovascular diseases: 5.5	Diabetes mellitus: 8.55	Cerebrovascular diseases: 7.1	Cerebrovascular diseases: 7.2
9th	Chronic lower respiratory diseases: 5.2	Chronic lower respiratory diseases: 8.03	Chronic lower respiratory diseases: 6.2	Chronic lower respiratory diseases: 4.6
10th	Sepsis (septicemia): 4.7	Cerebrovascular diseases: 7.38	Sepsis (septicemia): 4.7	Nephritis, nephrotic syndrome & nephrosis: 3.4

Black (non-Hispanic) individuals between the ages of 20 and 59 were more likely than white (non-Hispanic) individuals to die due to many of these leading causes; this was especially the case for accidents, heart diseases, and diabetes.

Leading Causes of Death by Race – Adults (age 20-59; rate per 100,000)

	White (non-Hispanic)	Black (non-Hispanic)	Hispanic
1st	Accidents: 94	Accidents: 134.4	Accidents: 122.8
2nd	Cancer (malignant neoplasms): 46.8	Heart diseases: 68.7	
3rd	Heart diseases: 40.1	Assault: 47.1	
4th	Intentional self-harm: 18.5	Cancer (malignant neoplasms): 39.6	
5th	Chronic liver disease & cirrhosis: 12.5	Intentional self-harm: 16.9	
6th	Diabetes mellitus: 7.6	Diabetes mellitus: 15.7	
7th	Chronic lower respiratory diseases (includes COPD, asthma, others): 6.2	Cerebrovascular diseases: 12.2	
8th	Assault: 5.8		

The leading cause of death among Franklin County adults age 60+ was heart diseases, followed by cancer, cerebrovascular disease, accidents, chronic lower respiratory disease, and Alzheimer's disease.

Leading Causes of Death – Older Adults (age 60+; rate per 100,000)

	HM2025	HM2022	Ohio	US
1st	Heart diseases: 689.7	Heart diseases: 772.2	Heart diseases: 849.6	Heart diseases: 764.4
2nd	Cancer (malignant neoplasms): 673.4	Cancer (malignant neoplasms): 627.9	Cancer (malignant neoplasms): 721.2	Cancer (malignant neoplasms): 666.3
3rd	Cerebrovascular diseases: 212.1	COVID-19: 372.7	Cerebrovascular diseases: 226.4	Cerebrovascular diseases: 189.1
4th	Accidents: 185.7	Cerebrovascular diseases: 187.2	Chronic lower respiratory diseases (includes COPD, asthma, others):203.5	Chronic lower respiratory diseases (includes COPD, asthma, others):173.2
5th	Chronic lower respiratory diseases (includes COPD, asthma, others):171.3	Chronic lower respiratory diseases (includes COPD, asthma, others):177.0	Alzheimer's disease: 163.8	Alzheimer's disease: 143.9

	HM2025	HM2022	Ohio	US
6th	Alzheimer's disease: 135.0	Alzheimer's disease: 157.2	Accidents: 128.4	Accidents: 111.5
7th	Diabetes mellitus: 77.1	Accidents: 126.0	Diabetes mellitus: 113.5	Diabetes mellitus: 98.8
8th	Nephritis, nephrotic syndrome & nephrosis: 64.7	Diabetes mellitus: 104.1	Nephritis, nephrotic syndrome & nephrosis: 70.8	Nephritis, nephrotic syndrome & nephrosis: 62.1
9th	Sepsis (septicemia): 52.7	Influenza & pneumonia: 57.5	COVID-19: 68.7	COVID-19: 58.9
10th	Parkinson's disease: 51.5	Nephritis, nephrotic syndrome & nephrosis: 57.1	Sepsis (septicemia): 56.4	Parkinson's disease: 50.5

The leading causes of death for black and white residents age 60 and over are relatively similar to another. However, Asian residents were significantly less likely to die of heart disease or cancer.

Leading Causes of Death by Race – Older Adults (age 60+; rate per 100,000)

	White (non-Hispanic)	Black (non-Hispanic)	Asian
1st	Heart diseases: 743.1	Cancer (malignant neoplasms): 732.1	Heart diseases: 308.4
2nd	Cancer (malignant neoplasms): 710.8	Heart diseases: 695.8	Cancer (malignant neoplasms): 275.4
3rd	Cerebrovascular diseases: 211.4	Cerebrovascular diseases: 258.3	
4th	Accidents: 195	Accidents: 209.2	
5th	Chronic lower respiratory diseases (includes COPD, asthma, others): 193.9	Chronic lower respiratory diseases (includes COPD, asthma, others): 145.1	
6th	Alzheimer's disease: 156.6	Diabetes mellitus: 119.5	
7th	Diabetes mellitus: 71.2	Nephritis, nephrotic syndrome and nephrosis: 119.5	
8th	Parkinson's disease: 63.5	Alzheimer's disease: 91.8	
9th	Nephritis, nephrotic syndrome & nephrosis: 55.3	Sepsis (septicemia): 72.6	
10th	Nutritional deficiencies: 53.1	Essential hypertension & hypertensive renal disease: 51.2	

Additional Information & References

To measure leading causes of death in Franklin County, raw numbers of the leading causes of death were obtained from the Ohio Department of Health Mortality tool,[1] which were then

converted into crude rates using the age and year appropriate population. Among children, the numbers for certain causes of death were particularly small. Therefore, only those causes of death that had at least 15 observations were included; that is the reason why only 4 leading causes of death are included in the table titled, "Leading Causes of Death – Children (age 0-17; rate per 100,000)."

In Ohio and the United States, the crude rates of leading causes of death are from the Centers for Disease Control WONDER database.[2]

For the overall leading causes of death, we defined children as age 0-17, adults as age 18-59, and older adults as age 60+. However, due to the age categories reported by the U.S. Census Bureau, it was not possible to obtain rates by race using the same age categories. Therefore, the age categories for leading causes of death by race were defined as 0-19, 20-59, and 60+.

[1] DataOhio. (2023). *Mortality* [Interactive Dashboard]. Ohio Department of Health, Bureau of Vital Statistics. Retrieved in 2024 from https://data.ohio.gov/wps/portal/gov/data/view/mortality

[2] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database. Data are from the final Multiple Cause of Death Files, 2018-2022, and from provisional data for years 2023-2024, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. http://wonder.cdc.gov/mcd-icd10-provisional.html

Traumatic Injury

A traumatic injury is a severe physical injury that occurs suddenly and requires hospital admission. Examples of such injuries include musculoskeletal injuries, visceral injuries, nerve injuries, soft tissue damage, spinal injuries, and limb loss, all of which might be caused by a variety of blunt, penetrating, or other mechanisms.[1,2] Major traumatic injuries like these are one of the leading causes of death in children and adults under the age of 40, both nationally and here in Franklin County (see page 145).

57% of residents who were hospitalized due to trauma **experienced a fall**.

≈ Similar to HM2022 (53.7%)

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Older adults more likely (falls)	Male more likely (firearms, being struck, being cut/pierced)	Black more likely (firearms)	Observed (see maps)

Among those Franklin County residents who were hospitalized due to bodily trauma, the most common type of trauma was a fall. The next most common types of trauma hospitalizations were accidents involving an occupant of a motor vehicle and being struck (either by something or against something).

Leading Causes of Trauma Hospitalizations

	HM2025	**HM2022**	**HM2019**
1st	Fall: 56.6%	Falls: 53.7%	Falls: 48.5%
2nd	Motor vehicle accident (occupant): 12.2%	Motor vehicle accident (occupant): 12.7%	Motor vehicle accident (occupant): 15.5%
3rd	Struck by or against: 7.9%▼	Struck by or against: 9.6%	Struck by or against: 9.2%
4th	Firearm: 5.1%▲	Firearm: 4%	Firearm: 5.5%
5th	Cut or Pierce: 2.6%	Cut or Pierce: 2.6%	Cut or Pierce: 2.6%

As shown below, fall injuries that lead to hospitalization occur more frequently among older adults (age 65+), whereas most other types of injuries that lead to hospitalization occur among adults aged 18-64.

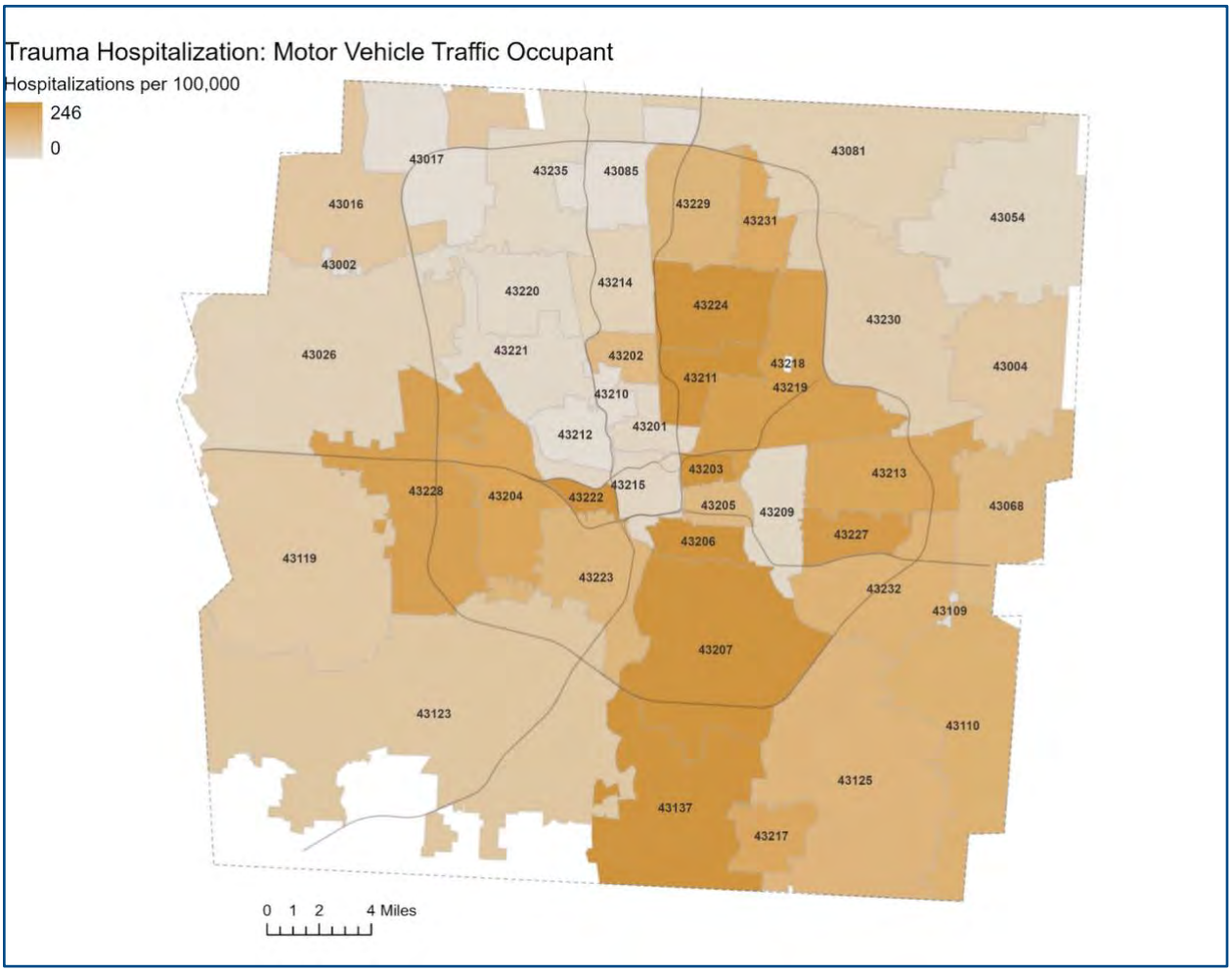
Injuries due to firearms, being struck (by or against something), or cutting/piercing that lead to hospitalization all occur more frequently among males than females. Injuries due to firearms that lead to hospitalization occur more frequently among black individuals.

