2025-2027 Community Health Needs Assessment

NATIONWIDE CHILDREN'S®

When your child needs a hospital, everything matters.

Introduction

Nationwide Children's Hospital is pleased to have participated in the development and adoption of the Franklin County *HealthMap**2025*** as its Community Health Needs Assessment. Nationwide Children's had several representatives actively participate in the needs assessment with other members of the Central Ohio Hospital Council and community partners.

Our Mission

Providing exceptional care and best outcomes, regardless of ability to pay.

Our Vision

Leading the transformation of child health to achieve best outcomes.

Our Values

As One Team where Everyone Matters, we:

Do the Right Thing

- We are committed to health equity for all children
- We always act with integrity, kindness, empathy and honesty
- We are inclusive and respectful, embracing the uniqueness and differences of each individual

Prioritize Quality and Safety

- We put patients and families at the center of every decision
- We create a safe day every day
- We communicate clearly and completely
- We routinely seek input from others and always support our colleagues

Promote Health and Well-Being

- We balance work and life demands
- We generate optimism and energy in one another
- We advance our health, and the health of our community

Are Agile and Innovative

- We embrace and lead positive change
- We fuel a streamlined environment and an entrepreneurial spirit
- We generate and share new knowledge and ideas

Get Results

- We're accountable (we do what we say we'll do)
- We're determined (we get the desired results)
- We're committed to best outcomes and constant improvement
- We leverage our diverse strength and talents

Nationwide Children's is located at 700 Children's Drive, Columbus, OH 43205. The main hospital is based in Franklin County. In developing its Community Health Needs Assessment, Nationwide Children's has defined the community it serves as the residents of Franklin County. Nearly 49.1% of the hospital's inpatient discharges and 44.3% of inpatient gross charges are from residents of Franklin County. In addition, of the 80 clinical off-site facilities that Nationwide Children's operates, 59 are in Franklin County.

Community input for this report was obtained through a series of meetings with community representatives on the Franklin County Community Health Needs Assessment Steering Committee, led by the Central Ohio Hospital Council. Individuals representing the broad interests of the community served by our organization participated on the steering committee. See pages 15 through 18 of the Franklin County *HealthMap**2025*** for the participant list.

As required by Section 501(r) of the Internal Revenue Code, members of the Nationwide Children's Neighborhood Advisory Committee, who are Franklin County residents, provided input to ensure proper representation of community needs. They helped determine and prioritize health needs and identify resources and agencies to help address specific needs in the Community Health Needs Assessment. A staff member of Columbus Public Health, a local health community entity, also reviewed and provided feedback regarding the identified and prioritized health needs to ensure proper alignment with community concerns.

Executive Summary

To address the needs of its community, Nationwide Children's has collaborated with dozens of community partners and agencies to create a roadmap to better health for all children in Franklin County. Although Nationwide Children's has already made significant progress toward providing high-quality, accessible and appropriate care for the children in its service area, it will continue to address the needs identified by community representatives and the Franklin County *HealthMap**2025*** through the methods discussed in the accompanying Implementation Strategy.

The primary targets for Nationwide Children's efforts fall into the following categories, which were identified as areas of need by the Franklin County *HealthMap**2025***.

Additionally, Nationwide Children's added Preventive Care and Disease Management as targets. These were chosen for the 2022-2024 Implementation Strategy by the Nationwide Children's steering committee and remain part of the 2025 targets due to the importance they have for our pediatric population.

- **Basic Needs**
  - Housing security
  - Financial stability
  - Neighborhood safety
  - Transportation and neighborhood safety
  - Education and health care access
- **Mental Health**
  - Access to mental health care resources
  - Screening for mental health issues
- **Adverse Childhood Experiences (ACEs)**
  - Prevention and early intervention
  - Increased awareness and access to care
- **Maternal and Infant Health**
  - Infant mortality
  - Maternal pre-pregnancy, pregnancy and postpartum health
- **Violence and Injury-Related Deaths**
  - Mental and social health
  - Decreased unintentional drug and alcohol deaths
- **Preventive Care**
  - Well-child visits
  - Immunizations
  - Dental care access
- **Disease Management**
  - Asthma
  - Diabetes
  - Obesity
  - Autism

This Community Health Needs Assessment also includes Nationwide Children's Hospital's Community Impact Report. The report describes Nationwide Children's efforts addressing the priority pediatric health care needs in the community identified in the Franklin County *HealthMap**2022*** and impacts of the efforts.

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.

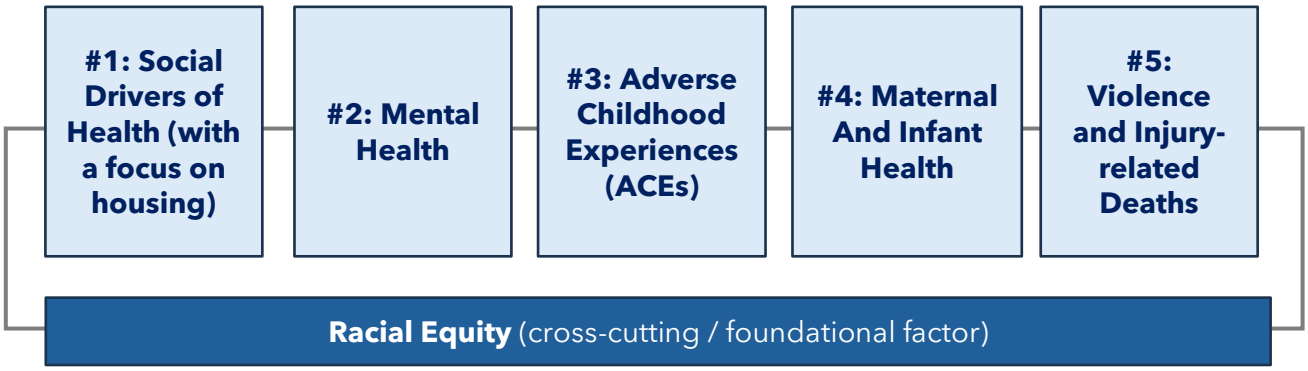
regulations for conducting community health needs assessments. CPH and FCPH also conducted internal reviews to ensure the report satisfied the requirements set forth by the Public Health Accreditation Board (PHAB). No information gaps that may impact the ability to assess the health needs of the community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