Leading Causes of Trauma Hospitalizations (by Key Demographics)

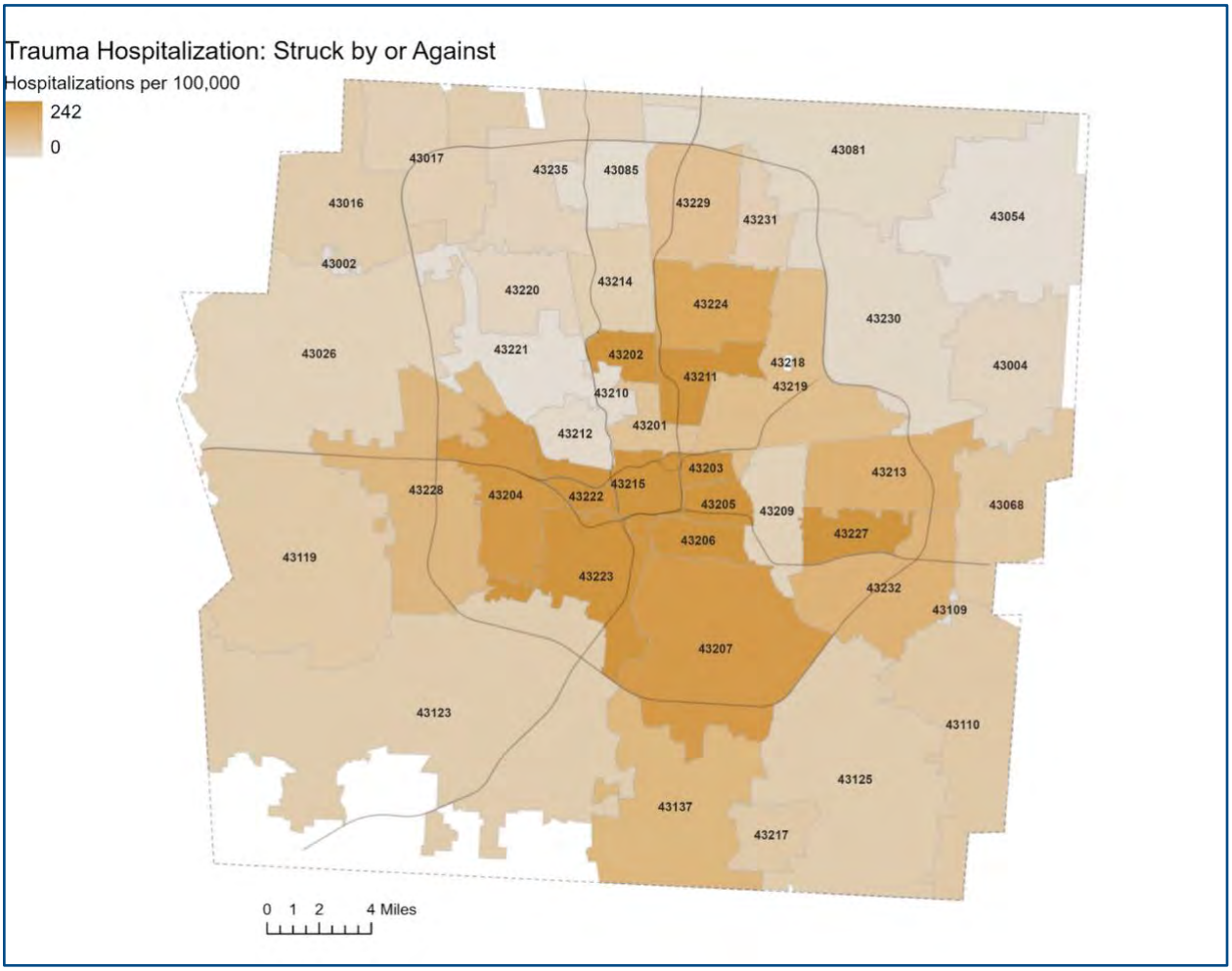
	Fall	Motor vehicle (occupant)	Struck by or against	Firearm	Cut or pierce	All others
Total	**5,766**	**1,245**	**805**	**521**	**266**	**1,577**
	56.6%	**12.2%**	**7.9%**	**5.1%**	**2.6%**	**15.5%**
Age						
0-17 Years	6.9%	7.4%	12.4%	14.8%	10.2%	
18-64 Years	30.8%	***75.8%***	***81.1%***	***83.5%***	***83.1%***	
65+ years	***62.4%***	16.8%	6.5%	1.3%	6.8%	
Gender						
Female	54.7%	48.8%	23.6%	14.0%	21.1%	
Male	44.8%	51.0%	***76.0%***	***85.8%***	***79.0%***	
Race						
American Indian	0.1%	0.1%	0.1%	0.2%	-	
Asian	2.2%	2.3%	1.4%	0.8%	2.3%	
Black/African American	14.9%	35.3%	42.6%	***74.7%***	44.7%	
Native Hawaiian, Other	0.1%	0.2%	0.1%	0.2%	0.8%	
Unknown	5.3%	9.6%	8.9%	5.8%	13.5%	
White	***77.4%***	52.6%	46.8%	18.4%	38.7%	

The rate of trauma hospitalizations due to falls seems to be relatively evenly distributed throughout Franklin County; that said, rates for that type of injury tend to be lower in northwestern zip codes, western zip codes, and far northeastern zip codes.

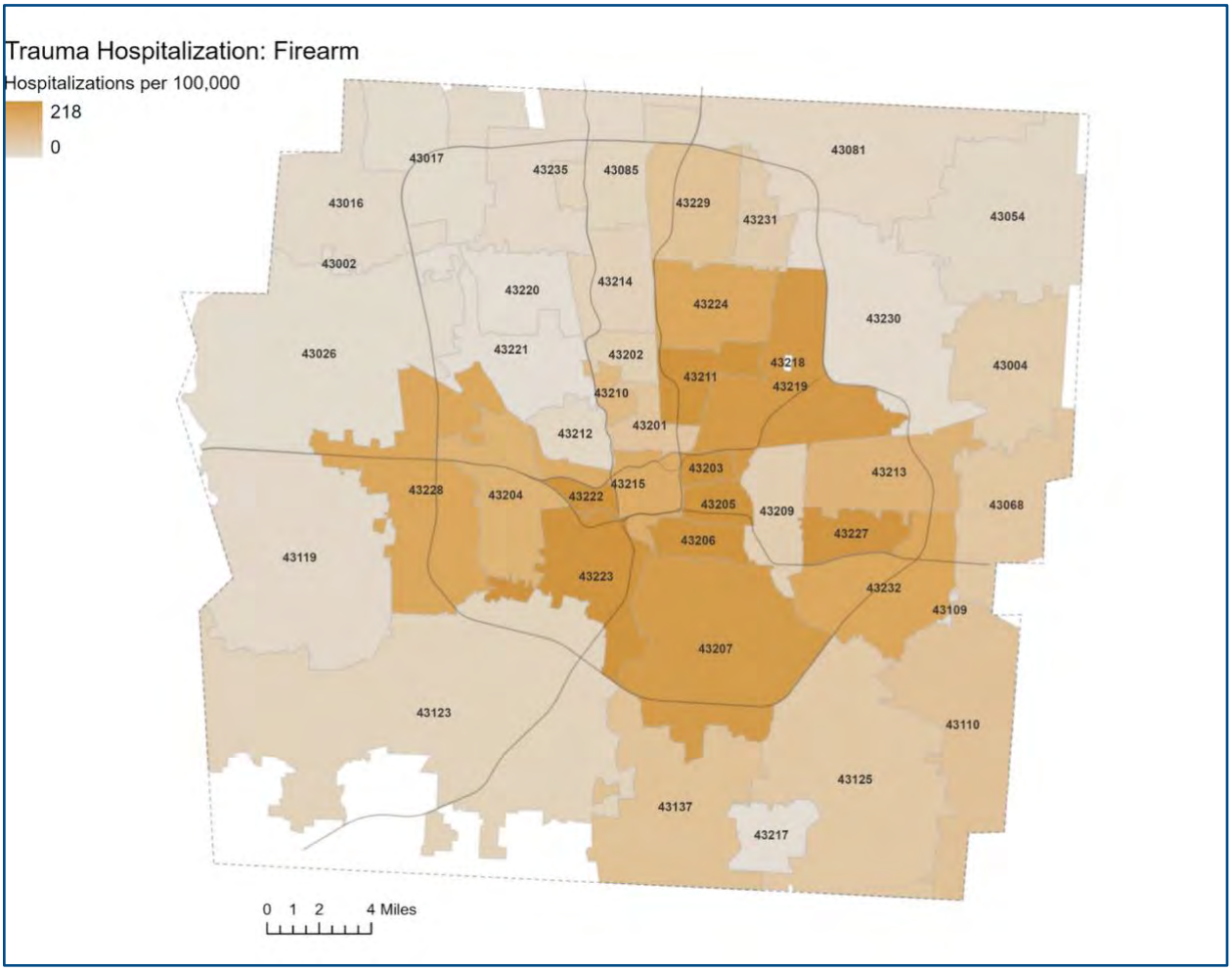
The rate of trauma hospitalizations involving an occupant of a motor vehicle that was in an accident is greater in north-central zip codes (43211, 43224), west-central zip codes (43222, 43204, 43228), and southern zip codes (43206, 43207).



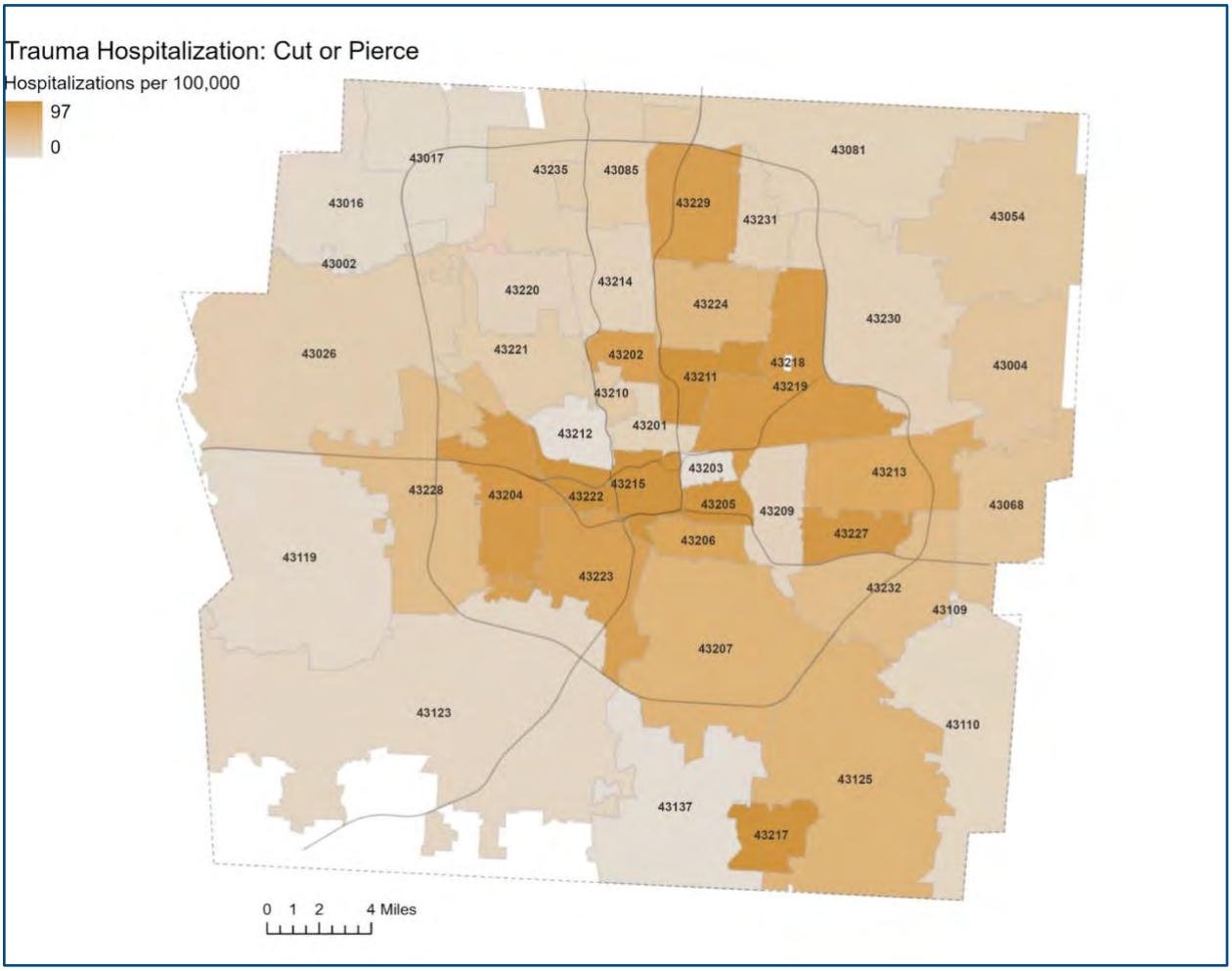
The rate of trauma hospitalizations due to being struck by or against something is greater in north-central zip codes (43202, 43211), central zip codes (43203, 43208, 43215, 43222, 43204, 43223), southern zip codes (43206, 43207), and the Whitehall area (43227).



The rate of trauma hospitalizations due to firearms is greater in north-central zip codes (43211, 43218, 43219), east-central zip codes (43203, 43205), west-central zip codes (43222, 43223), southern zip codes (43206, 43207), and the Whitehall area (43227).



The rate of trauma hospitalizations due to being cut or pierced is greater in north-central zip codes (43211, 43202, 43218, 43219), east-central zip codes (43215, 43205), west-central zip codes (43222, 43204), and the Whitehall area (43227).



Additional Information & References

Trauma-related hospitalization data were provided by the Ohio Department of Public Safety, which accessed the Trauma Acute Care Registry (TACR) system for 2022, 2019, and 2016.[3]

Franklin County Public Health staff then mapped these data for each zip code in Franklin County.

[1] Rehabilitation after traumatic injury. London: National Institute for Health and Care Excellence (NICE); 2022 Jan 18. (NICE Guideline, No. 211.) Available from: https://www.ncbi.nlm.nih.gov/books/NBK579697/

[2] Dumovich J, Singh P. Physiology, Trauma. [Updated 2022 Sep 19]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK538478/

[3] Ohio Division of Emergency Medical Services, Ohio Department of Public Safety. (2024). *Trauma Acute Care Agency* [Dataset].

Cancer

During their lifetime, 1 in 3 people in the United States will be diagnosed with cancer – a disease in which some of the body's cells grow uncontrollably and spread to other parts of the body.[1,2] As noted in *HealthMap2025's* Leading Causes of Death section, cancer ("malignant neoplasms") is the 3rd leading cause of death among Franklin County adults aged 18-59 and the 2nd leading cause of death among Franklin County adults aged 60+.

The incidence for two leading types of cancers (**lung & bronchus; colon and rectum**) has decreased.	⬇ Down from HM2022
The incidence for one leading types of cancers (**breast**) has increased.	⬆ Up from HM2022
The cancer that most frequently led to the death of Franklin County residents is **lung & bronchus**.	≈ Similar to HM2022

Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Unavailable	Unavailable	Observed (see below)	Observed (see map)

Prostate cancers and breast cancers continue to have the highest incidence rates[3] among Franklin County residents, followed by lung and bronchus cancers.

Cancer Incidence (age-adjusted rate per 100,000)

	HM2025	**HM2022**	**HM2019**	**Ohio**	**US**
1st	Prostate: 133.5	Prostate: 140.1	Prostate: 124.7	Prostate: 121.3	Prostate: 114.7
2nd	Breast: 81.4 ▲	Breast: 72.2	Breast: 74.9	Breast: 73.0	Breast: 70.4
3rd	Lung & Bronchus: 56.4 ▼	Lung & Bronchus: 63.1	Lung & Bronchus: 71.3	Lung & Bronchus: 60.6▼	Lung & Bronchus: 49.1▼
4th	Other Sites/Types:38.6	Colon & Rectum: 38	Colon & Rectum: 40	Colon & Rectum: 38.3	Colon & Rectum: 36.0
5th	Colon & Rectum: 32.5 ▼	Other Sites/ Types:35.8	Other Sites/ Types: 37.1	Uterus: 29.8	Uterus: 27.3

Cancer Incidence by Race (age-adjusted rate per 100,000)

	White (non-Hispanic)	Black (non-Hispanic)	Asian	Hispanic
1st	Prostate: 118.9 ▼	Breast: 62.1 ▼	Prostate: 183.1 ▲	Prostate: 60 ▼
2nd	Breast: 81.9	Prostate: 25.4 ▼	Breast: 76.9	Uterus: 44.7
3rd	Lung & Bronchus: 56.9	Other Sites/Types: 25.2▼	Lung & Bronchus: 61.5	Breast: 32.5 ▼
4th	Other Sites/Types: 37.6	Lung and Bronchus: 17.2▼	Other Sites/Types: 38.8	Kidney & Renal Pelvis: 24.2
5th	Colon & Rectum: 33.9	Non-Hodgkins Lymphoma: 14.4	Colon & Rectum: 29.9	Other Sites/Types: 22.1▼

Lung and bronchus cancers have the highest mortality rate among Franklin County residents, followed by other sites/types of cancers.

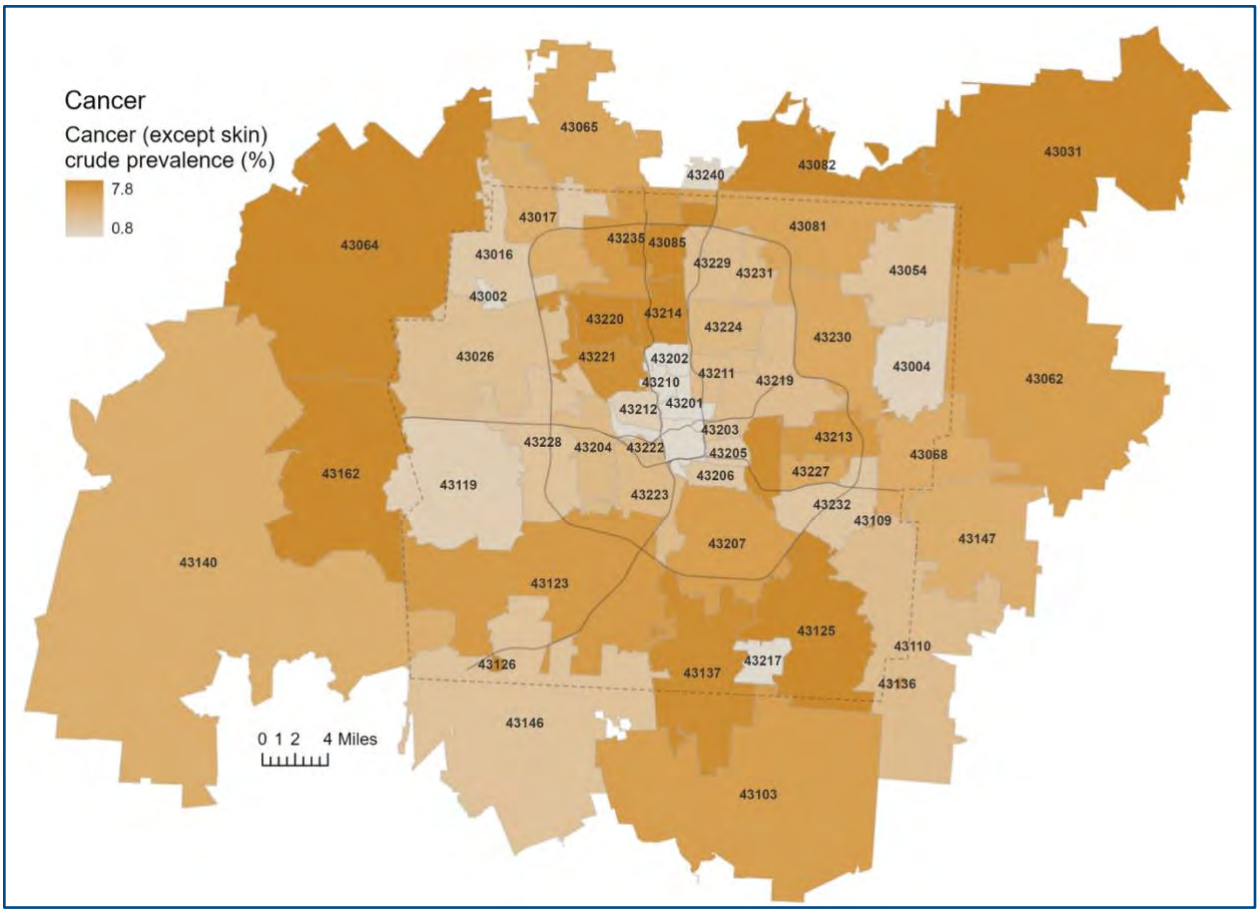
Cancer Mortality (age-adjusted rate per 100,000)