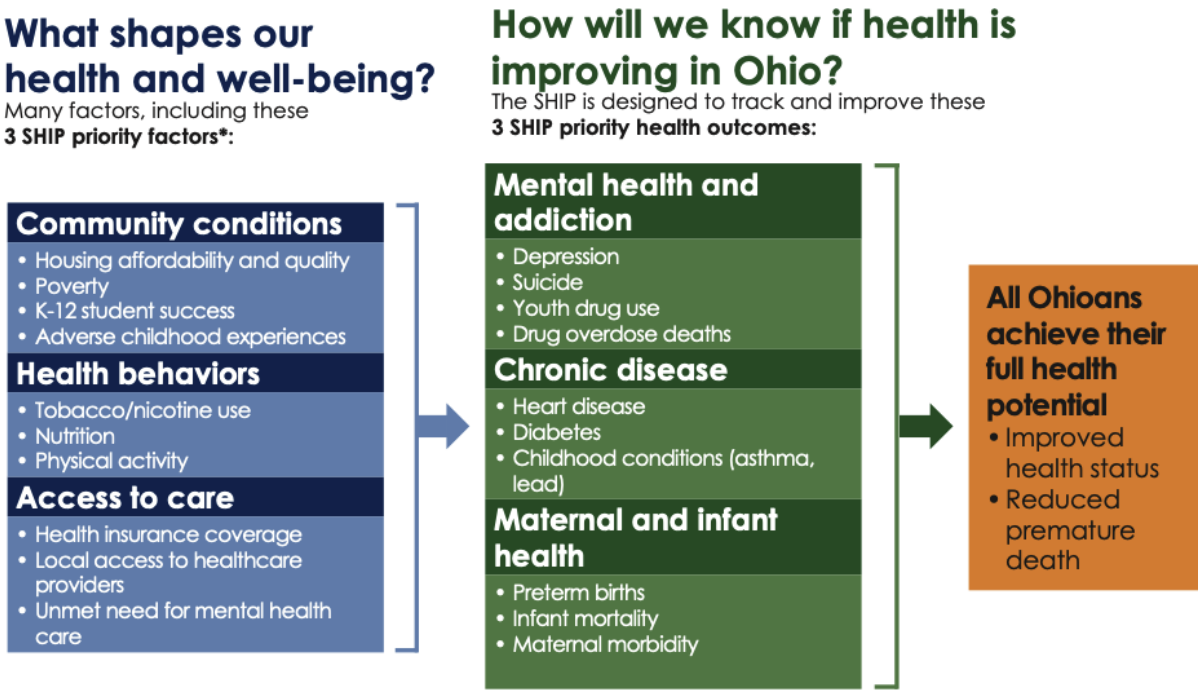
Relevant indicators	See pages
Drug overdose death rate	164
Alcohol-attributable death rate	138
Traumatic injury prevalence	151-157
Violent crime	162

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▲

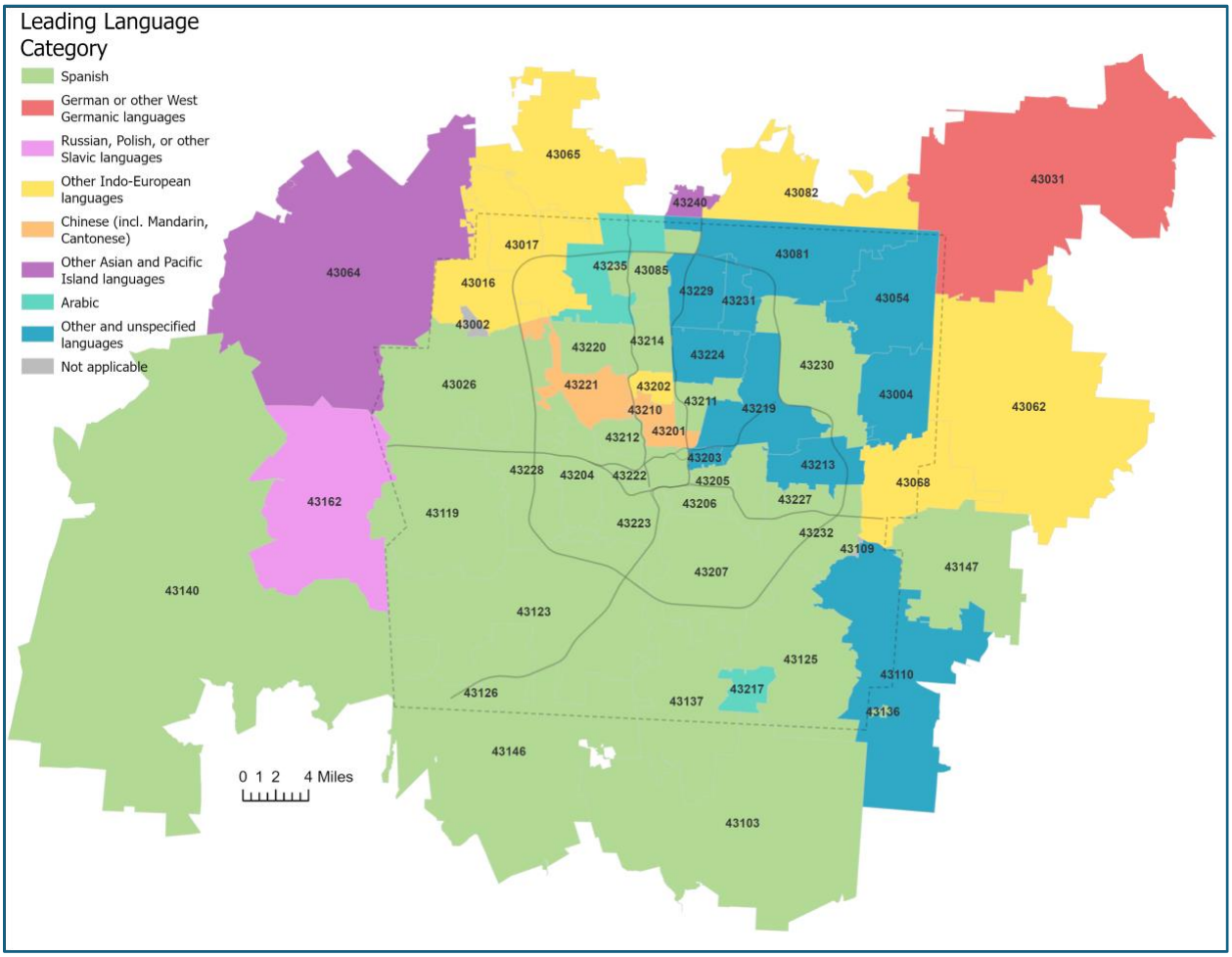
		Franklin County		
		HM2019	HM2022	HM2025
Educational Attainment	No/Some high school, no degree	9.7%	8.8%	8.7%
	High school graduate	25%	24.6%	24.5%
	Some college (no degree)	20.2%	19.6%	18%
	Associate's degree	6.8%	6.9%	6.5%
	Bachelor's degree	24.4%	25.3%	25.8%
	Graduate/Professional degree	14%	14.8%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