	HM2025	HM2022	HM2019	Ohio	US
1st	Lung & Bronchus: 33.1	Lung & Bronchus: 34.3	Lung & Bronchus: 41.6	Lung & bronchus: 38.8▼	Lung & Bronchus: 31.3▼
2nd	Other Sites/ Types: 21.3	Other Sites/ Types: 20	Other Sites/ Types: 15.6	Prostate: 19.7	Prostate: 18.8
3rd	Pancreas: 11.1	Pancreas: 13.1	Colon & Rectum: 12.8	Colon & Rectum: 13.8	Colon & Rectum: 12.8
4th	Colon & Rectum: 11.1	Breast: 11.5	Breast: 11.9	Pancreas: 11.6	Pancreas: 11.2
5th	Breast: 10.1 ▼	Colon & Rectum: 10.4	Pancreas: 11.1	Breast: 11.1	Breast: 10.5

Cancer Mortality by Race (age-adjusted rate per 100,000)

	White (non-Hispanic)	Black (non-Hispanic)
1st	Lung & Bronchus: 45.98 ▲	Lung & Bronchus: 29.14
2nd	Pancreas: 15.2 ▲	Breast: 12.17 ▲
3rd	Colon & Rectum: 13.81 ▲	Pancreas: 9.61 ▼
4th	Breast: 12.79 ▲	Liver & Intrahepatic Bile Duct: 8.97
5th	Prostate: 8.99	Colon & Rectum: 8.65 ▼

As shown in the map below, cancer prevalence is highest among Franklin County residents in northwest-central zip codes (43221, 43220), north-central zip codes (43214, 43085), and southern zip codes (43137, 43125).



Additional Information & References

Cancer incidence rates were obtained from a variety of sources. For Franklin County, age-adjusted rates from ODH's Invasive Cancer Report were used for the years 2021, 2018, and 2015.[3] For Ohio and the United States, age-adjusted data from Centers for Disease Control and Prevention's WONDER database were used for 2021.[4] Likewise, cancer mortality rates were obtained from a variety of sources. For Franklin County, data from ODH's Mortality Report were used for the years 2022, 2019, and 2016 overall, and 2021 for race.[3] These data were then converted into crude rates by dividing the total number of deaths by the total population in that year. For Ohio and the United States, age-adjusted data from Centers for Disease Control and Prevention's WONDER database were used for the year 2021.[4]

To map cancer prevalence at the zip code level, Franklin County Public Health staff obtained estimates from the CDC's PLACES resource, which uses BRFSS data (2021 or 2022), Census

Bureau data (either the 2020 decennial census or 2022 annual population estimates), and American Community Survey data (2018-2022 estimates).

[1] National Cancer Institute. (n.d.) What is cancer? https://www.cancer.gov/about-cancer/understanding/what-is-cancer

[2] American Cancer Society. (n.d.) Understanding cancer. https://www.cancer.org/cancer/understanding-cancer.html

[3] DataOhio. (2021). Invasive Cancer Report [Interactive Dashboard]. Ohio Department of Health, Bureau of Vital Statistics. Retrieved in 2024 from https://data.ohio.gov/wps/portal/gov/data/view/ohio_births

[4] Centers for Disease Control and Prevention, CDC WONDER Online Database. United States and Puerto Rico Cancer Statistics, 1999-2021 Incidence Results. Accessed at https://wonder.cdc.gov/cancer-v2021.html

[5] DataOhio. (2022). Mortality [Interactive Dashboard]. Ohio Department of Health, Bureau of Vital Statistics. Retrieved in 2024 from https://data.ohio.gov/wps/portal/gov/data/view/ohio_births

[6] Centers for Disease Control and Prevention, CDC WONDER Online Database. United States and Puerto Rico Cancer Statistics, 1999-2021 Mortality Request. Accessed at https://wonder.cdc.gov/cancermort-v2021.html

Violent Crime

High rates of local violent crime are associated with health impacts such as increased cardiovascular disease and lower self-rated health.[1,2] This is theorized to be due in part to greater stress from feeling unsafe, as well as co-occurrence with related risk factors such as poverty and lack of access to healthcare.

There were **401.3 violent crimes** per 100,000 Franklin County residents.

≈ Similar to HM2022 (424.1)

The overall incidence of violent crime has not changed significantly since HM2022, but there is a steady downward trajectory since HM2019. Unfortunately, Franklin County still has higher rates of overall violent crime as well as each individual crime. Murder has risen across Franklin County, Ohio, and the US while robbery has decreased in the same geographies. Rape has increased in Franklin County and aggravated assault has risen in Ohio.

Violent Crime (rate per 100,000)

	Overall	Murder	Rape	Robbery	Aggravated Assault
HM2025	401.3	10.7 ▲	85.1 ▲	113.5 ▼	191.9
HM2022	424.1	9.4	76.9	159.2	178.5
HM2019	455.9	8.9	85.7	206.2	155.1
Ohio	293.6	6.1 ▲	48.4	53.1 ▼	185.9
US	380.7	6.3 ▲	40	66.1 ▼	268.2 ▲

Additional Information & References

Overall violent crime is defined as the combined rate of four different offences: murder, rape, robbery, and aggravated assault. To assess violent crime in Franklin County, we used the Ohio Office of Criminal Justice Services dashboard for crime by county for 2022, 2019, and 2016.[3] Crime rates in Ohio and the United States were sourced from the Federal Bureau of Investigation Crime Data Explorer tool.[4]

Crime rates in Franklin County were calculated by dividing the raw number of incidents reported by the total population and multiplying by 100,000. Overall violent crime was calculated by first adding the individual numbers of murder, rape, robbery, and aggravated assault for the year in question and then converting into a rate.

Data Gap: Future HealthMaps should consider obtaining demographic data (e.g., age, gender, racial/ethnic background) about those who experience violent crime.

Data Gap: Since 2013, the Columbus Division of Police did not report ~119,000 crimes to the Ohio Office of Criminal Justice Services' Incident-Based Reporting System (OIBRS). Because of this, readers should exercise care when interpreting Franklin County's crime rates over time. For more information about this, readers are encouraged to visit the Columbus Division of Police's webpage, which can be accessed at https://www.columbus.gov/Services/Public-Safety/Police.

[1] Eberly, L. A., Julien, H., South, E. C., Venkataraman, A., Nathan, A. S., Anyawu, E. C., Dayoub, E., Groeneveld, P. W., & Khatana, S. A. M. (2022). Association Between Community-Level Violent Crime and Cardiovascular Mortality in Chicago: A Longitudinal Analysis. *Journal of the American Heart Association*, *11*(14), e025168.

[2] Dong, B., White, C. M., & Weisburd, D. L. (2020). Poor Health and Violent Crime Hot Spots: Mitigating the Undesirable Co-Occurrence Through Focused Place-Based Interventions. *American journal of preventive medicine*, *58*(6), 799–806. https://doi.org/10.1016/j.amepre.2019.12.012

[3] Ohio Office of Criminal Justice Services. (2022). *OIBRS Data Dashboard: Crime in Ohio Counties 2016-2022 [Interactive Dashboard]*. Retrieved in 2024 from https://ocjs.ohio.gov/research-and-data/data-reports-and-dashboards/crime-in-ohio-counties

[4] Federal Bureau of Investigation. (2022). *Crime Data Explorer [Interactive Dashboard]*. Retrieved in 2024 from https://cde.ucr.cjis.gov/LATEST/webapp/#/pages/explorer/crime/crime-trend

Overdose Deaths

During the past 20 years, drug overdose deaths have increased exponentially, with a particular spike noted during the COVID-19 pandemic.[1,2] The rise in deaths is attributed to opioids, which includes prescription medications, heroin, fentanyl, and other synthetic opioids.[3] The combination of opioids and other substances, for example the veterinary sedative xylazine, is a rising trend that can increase the potential of fatal overdose.[4]

135.3 per 100,000 residents in Franklin County died of an **overdose**.

Up from HM2022 (115.1)

45.2 per 100,000 residents in Franklin County died of an overdose of a synthetic narcotic such **as fentanyl**.

Down from HM2022 (54.0)

Across all geographies for the last several HealthMap assessments, the leading cause of overdose death has been "other synthetic narcotics", a category that includes fentanyl. In Franklin County, that type of overdose death decreased since the last *HealthMap*; however, it is still much higher than the estimates for Ohio, US, or HM2019.

In Franklin County, overdose deaths due to cocaine use have increased rapidly over time.

Overdose Mortality (rate per 100,000)

	HM2025	HM2022	HM2019	Ohio	US
Total	**135.3▲**	**115.1**	**63.5**	**98.1**	**70.9▲**
1st	Other synthetic narcotics: 45.2▼	Other synthetic narcotics: 54.0	Other synthetic narcotics: 25.2	Other synthetic narcotics: 30.5	Other synthetic narcotics: 21.8
2nd	Cocaine: 28.2▲	Cocaine: 20.1	Cocaine: 13.7	Cocaine: 15.1	Psychostimulants with abuse potential: 10.5
3rd	Psychostimulants with abuse potential: 10.2▲	Psychostimulants with abuse potential: 9.1	Other opioids: 6.8	Psychostimulants with abuse potential: 11.2	Cocaine: 8.8
4th	Other opioids: 4.8▼	Other opioids: 5.4	Heroin: 5.4	Benzodiazepines: 3.5	Benzodiazepines: 3.2
5th	Benzodiazepines: 4.2▲	Benzodiazepines: 3.6	Benzodiazepines: 1.9	Antiepileptic and sedative-hypnotic drugs, unspecified: 3.3	Other opioids: 3.0

Additionally, overdose deaths from psychostimulants with abuse potential (which includes methamphetamines) have increased since the last *HealthMap*, as have overdose deaths from benzodiazepines (e.g., depressants that sedate, relieve anxiety, and reduce seizures, such as Valium®, Xanax®, Klonopin®, and others).

Franklin County has progress to make regarding overdose deaths, particularly from synthetic opioids. Drug abuse is a nationwide crisis, and a comprehensive federal, state, and local approach will be needed to address drug supply, law enforcement, and addiction treatment.

HP2030 objective for Overdose Deaths: Not met[7]

Healthy People Objective:	Most recent Franklin County data (HM2025)
20.7	**135.3**

HP2030 objective for Synthetic Opioid Deaths: Not met[8]

Healthy People Objective:	Most recent Franklin County data (HM2025)
8.9	**45.2**

HP2030 objective for Other Opioid Deaths: Not met[9]

Healthy People Objective:	Most recent Franklin County data (HM2025)
3.4	**4.8**

Additional Information & References

Readers who are interested in learning more about local efforts to decrease overdoses, overdose deaths, and infectious diseases like Hepatitis C and HIV/AIDS should visit the Columbus and Franklin County Addiction Plan, which can be accessed by **clicking here**.

To measure overdose mortality in Franklin County, we sourced data from the Centers for Disease Control and Prevention WONDER portal.[5,6] In alignment with the Healthy People 2030 goals, these statistics included deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as well as drug poisoning as a multiple cause of death (ICD-10 codes T36-T50).

Note that "Other synthetic narcotics" includes fentanyl deaths, "Psychostimulants with abuse potential" includes methamphetamines, and "Other opioids" includes prescribed opioids such as oxycodone.

[1] Fujita-Imazu, S., Xie, J., Dhungel, B., Wang, X., Wang, Y., Nguyen, P., Khin Maung Soe, J., Li, J., & Gilmour, S. (2023). Evolving trends in drug overdose mortality in the USA from 2000 to 2020: an age-period-cohort analysis. *EClinicalMedicine*, *61*, 102079. https://doi.org/10.1016/j.eclinm.2023.102079

[2] DiGennaro, C., Garcia, G. P., Stringfellow, E. J., Wakeman, S., & Jalali, M. S. (2021). Changes in characteristics of drug overdose death trends during the COVID-19 pandemic. *The International journal on drug policy*, *98*, 103392. https://doi.org/10.1016/j.drugpo.2021.103392

[3] Ciccarone D. (2019). The triple wave epidemic: Supply and demand drivers of the US opioid overdose crisis. *The International journal on drug policy*, *71*, 183–188. https://doi.org/10.1016/j.drugpo.2019.01.010

[4] Hays, H. L., Spiller, H. A., DeRienz, R. T., Rine, N. I., Guo, H. T., Seidenfeld, M., Michaels, N. L., & Smith, G. A. (2024). Evaluation of the relationship of xylazine and fentanyl blood concentrations among fentanyl-associated fatalities. *Clinical toxicology (Philadelphia, Pa.)*, *62*(1), 26–31. https://doi.org/10.1080/15563650.2024.2309326

[5] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database. Data are from the final Multiple Cause of Death Files, 2018-2022, and from provisional data for years 2023-2024, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. http://wonder.cdc.gov/mcd-icd10-provisional.html

[6] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999-2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999-2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

[7] Healthy People 2030 objective SU-03, U.S. Department of Health and Human Services

[8] Healthy People 2030 objective IVP-22, U.S. Department of Health and Human Services.

[9] Healthy People 2030 objective IVP-21, U.S. Department of Health and Human Services.

The Columbus and Franklin County Addiction Plan can be accessed at https://cfcap-columbus.hub.arcgis.com/.

ENVIRONMENTAL HEALTH

Elevated blood lead levels (EBLL)

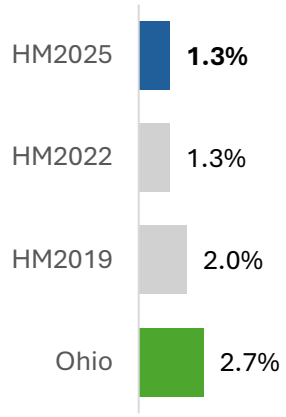
Although elevated blood lead levels (EBLL) are detrimental to all people, they are particularly harmful to children. Young children exposed to high levels of lead are at increased risk for brain damage and developmental delays, lower muscle function, and damage to the kidneys and other organs.[1] Children are primarily exposed to lead by consuming contaminated paint, dust, or water.[1]

1.3% of tested children under 6 years old had an **elevated blood lead level**.

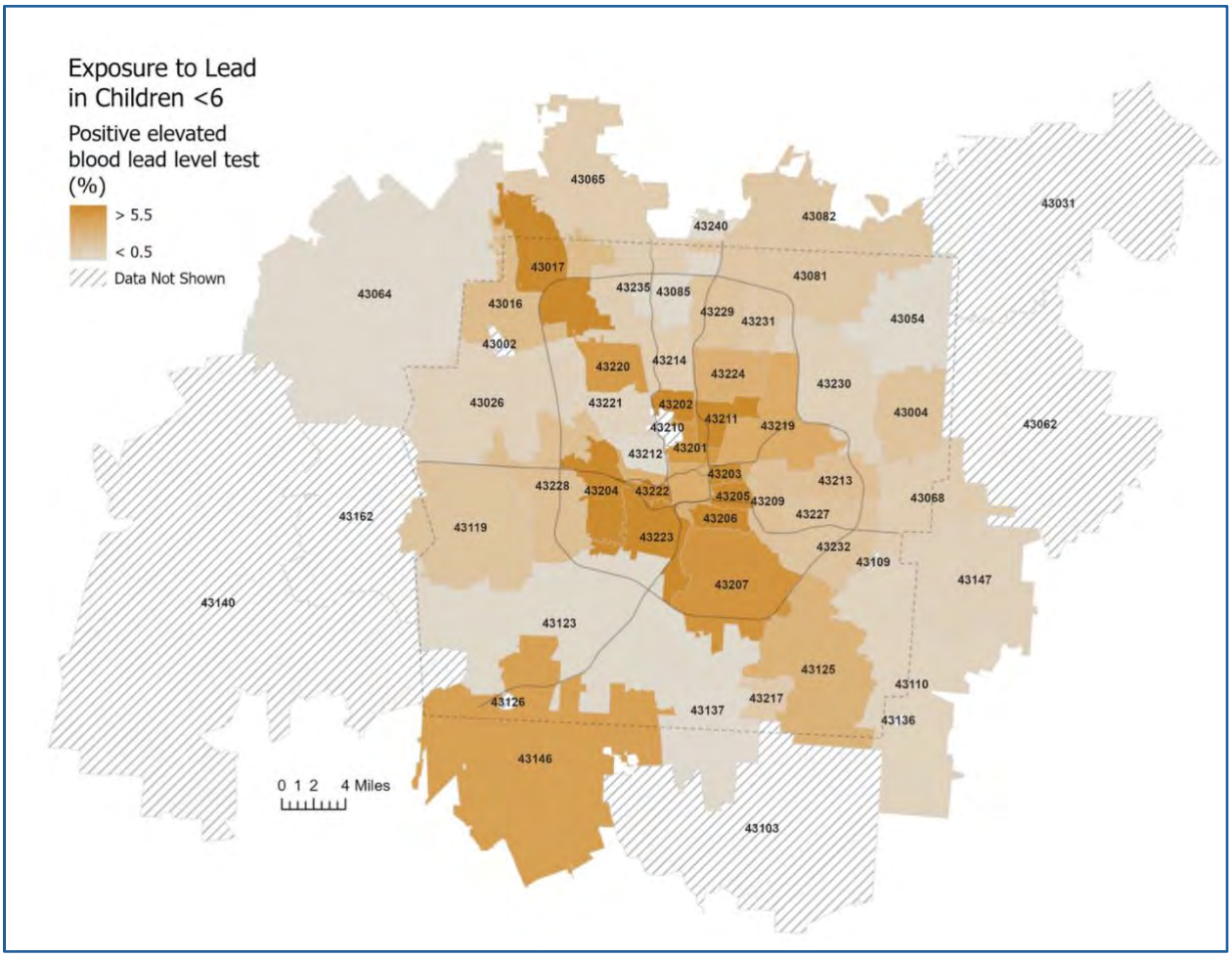
≈ Similar to HM2022 (1.3%)

Since HM2019, the percentage of tested young children with elevated blood lead levels has decreased. Currently, the percentage of tested young children with elevated blood lead levels in Franklin County is less than half that of tested young children in Ohio overall.

Elevated Blood Lead Levels (≥5 µg/dL) among children under age 6 who were tested for lead



As shown in the map on the next page, greater percentages of children under age 6 in the following areas have elevated blood lead levels: east-central Franklin County (43203, 43205), southern Franklin County (43206), west-central Franklin County (43222, 43223, 43204), northern Columbus (43202, 43211), and far northwestern Franklin County/Dublin (43017).



Additional Information & References

To assess elevated blood lead levels in children under 6 years old, data were obtained from Ohio's Blood Lead Testing Program.[2] Although the threshold for determining elevated blood lead levels in Ohio changed in 2023 (i.e., from ≥5 µg/dL to ≥3.5 µg/dL), for the sake of historical comparisons *HealthMap2025* retained the threshold of ≥5 µg/dL. In the map visualizations for 2023, the updated threshold of ≥3.5 µg/dL was used. Franklin County Public Health staff then mapped these data for each zip code in Franklin County.

[1] Abadin, H., Ashizawa, A., Stevens, Y. W., Llados, F., Diamond, G., Sage, G., Citra, M., Quinones, A., Bosch, S. J., & Swarts, S. G. (2007). *Toxicological Profile for Lead*. Agency for Toxic Substances and Disease Registry (US).

[2] DataOhio. (2023). *Blood Lead Testing Public (2016-present)* [Interactive Dashboard]. Ohio Department of Health, Bureau of Vital Statistics. Retrieved in 2024 from https://data.ohio.gov/wps/portal/gov/data/view/blood-lead-testing-public-_2016-present_?visualize=true

Asthma

Asthma is a chronic disease that affects people's lungs, and is one of the most common long-term diseases among children.[1] Because environmental health factors such as outdoor air pollution (e.g., ozone, particulate matter) has been associated with increased asthma symptoms, asthma is included in this section of *HealthMap2025*.[2]

9.9% of Franklin County adults reported asthma.