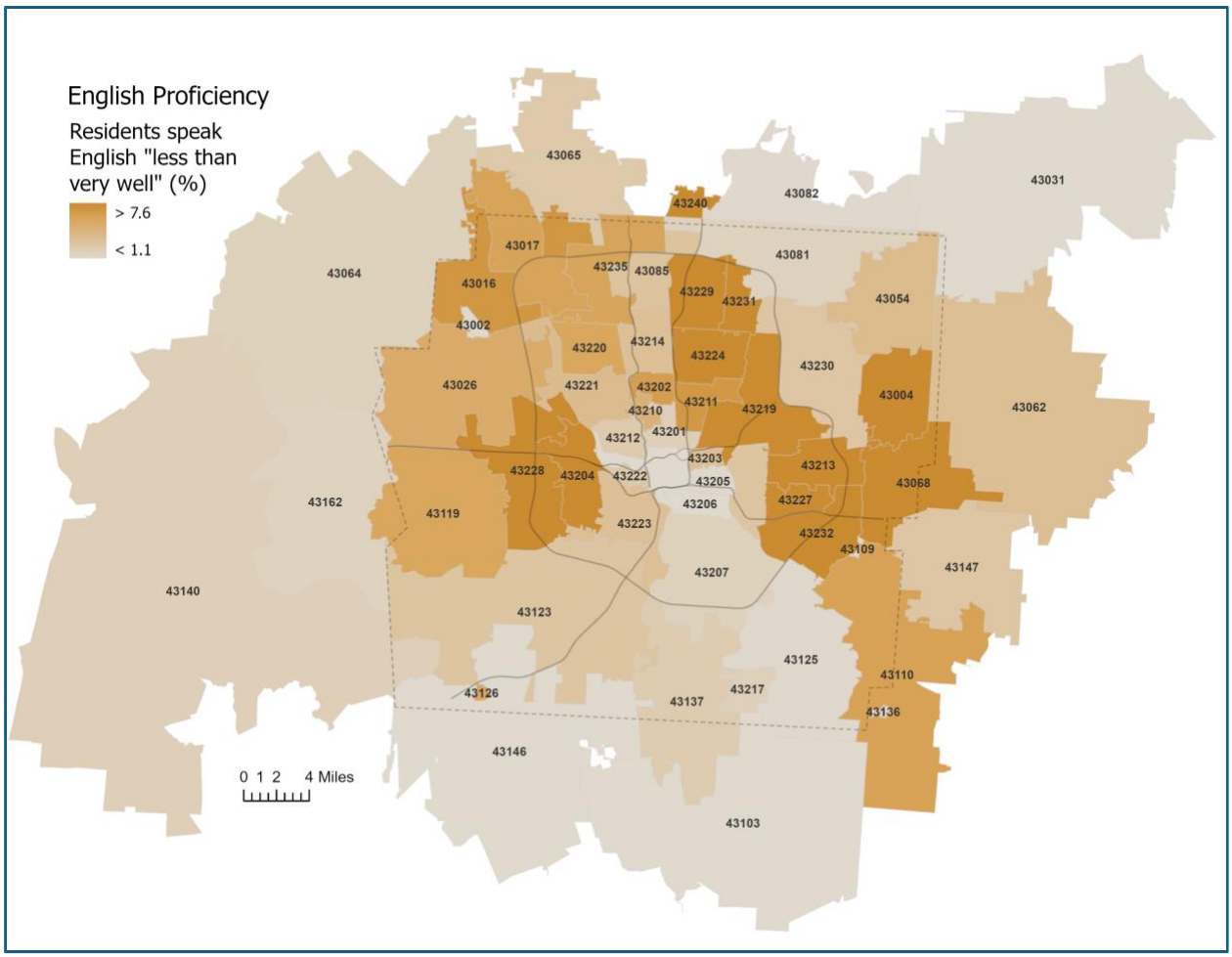


The following zip codes have the highest percentage of residents who speak a non-English language at home. Per the United States' Census Bureau[4]:

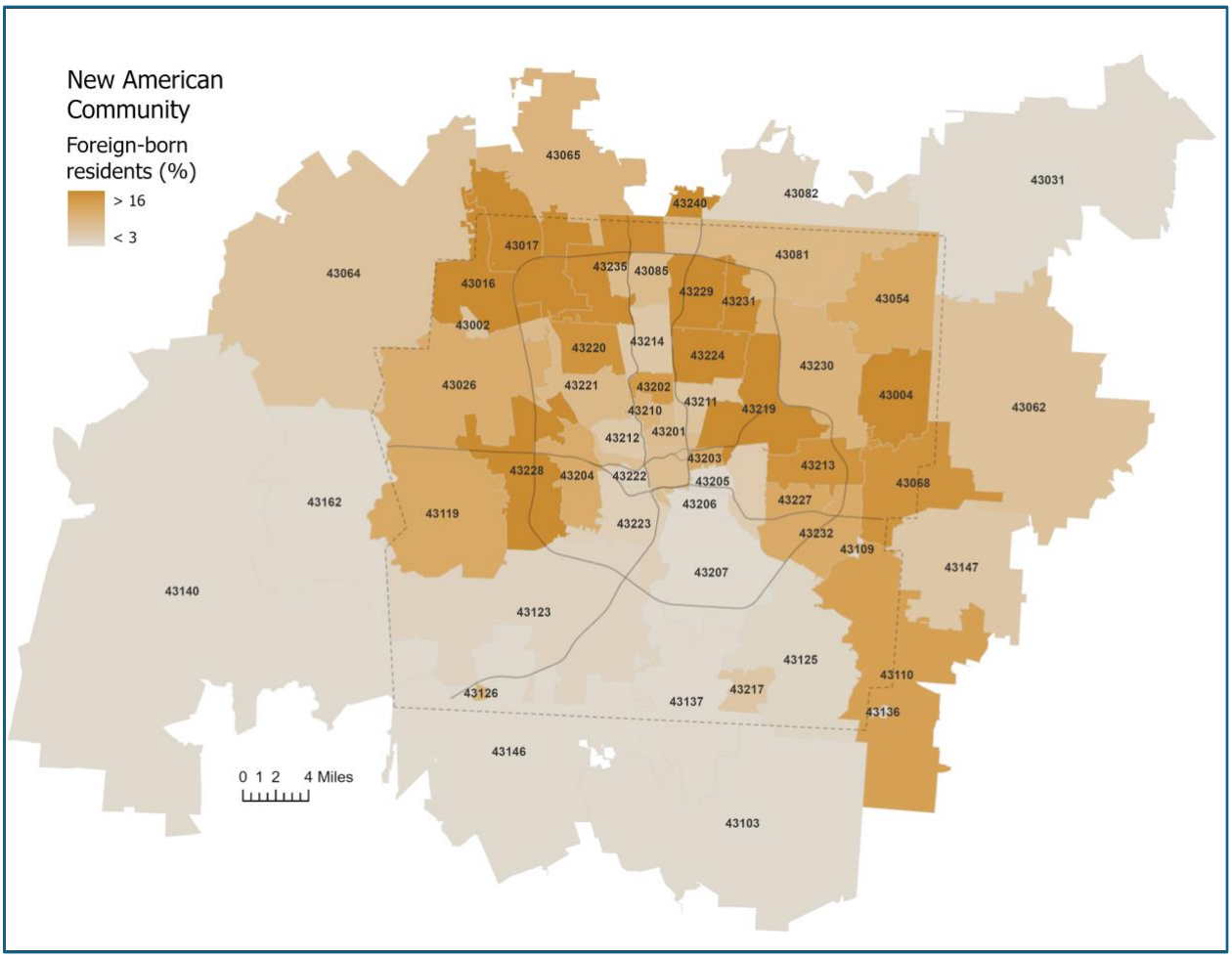
- 26% of residents in zip code **43231** speak a language other than English at home. In that zip code, the most common countries of birth besides the United States are Somalia, Ghana, and Kenya.
- 21% of residents in zip code **43229** speak a language other than English at home. In that zip code, the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

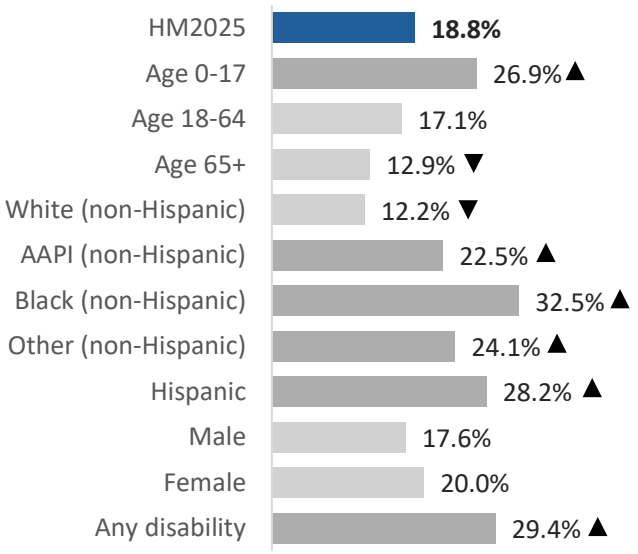
Overall, the median household income among Franklin County residents is higher than Ohio residents overall but lower than US residents overall. However, after adjusting for inflation, the average household income in Franklin County for HM2025 is *slightly less* than what was observed six years ago (i.e.,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

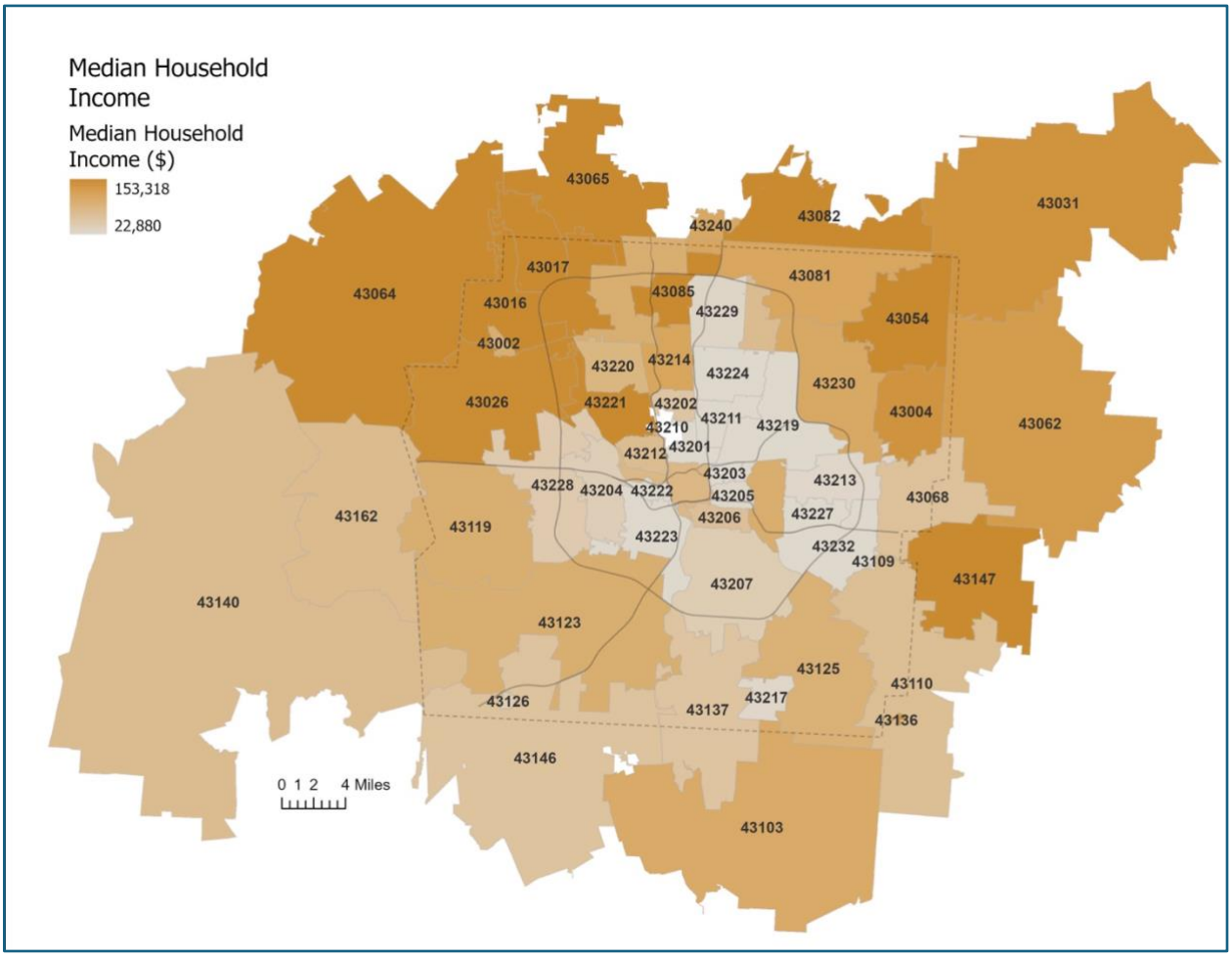


As shown below, income distribution near a variety of federal poverty level thresholds has remained relatively consistent over time. Compared to both the United States and Ohio, Franklin County does have a slightly higher proportion of people in the below 125% bracket.