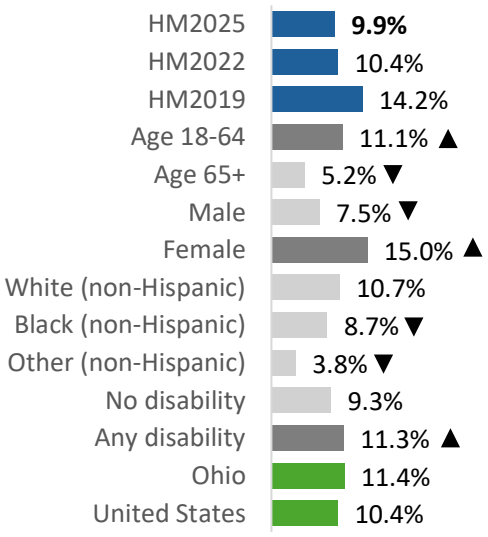
≈ Similar to HM2022 (10.4%)

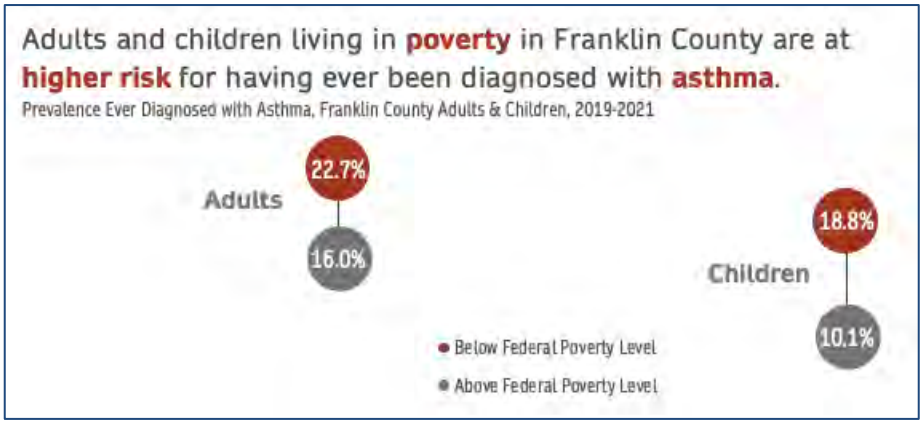
Disparities by selected social determinants of health

Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Younger more likely	Female more likely	None observed	Observed (see map)

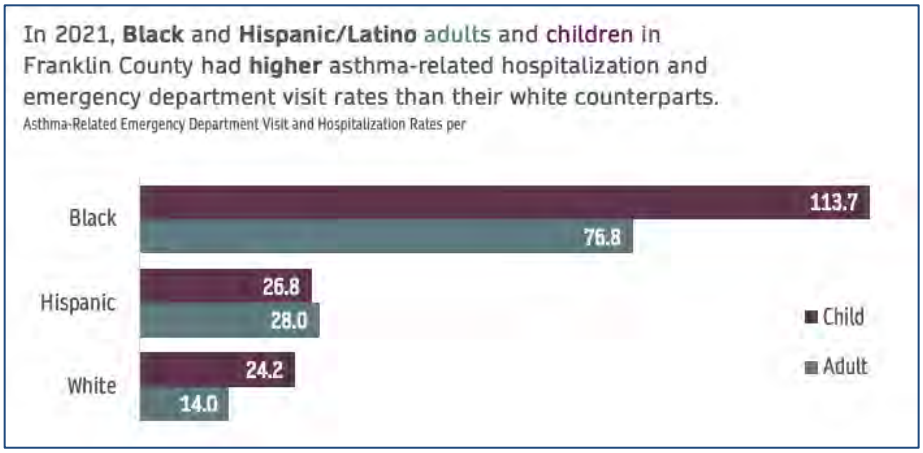
Asthma is lower among older adults than younger adults, which could be due to either changes in diagnoses or superseding respiratory diagnoses in the elderly (e.g., chronic obstructive pulmonary disease, or COPD). Females and individuals with disabilities are both more likely to report this health condition.

A recent analysis of asthma prevalence by poverty status revealed that among Franklin County residents living in poverty, 22.7% of adults and 18.8% of children have ever been diagnosed with asthma (see below).

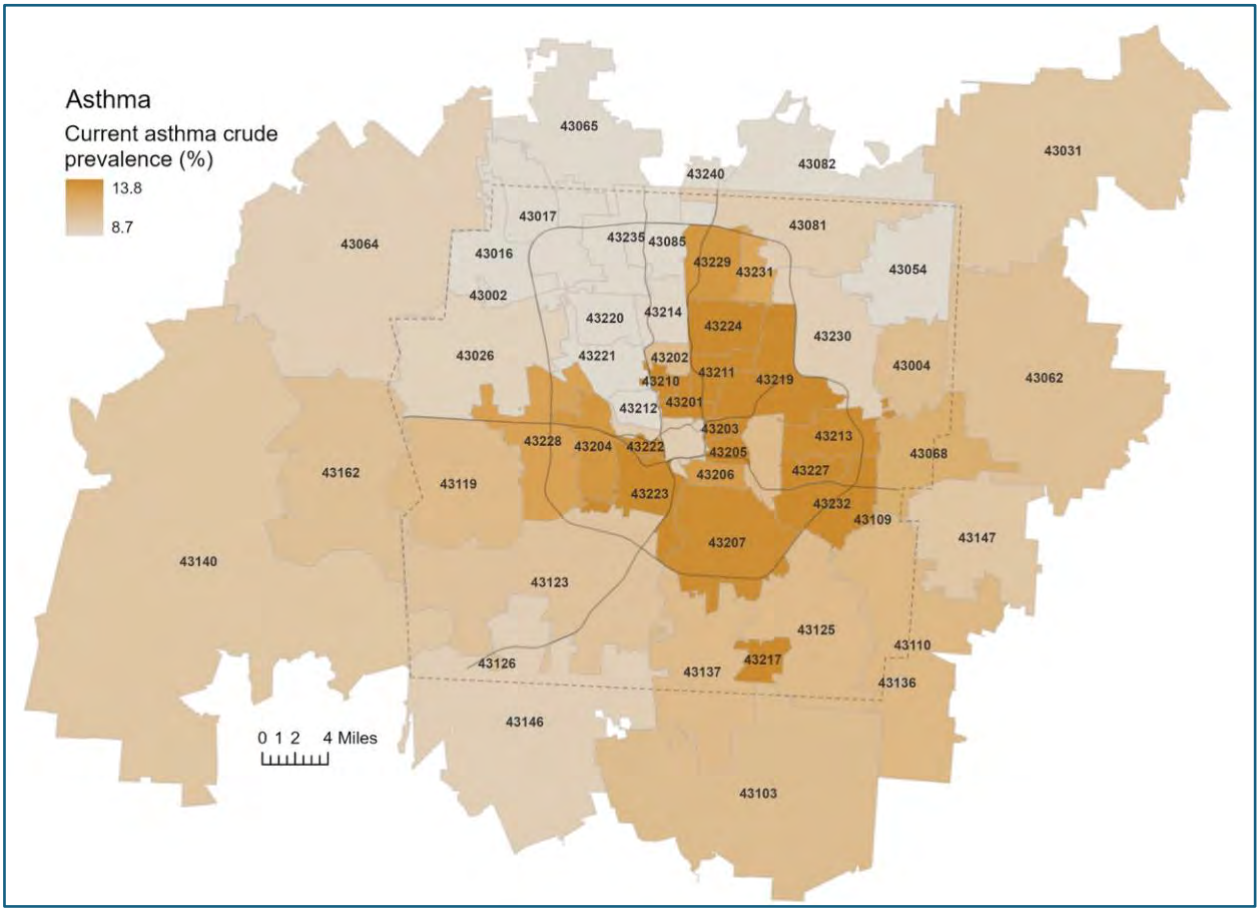




Additionally, a recent analysis revealed that black and Hispanic adults and children in Franklin County had much higher rates of asthma-related hospitalization and emergency department visits as compared to white individuals.



As shown in the map below, asthma prevalence is higher in most Franklin County zip codes that are within I-270, except for those zip codes in the northwestern quadrant.



Additional Information & References

Readers who are interested in learning more about this topic should also consider visiting the Mid-Ohio Regional Planning Commission's 2023 Report on Central Ohio's Air Quality, which can be accessed by **clicking here**, as well as Franklin County Public Health's Data Hub Climate & Health webpage which can be accessed by **clicking here**.

To assess the prevalence of this chronic condition, *HealthMap2025* obtained recent data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS), which completes structured survey interviews with residents via telephone.[3] In most cases, survey respondents were asked if a doctor, nurse, or other health professional ever told them that they had a specific chronic health condition.

To enable comparisons by demographic subgroups (e.g., age, sex, race), Columbus Public Health staff analyzed BRFSS data using the most recent year or two available (typically 2021 & 2022). To map the prevalence of these indicators at the zip code level, Franklin County Public Health staff obtained prevalence estimates from the CDC's PLACES[4] resource, which uses BRFSS data (2021 or 2022), Census Bureau data (either the 2020 decennial census or 2022 annual population estimates), and American Community Survey data (2018-2022 estimates).

Franklin County Public Health staff conducted the analyses of asthma prevalence by poverty status and rates of asthma-related hospitalization by racial/ethnic background and created the visuals depicting the key findings from those analyses.[5]

[1] Centers for Disease Control and Prevention. (n.d.) About Asthma. https://www.cdc.gov/asthma/about/index.html

[2] Centers for Disease Control and Prevention. (n.d.) Environmental Triggers of Asthma. https://www.atsdr.cdc.gov/csem/asthma/treatment_management_prevention.html#outdoor

[3] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data, 2022 (HM2025), 2019 (HM2022), 2015 (HM2019)

[4] Centers for Disease Control and Prevention, PLACES: Local Data for Better Health. (n.d.). https://www.cdc.gov/places/index.html

[5] Franklin County Public Health. (2024). Personal communication: Asthma Grant Statement of Need.

The Mid-Ohio Regional Planning Commission's 2023 Report on Central Ohio's Air Quality can be accessed at https://www.morpc.org/2023/wp-content/uploads/2024/03/MORPC_End-of-season-AQ-report-2023-updated.pdf. Franklin County Public Health's Data Hub Climate & Health webpage can be accessed at https://fcph-data-hub-fca.hub.arcgis.com/pages/climate.

Lyme Disease

Lyme disease is a bacterial infection that can occur after a person is bit by a tick. The Annual Summary of Reportable Diseases (2022) for Columbus and Franklin County, Ohio, which can be accessed by **clicking here**, presented recent data about the number of Lyme disease cases, along with various rate calculations. A snippet from that report is displayed below.

DISEASE SPOTLIGHT:

LYME DISEASE

LYME DISEASE		2022
Number of Cases		38
Rate*	*Overall*	2.9
	Female	2.4
	Male	3.4
Age of cases (in years)	*Mean*	29
	Median	18
	Range	4-72

* Rate per 100,000 population

LOCAL FACTS:

In Columbus and Franklin County in 2022:

- The Lyme disease rate among males was higher than the rate among females.
- 50% of confirmed and probable cases were pediatric cases.
- 96.8% of confirmed and probable cases were among whites of non-Hispanic or non-Latino descent.

EPIDEMIOLOGY[3]

Infectious Agent: *Borrelia burgdorferi* or *Borrelia mayonii*, spirochete-type bacteria

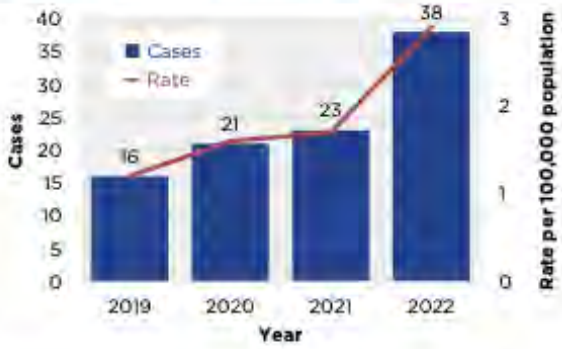
Case Definition: Please see the Ohio Infectious Disease Control Manual: Lyme Disease.

Mode of Transmission: The spirochete-type bacteria is transmitted through the bite of a tick: *Ixodes pacificus* in the western and *Ixodes scapularis* in the eastern and midwestern United States.