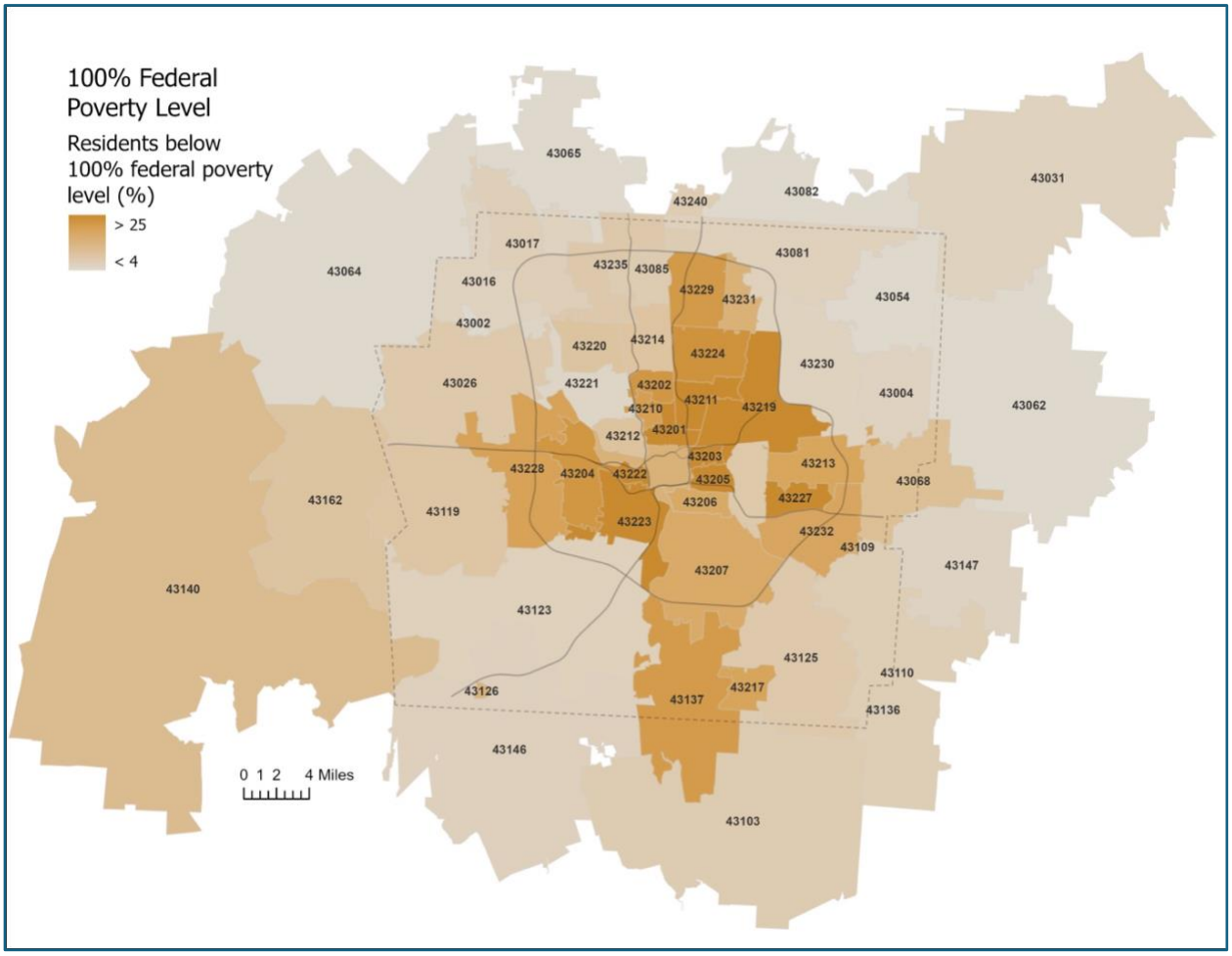
Income Distribution

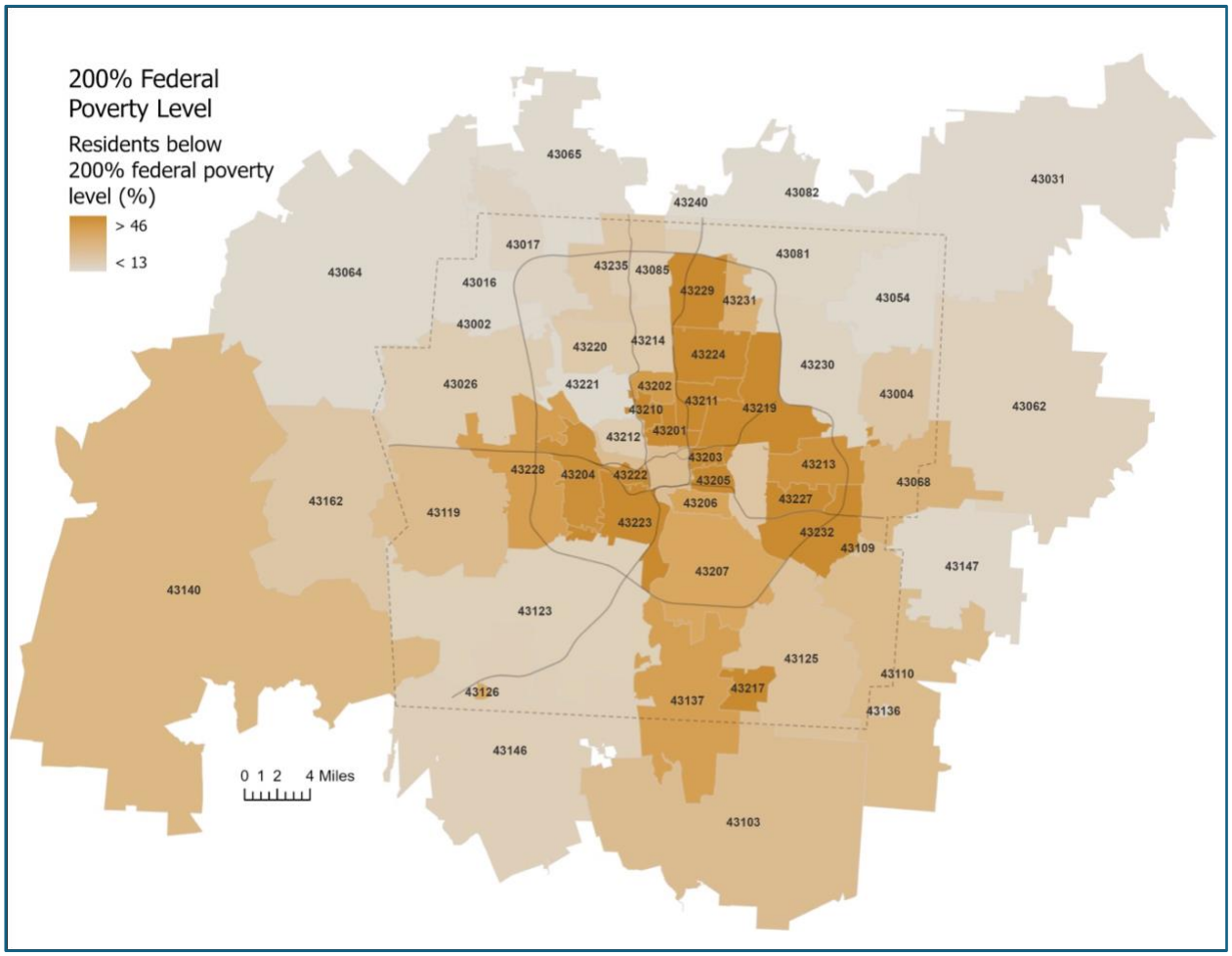
	Below 125% FPL	125%-200% FPL	200% FPL or Below	201%-400% FPL
HM2025	**243,546 (18.8%)**	**147,662 (11.4%)**	**391,208 (30.3%)**	**377,029 (29.2%)**
HM2022	**227,330 (17.7%)**	**162,267 (12.6%)**	**389,597 (30.3%)**	**379,629 (29.5%)**
HM2019	**263,627 (21.4%)**	**143,589 (11.7%)**	**407,216 (33.0%)**	**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.

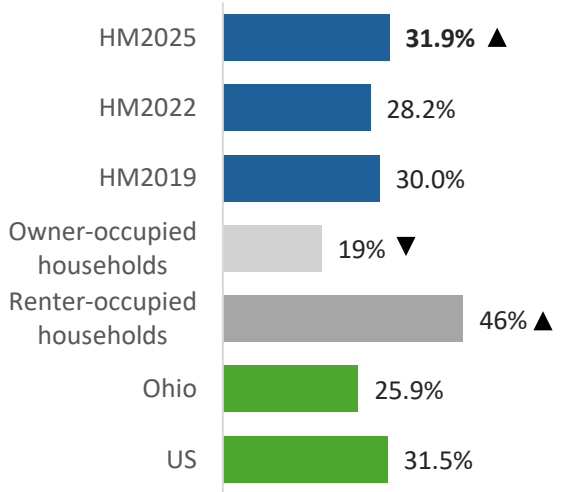
"I work for the homeless shelter, so when it comes to housing, the ones that are on canes, using walkers, it's very hard to find handicap accessible housing. It's not that many options. And the ones that are, they're already filled. So we might have someone who is on a walker who, their stay might be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

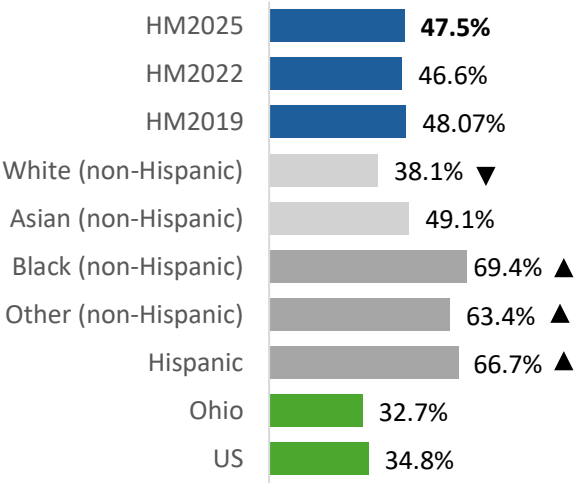
Unfortunately, housing insecurity has not improved since *HealthMap2022*. The percentage of cost-burdened households – those that spend 30% or more of their monthly household income on housing costs – has increased. Furthermore, nearly half of renter-occupied households in Franklin County are cost-burdened.

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.

Unhousing 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

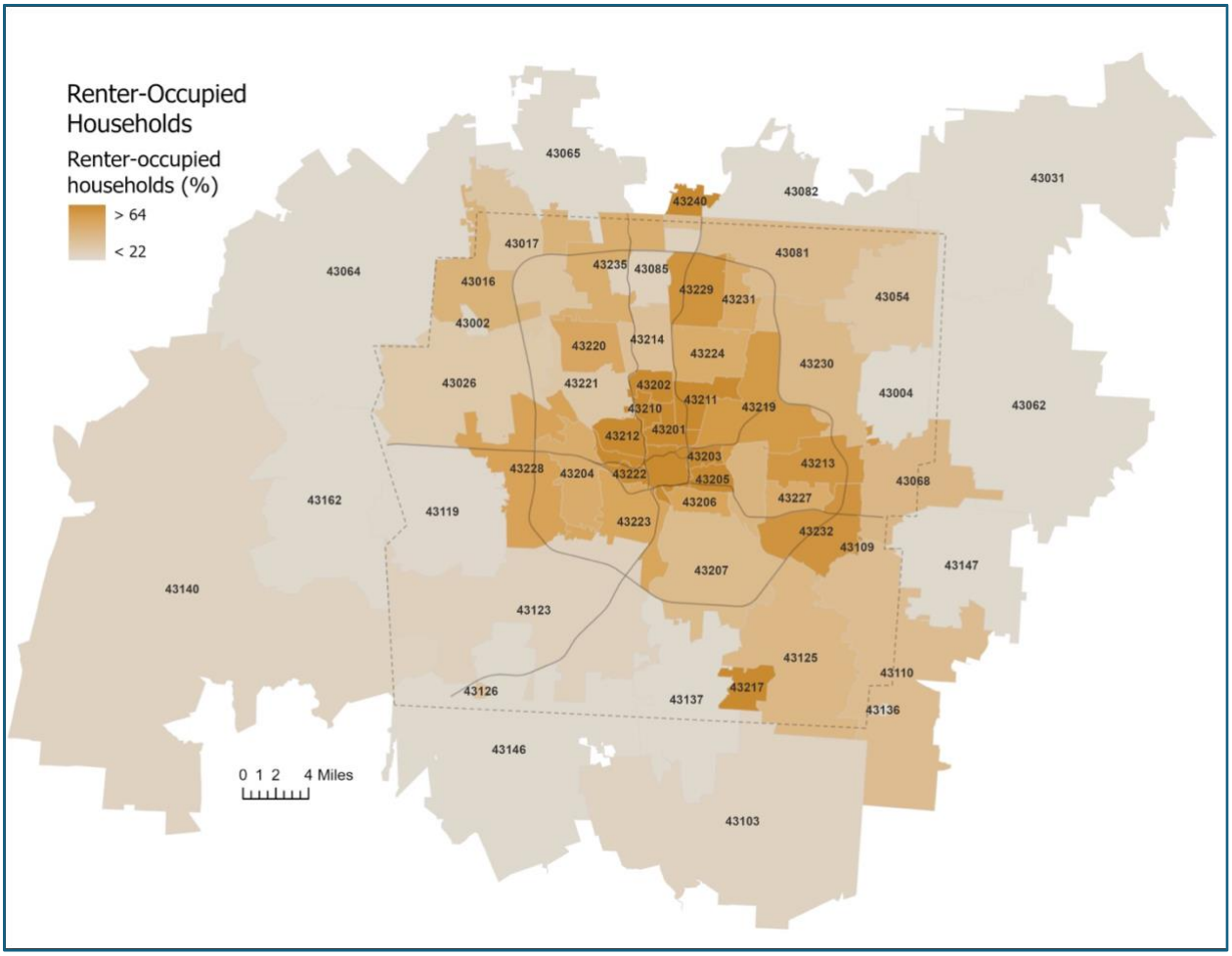
Unfortunately, Franklin County is moving further away from the Healthy People 2030 objective on housing cost burden.[5] Further intervention is likely needed to address this issue facing many Franklin County residents.