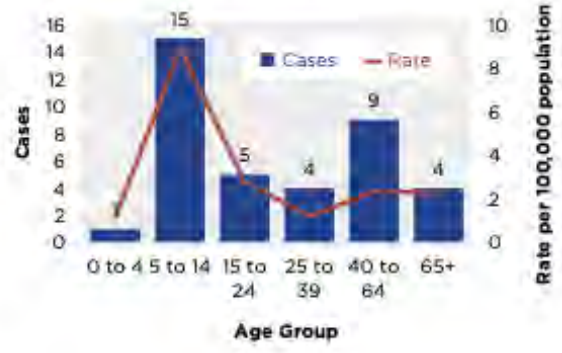
Incubation Period: Erythema migrans rash appears 3-32 days after tick bite (mean 7-10 days); early stages of the illness may be unapparent and the patient may present with later manifestations.

Symptoms: Approximately 70-80% of infected persons develop a circular rash called erythema migrans (EM) that begins at the site of a tick bite after a delay of 3-32 days (average is 7 days). The rash gradually expands over a period of several days, reaching up to 12 inches (30 cm) across. Other symptoms include fatigue, chills, fever, headache, muscle and joint aches, and swollen lymph nodes.

LYME DISEASE CASES AND RATES BY YEAR, FRANKLIN COUNTY, 2019-2022



LYME DISEASE CASES AND RATES BY AGE GROUP, FRANKLIN COUNTY, 2022



VISION OF A HEALTHY FRANKLIN COUNTY

Vision of a Healthy Franklin County

Over the course of eleven community focus groups and multiple Steering Committee meetings, Franklin County residents shared their perceptions of and vision for a healthy community.

According to community members, a healthy community is one in which:

- Residents have **financial stability** at a level that allows them **to meet their basic needs**. In this vein, residents also believe that a healthy community is one in which it is easier to access financial assistance when needed.
- Residents **feel connected to their community**; they know their neighbors and have open communication with members of the community, including government officials.
- Residents can **move more easily around Franklin County**, which includes having better public transportation options and more walkable communities.
- Residents' **health needs are reflected in the built environment,** which would contain more green spaces, spaces to socialize with neighbors, grocery stores, and medical offices.
- Residents feel **safe** in their homes and neighborhoods.
- Residents can **easily access healthy food**, specifically unprocessed and nutritious food.
- The community's **youth have resources they need to thrive.** This includes ensuring youth can access safe and engaging parks and playgrounds. It also includes ensuring parents and others in the community provide youth with the needed support to achieve good outcomes in terms of mental health, education, and jobs.

Community Voices: Financial Stability

Franklin County residents believe that addressing poverty and income inequality is necessary to have a healthy community. They know that residents cannot focus on improving their health when they are worried about finances, and also that a lack of financial stability is related to crime in their communities.

> *"You have to eliminate poverty in order to have a healthy community so that people will see opportunity. They don't see opportunity as long as they don't have any [resources]. If you don't have any resources, then your whole day is taken, scrambling. You only see the next 10 hours, the next 12 hours, the next maybe 24 if you're feeling good on that day. And that's not a way to have a healthy community."*
>
> *"I think where everybody's needs are met, whatever they may be, at whatever level they are at, from the very wealthy to those with pennies. It shouldn't be such a struggle for so many. I think about the single moms…rent is astronomical, and people want to be independent, but they*

> *can't because it's prohibitive. And the equality of just a standard of living, I think should be more easily reachable than it is."*
>
> *"Healthy looks like everybody being able to go 8 hours and be able to pay your bills, because a lack of resources or money leads to crime. Everything is a trickledown effect, and until people that are sitting high and looking low meet people where they're at, it will always look unhealthy because people don't have what they need."*
>
> *"Everybody being able to survive. Not so much worrying about, "I got this, but my neighbor doesn't. So are they gonna try to come and get it?" If everybody was able to, not so much have the same thing, but to be able to afford the same things…being able to get your groceries weekly, being able to keep your lights on, keeping your roof over your head without having to worry…"*

Many Franklin County residents need help securing basic needs due to a lack of financial stability. Residents believe that a healthy community would better promote the resources available to help residents.

> *"I think a healthy community could be a community that is well educated and knows what resources are available to them. And because we've got all these generational gaps, the information is given in certain ways that it's hard to say for the masses, 'This is where you can go get food at Mid-Ohio. These are the times that this church will let you come and get clothing, or this is what the Buckeye Ranch is for. This is what the Lions International does here in Grove City or our Rotary department.' Like, what are all our nonprofits that are available throughout Franklin County, and what they do."*
>
> *"I noticed that my whole community is families. And at one point in time, I was just gonna put my feet on the ground, just go out there and just start passing off flyers because there's so much stuff that goes on that people don't know about. We have people out there who are not computer literate. You have grandparents raising their grandkids that don't know about resources or that need help with certain things and they can't get it because how can they know if you're not out there advocating in the community?"*
>
> *"Resources, like the community just coming out advocating— I noticed in my neighborhood we have churches, and those churches do not come out there and say, 'Hey, we're having this or we're having that.' None of that. I stay in the area which is off of Fairwood. I get most of my resources over off of Parsons. It's really bad."*

Residents also think that in a healthy community, it would be easier to access resources for assistance. They named specific barriers to utilizing childcare support and housing support that need to be addressed in Franklin County.

"A lot of the older community doesn't know how to access [things], because it used to be picking up the phone. They don't know how to text, and now you have to text or you have to use your laptop or your computer."

"Don't make them beg for it, if they need it. It takes six months [to get assistance], when they was hungry six months ago. Don't do that."

"Even with Title 20, I could not afford work because daycare for my two babies cost me $2,600 a month. I think they work backwards. I understand that you have to have the job, but you take forever to process my application to put my kids in daycare. So if I say I start work this day and you say, 'Well, your application is not processed,' then what am I supposed to do with my kids? So there goes my job. Now I got to start back over again."

"They were supposed to have something set up within the city where landlords could not restrict certain people who did not meet the income criteria if they had a voucher. Well, they've gotten around that. [housing program] just recently gave over 10,000 vouchers. And so you look at all the people who have had vouchers before on top of that, and then when [housing program] switched over to [housing program], people have just been losing places where they live because the process has not been set straight properly yet, and so it's just not a good thing all the way."

Community Voices: Feeling Connected to their Community

Franklin County residents think a healthy community is one where people feel connected with each other, where lines of communication between neighbors and others in the community are open and mutually beneficial.

"I think it's a community where you feel safe to share what you truly need, and you can go to any neighbor for what that need is. Maybe they can help, maybe they can't. But you feel safer to share what you need and who you are."

"The ability to interact with other people and meet people. It's really important to have a social community."

"I think a healthy community is what people make it. So I feel like a lot of togetherness and a lot of people coming together to promote healthiness, do group walks or things like that."

"Communication in the community. I grew up, we were never friends with our neighbor. She told us the neighbors just want to be in your business. It was like a 'hi', 'bye.' But I think now, as I got older, I realized that communicating with other people in the community actually helps the neighborhood. We're all on the court, let's help clean this up. Like, we had

> *an older gentleman who couldn't cut his grass. So we started taking turns helping him out with his yard."*
>
> *"There's more and more interaction between the people living there…when we think about our government officials and making decisions about laws and financial decisions, even involving property taxes and all those types of things. It feels like there's a big disconnect in many different levels between community members, legislators, neighbors. And it'd be great if we could all just get along."*

Residents believe that in a healthy community, neighbors feel safe talking to each other about issues in the community and ways that they can better coexist.

> *"Being able to communicate with your neighbors. Just having that dialogue, if something's going on, knowing that you are safe to go to that person and say, 'Hey.'…Just being able to have that, without a fear of retaliation kind of thing."*
>
> *"Sensitivity and respect to boundaries. I think that a simple one could be, 'Hey, I would prefer you not to walk through my grass.' And picking up after dogs. Some people can just be completely disrespectful, disregard things like that."*

Residents also feel that in a healthy community, residents would not fear or stigmatize people based on their race, religion, or past incarceration.

> *"Neighborhoods where anybody can belong, no matter what color, what religion."*
>
> *"People don't trust each other anymore. People, they need to talk and come together. And I think it's almost like a racial divide… A lot of times I'm profiled…Just assuming 'she got a bookbag, she must be—' It happens, especially in the summertime. I love books. I'm in [a neighborhood bookstore]. A lot of people [there], they're scared of me. Why are you scared of me? That's why people need to come and talk to each other, period."*
>
> *"Breaking stigmas [around] restored citizens, no matter what their background is. Normalizing, getting over a stigma for your neighbors, like, what if it is your brother? What if it is your sister? I think helps build relationships and be more accepting. Because I do believe, even if they have done some of the most egregious crimes…they still have to be our neighbors, and they still deserve a second chance, in my opinion."*

Community Voices: Mobility in Franklin County

Franklin County residents believe that public transportation needs to be improved for the community to be healthy.

> *"I think there has to be good transportation. It's great if you have a car, but if you don't have a car, it's hard to get places. It takes a long time. You really have to think about it. Like, it's a task. And I think that's detrimental to getting people where they need to be. And I just think that it would be nice if there was some sort of transportation that would make getting places easier."*
>
> *"[public transportation provider] is not always the best. They have some sketchy characters and different things that don't make you feel as safe."*

Residents also think their communities could be healthier if they were more walkable. Along with having more resources within walking distance, residents say sidewalks need to be improved for people to feel safe walking in their communities.

> *"Walkability to do your errands, like grocery shopping, post office, or whatever it could be."*
>
> *"Where I live at, there's not a lot of sidewalks. So a lot of times you see people walking the brims or drain part or whatnot. There's accidents that be out there. You walk at night, there's not a lot of lights. So you could be out there and nobody sees you."*
>
> *"I live in a really more aging community. Even though I find it walkable, because we do have sidewalks, a lot of people have a hard time getting around if the sidewalks aren't fixed or if they can't necessarily drive themselves. And we don't have a lot of public transportation where I live."*
>
> *"When I think of a healthy community, I think of places where there are sidewalks, the sidewalks are accessible, and ideally clean. Not only that, but walkable access to resources. So it's not mandatory that you have to have a car to be able to get to those resources."*

Community Voices: A Healthy Built Environment

A healthy community would also have improvements to the built environment, including more parks, more places to socialize aside from bars, and more grocery stores, daycares, and medical facilities. Overall, the residents would be more mindful of the environment, keeping it clean and quiet.

"Having a lot of places where neighbors can gather, even if that's like a park or coffee shop or like, a grassy space available. And ideally, places where neighbors can gather that aren't always driven by alcohol, like a bar. Both of those options…those physical elements can kind of facilitate those social elements. So I'm thinking, like, unless I'm going door to door, how would I meet my neighbors if I'm not going for a walk in my neighborhood or something like that?"

"Access to green space."

"We don't have any grocery stores. We don't have daycares. I've got to go over to OSU East in order to find medical care. I mean, there's a clinic on Main Street, but it's just overflowing."