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

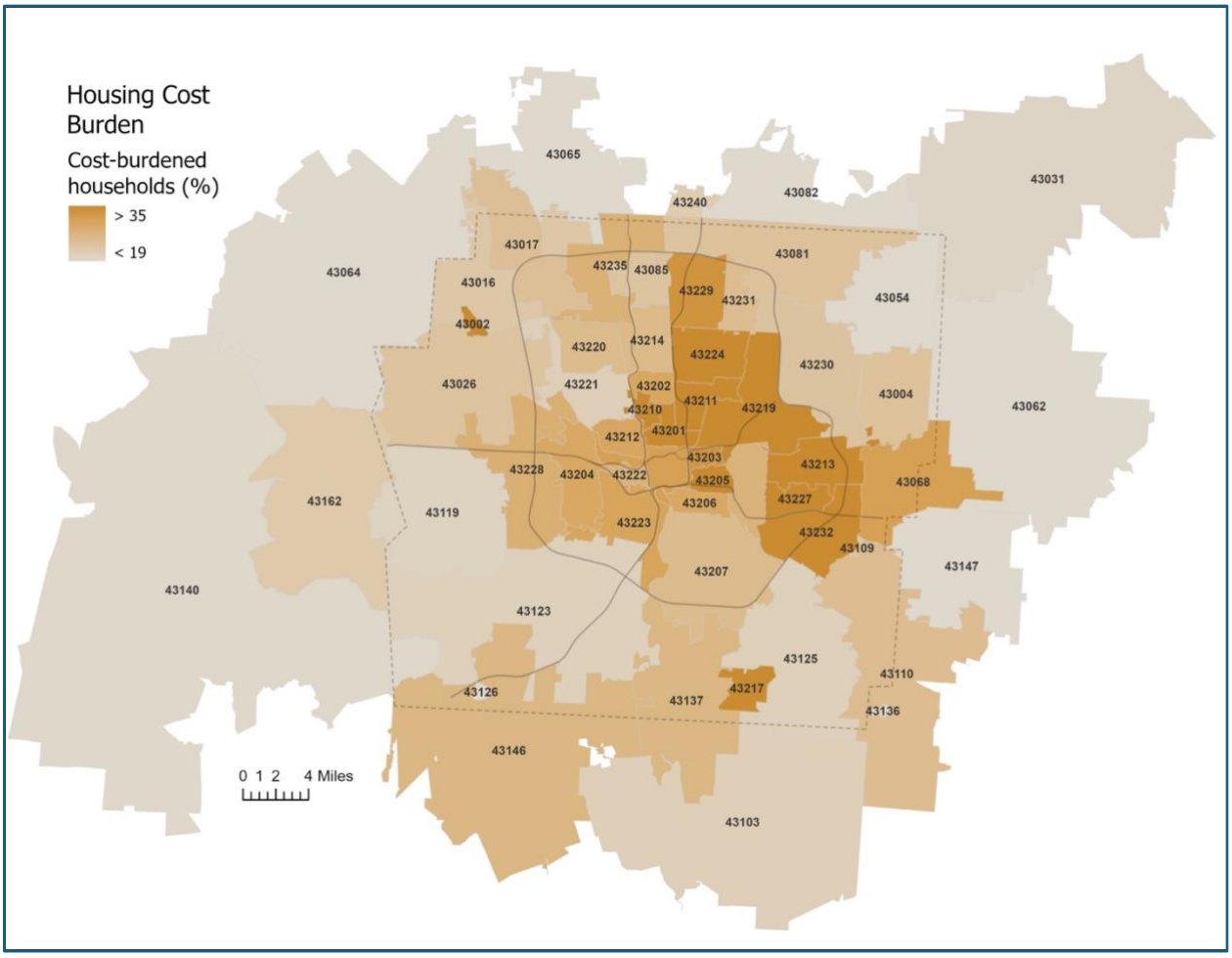
Healthy People Objective:
25.5%

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).



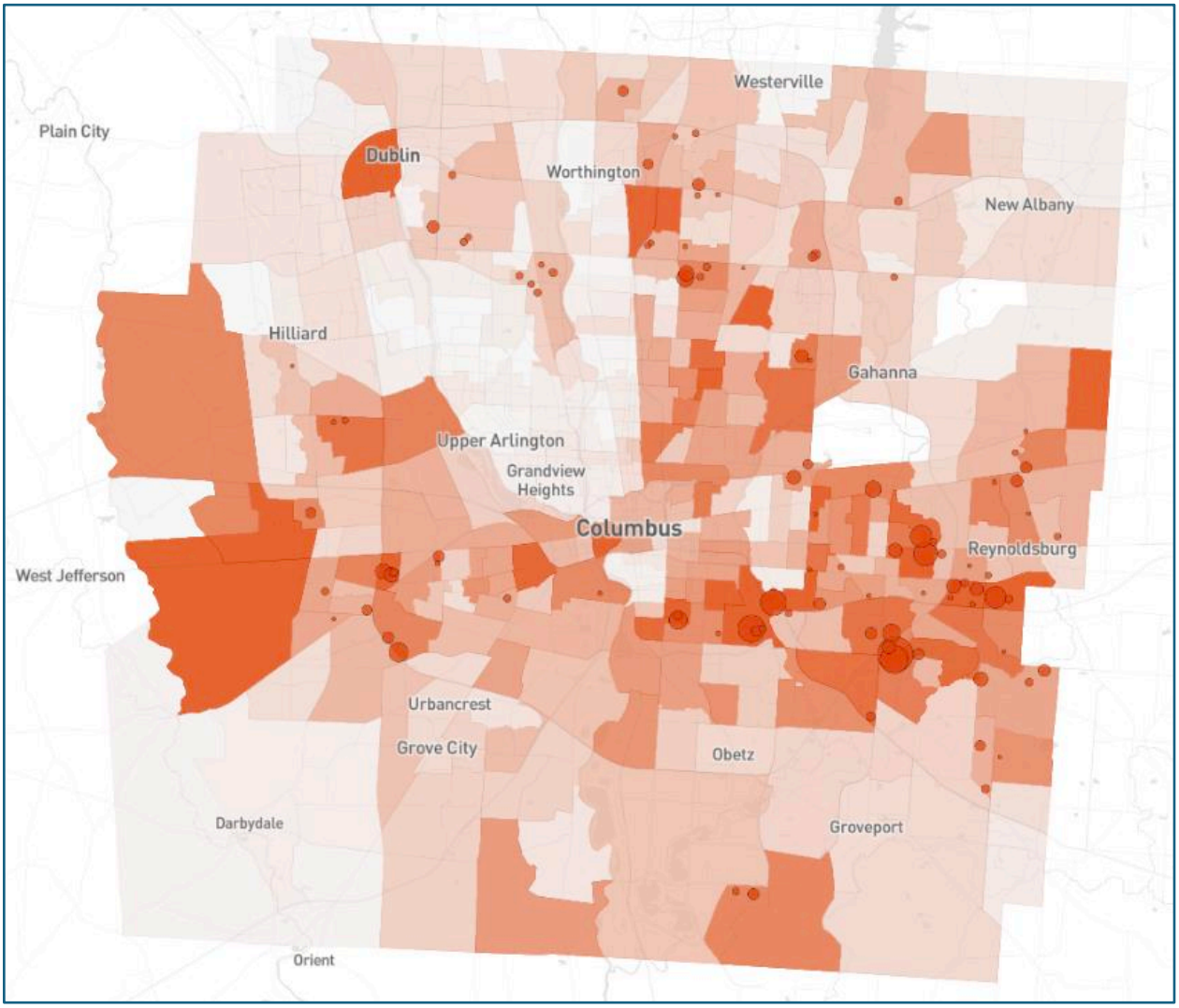
The zip codes with the greatest percentage of cost burdened households (i.e., an overall burden of 30% or higher) are concentrated in the eastern and north-central parts of Franklin County (e.g., 43213, 43227, 43232, 43219, 43211, 43224).



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."