"People take care of their yards or, you know, keeping the trash off the streets. [No] noise pollution. That drives me crazy."

Community Voices: Accessing Nutritious Food

Residents believe that for the community to be healthier, it needs to be easier to access quality and nutritious foods. Multiple residents brought up the fact that their neighborhoods are currently in food deserts, and more opportunities to access food need to be brought into the community.

"The community has quality food, accessible grocery stores, farmers markets and things like that."

"A healthy neighborhood for me is in my neighborhood they provide pantries, and a lot of things go on in our community center, like a fish fry Friday and stuff like that. So they provide to those that have lower incomes."

"Having access to free produce."

"Natural foods being grown and sold."

"Healthy neighborhood has diversity and resources. But we are in a food desert."

"We're still in a food desert, obviously. I gotta drive to, like, Whitehall or wherever is closest cause I live off of Fairwood. We just need more resources."

Community Voices: Feelings of Safety

Residents think that there could be improvements to how safe they feel in their homes and out in their communities. In a healthy community, they would see more evidence that crimes are addressed, and they would feel it is safer for children to play outside. Community members also worry about how safe youth are at school.

"Some sense of security, like physical security. If there is some type of crime, to have an actual response. Currently, if there's an issue that happens in our neighborhood, it's very rare that an officer comes out. You do an online report which just kind of disappears. I think that's a concern from an officer's standpoint. But security makes your neighborhood feel healthy."

"I think feeling safe in your community. And in your house and walking."

"Children feel safe to play in a neighborhood. Where they don't have to be concerned about what's happening around them. They can just be kids and play."

"We really want our kids to be outdoors and walk or ride their bikes and stuff. That's a health thing, right? That helps your health a lot. But all these speeding drivers on your streets, that's a barrier for our kids to be outside. Or for us to be outside."

"A safe and adequate education. Shouldn't have to worry they are gonna die every day they walk out the door. Safe getting there. Safe in the building. Safe."

Community Voices: Resources for Youth to Thrive

Many Franklin County residents say that a community looks healthy when they see children playing outside. They think that to encourage more children to do this, they need more opportunities and better infrastructure for playgrounds and parks.

"I was able to buy a house. And the street's awesome. And there's kids playing outside. And to me seeing kids playing and having fun, that's a sign of a healthy community."

"Kids really don't play outside. The engagement of kids being outside and them knowing their neighbors and being able to go to the park…But even parks nowadays need to be updated, they're run down, rusting, or have been torn down completely. So even when they're going to the park, they don't have anything to entertain them."

> *"Something as simple as having sidewalks in all communities, so kids can get up and get out all around…just playgrounds, sports courts, things like that to get kids outside active."*

Residents also believe a healthy community better supports youth when it comes to their education. They believe that the issues that keep kids from having good grades, school attendance, and future success are part of larger problems that need to be addressed.

> *"We lost the slogan of 'It Takes a Village.' I honestly believe that even with the school system, I feel like the support is just not there. Even when COVID happened, they threw these kids in homes talking about 'get on the computer and do the work.'"*
>
> *"Y'all don't know who they're staying with. Y'all don't know their living situations. Y'all don't even know if they're even living anywhere. Y'all don't even know what's going on. So I just feel like the support is just not there like it used to be…You're worried about attendance and kids coming to school every day, but y'all really need to be asking, why aren't these kids coming?...Because you've got older kids that have to stay home with the younger kids so that parents and guardians can go to work to keep a roof over their head. And these are problems that this town is not looking at."*
>
> *"We work in this school system…and school is nothing like it used to be. Because you have so many kids that are traumatized…You have more children with behavioral problems and emotional problems. And you can look at each classroom, maybe six or seven in each classroom that are doing what you're supposed to be doing. And it's a zoo. I mean, all the resources are there. You have psychologists, you have counselors, you have all this, and then you have a lot of wonderful parents. But then you got parents that don't care."*
>
> *"I work with the kids who have been kicked out of their home schools. And it is just really hard to get them motivated in this day and age to want to work or to learn a new skill. If we could have more resources to get them those hands-on skills to work jobs…I mean, I have a student who's 18, I've tried to get him to get his temps. I tried to get him to get a job or to volunteer, and they just say, 'I don't want to work fast food. I don't want this.' And I'm like, you have to try something."*

Other features of healthy communities brought up by community members included:

- A greater variety of small businesses in their communities.
- More accessible and affordable health care options throughout the county, such as mobile clinics that they typically only see in the inner city.
- Better access to mental health resources.

Community Assets and Resources

The list of non-profit and private organizations working to impact the priority health needs reviewed in this document is endless. The Central Ohio community is well positioned to impact adverse health outcomes because of these collective efforts.

The partners and multi-sector partnerships described in this section are currently working to address aspects of each prioritized health need identified by *HealthMap2025*; see page 185 for a visualization of the interrelated nature of this work. A more extensive resource list will be identified during subsequent health improvement planning; it will be included in future documents and at centralohiohospitals.org.

- **Alcohol, Drug, and Mental Health Board of Franklin County (ADAMH)** - plans, funds, and evaluates behavioral health care services that address mental health, addiction, and substance abuse. More information can be found at www.adamhfranklin.org.
- **Beautiful Beginnings** - a program funded by the Franklin County Board of Commissioners that provides home visiting and care coordination services to pregnant and postpartum individuals and their infants up to age 3. This program is one of several home visiting programs that are focused on serving Black community members and community members of color to impact racial disparities in maternal and child health outcomes. Examples of key focus areas include reducing infant mortality, reducing maternal mortality and other maternal complications, and increasing access to social determinants of health.
- **CelebrateOne** - created in November 2014 as a collective impact approach to carry out the Greater Columbus Infant Mortality Task Force's recommendations and to ensure Franklin County meets its ambitious goal. More information can be found at https://www.columbus.gov/Government/Mayors-Office/Initiatives/CelebrateOne/CelebrateOne-About-Us .
- **Columbus and Franklin County Addiction Plan** - a collaborative, multi-sector, comprehensive effort to address addiction and behavioral health issues impacting Franklin County residents. More information can be found at https://cfcap-columbus.hub.arcgis.com/.
- **Columbus Community Action Resilience Coalition (CARE)** - the CARE Coalition works to build a resilient community that honors survival and fosters hope by strengthening trauma-related policies, programs, and practices through collaboration and collective impact, and by mitigating the impact trauma has on the health and wellbeing of individuals and communities. More information can be found at

https://www.columbus.gov/Services/Public-Health/Find-Health-Care-Resources/Neighborhood-Social-Services/Columbus-CARE-Coalition.

- **Columbus Urban League** - the mission of the local affiliate of National Urban League is to empower African Americans and disenfranchised groups through economic, educational, and social progress. Visit www.cul.org for more information.
- **Community Shelter Board** - Community Shelter Board (CSB) leads a coordinated, community effort to make sure everyone has a place to call home, and is a collective impact organization driving strategy, accountability, collaboration, and resources to achieve the best outcomes for people facing homelessness in Columbus and Franklin County. More information on CSB can be found at https://www.csb.org.
- **Franklin County Human Service Chamber** - serves and represents over 200 health and human service nonprofit organizations that prioritize public policies that include food and nutrition, health, housing, transportation, legal and reentry services, refugee and immigration services, workforce development, as well as youth and education policy. A comprehensive list of members can be found at www.humanservicechamber.org.
- **Franklin County Suicide Prevention Coalition** – aims to increase communication, coordination, and collaboration efforts in Franklin County to prevent suicide and bring hope and support to those affected by suicide. It bridges organizations together with the end goal of enhancing the overall success of our collective suicide prevention efforts. These efforts include decreasing stigma, increasing awareness of available support, promoting suicide prevention education, and improving suicide data quality. Visit https://franklincountyspc.org for more information.
- **Ohio Better Birth Outcomes** - The Ohio Better Birth Outcomes (OBBO) collaborative is dedicated to reducing the infant mortality rate in Franklin County by improving the delivery of health care services for women and their families using quality improvement science to guide our work. OBBO is focused on three key initiatives: Improving reproductive health; Expanding access to prenatal care; and Enhancing clinical quality initiatives to help reduce prematurity. Visit https://ohiobetterbirthoutcomes.org for more information
- **Rise Together Innovation Center** - oversees implementation of "A Blueprint for Reducing Poverty in Franklin County," which was released by the Franklin County Commissioners in 2019 and includes 13 overarching goals and 120 action plans to address jobs, housing, health, and youth. More information on the Center can be found at https://risetogether.franklincountyohio.gov/.
- **The Kirwan Institute for the Study of Race and Ethnicity** - an interdisciplinary research institute at The Ohio State University that strives to connect individuals and communities with opportunities needed to thrive. More information can be found at https://kirwaninstitute.osu.edu.
- **United Way of Central Ohio** - fights poverty by funding and coalescing a network of more than 90 non-profit partners providing opportunities and resources to meet basic needs. More information can be found at www.liveunitedcentralohio.org.

Organization / Collective Impact Effort	Mental Health	Adverse Childhood Experiences (ACEs)	Maternal and Infant Health	Violence and Injury-related Deaths	Social Drivers of Health (with a focus on housing)
Alcohol, Drug, and Mental Health Board of Franklin County (ADAMH)	✓	✓		✓	
Beautiful Beginnings			✓		
CelebrateOne			✓		
Columbus and Franklin County Addiction Plan	✓	✓		✓	
Columbus Community Action Resilience Coalition (CARE)	✓	✓		✓	
Columbus Urban League	✓	✓	✓	✓	✓
Community Shelter Board					✓
Franklin County Human Service Chamber		✓		✓	✓
Franklin County Suicide Prevention Coalition	✓	✓			
Ohio Better Birth Outcomes			✓		
Rise Together Innovation Center		✓		✓	✓
The Kirwan Institute for the Study of Race and Ethnicity	✓	✓	✓	✓	✓
United Way of Central Ohio		✓			✓

Summary

Franklin County HealthMap2025 provides a comprehensive overview of our community's health status and needs. There are numerous indicators that suggest the health of Franklin County, Ohio's residents compares favorably with the state and country.

Franklin County HealthMap2025 also uncovered several indicators that suggest areas in which the health of Franklin County's residents either has diminished over time or compares unfavorably to Ohio or the nation.

Consistent with requirements, the participating hospitals and health departments will use this report to inform development and implementation of strategies to address its findings. It is intended that a wide range of stakeholders – many more than are represented on *Franklin County HealthMap2025's* Community Health Needs Assessment Steering Committee – will also use this report for their own planning efforts. Subsequent planning documents and reports will be shared with stakeholders and with the public.

Users of *Franklin County HealthMap2025* are encouraged to send feedback and comments that can help to improve the usefulness of this information when future editions are developed.

Questions and comments about *Franklin County HealthMap2025* may be shared with:

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Central Ohio Hospital Council

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH

Franklin County Public Health

Navigating Our Way to a Healthier Community Together