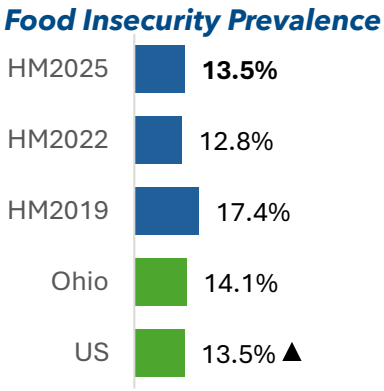
"A grocery store is here, but it's far away from the inner community, so they either have to have somebody bring it to them, or they have to drive. It's not within walking distance. And then there's not a lot of fresh stuff. Like, everything is packaged or processed."

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."*

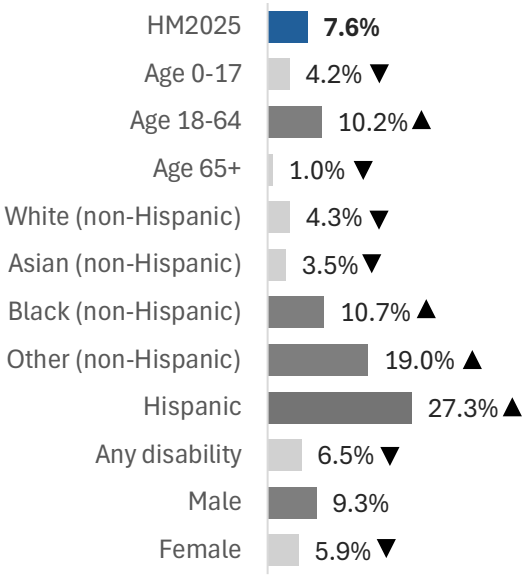
Franklin County residents also perceive that the quality of health care they receive depends on their health insurance. Specifically, they think those with Medicaid are more likely to experience rudeness from medical staff and inadequate treatment.

> *"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."*

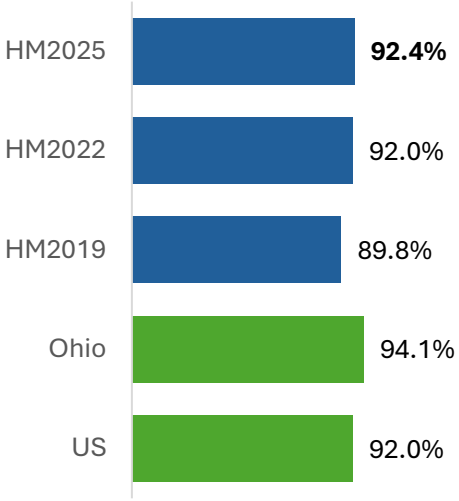
The vast majority of Franklin County residents are insured. The greatest disparities can be seen through the lenses of race and ethnicity, with Hispanic residents being significantly more likely to be uninsured than any other group. This may indicate the presence of cultural, language, or legal/political 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).

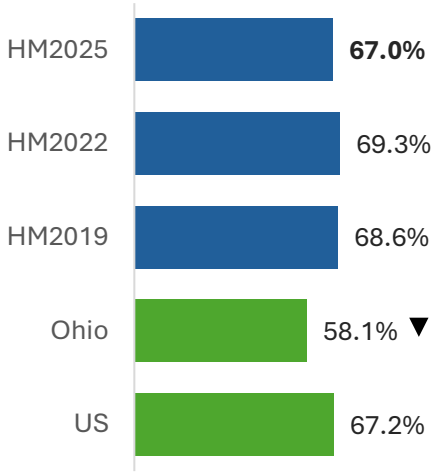
Uninsured Rate



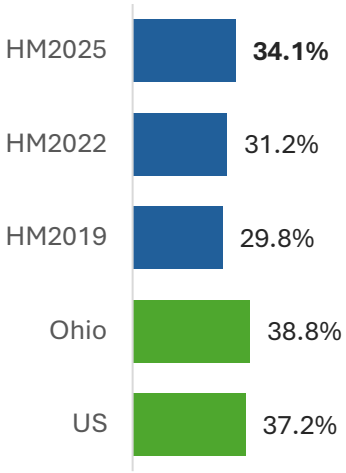
Insured Rate



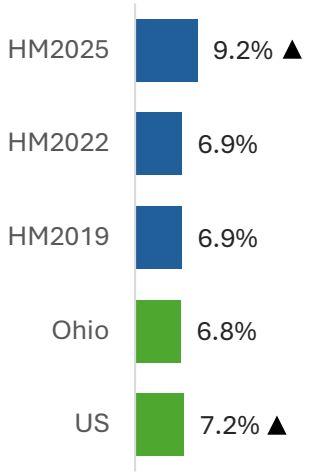
Private Health Insurance



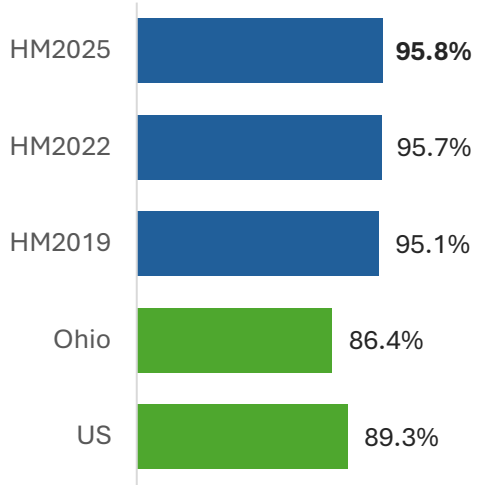
Public Health Insurance



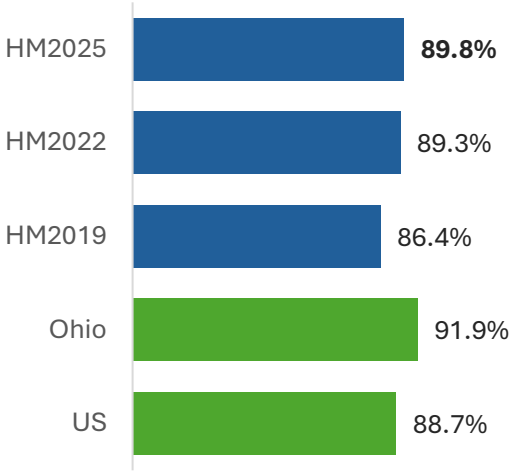
Group VIII Medicaid Insured



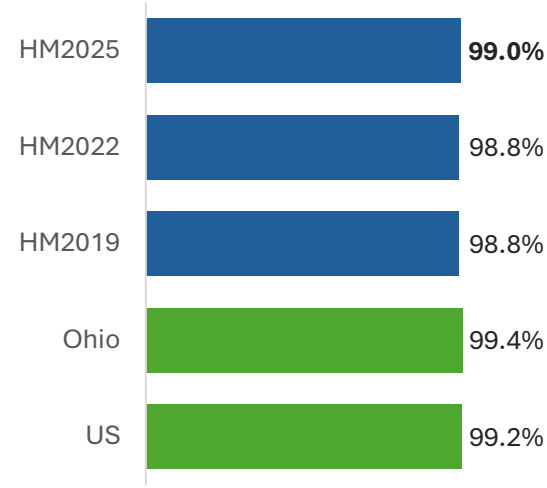
Insured Rate (ages 0-17)



Insured Rate (ages 18-64)



Insured Rate (ages 65+)



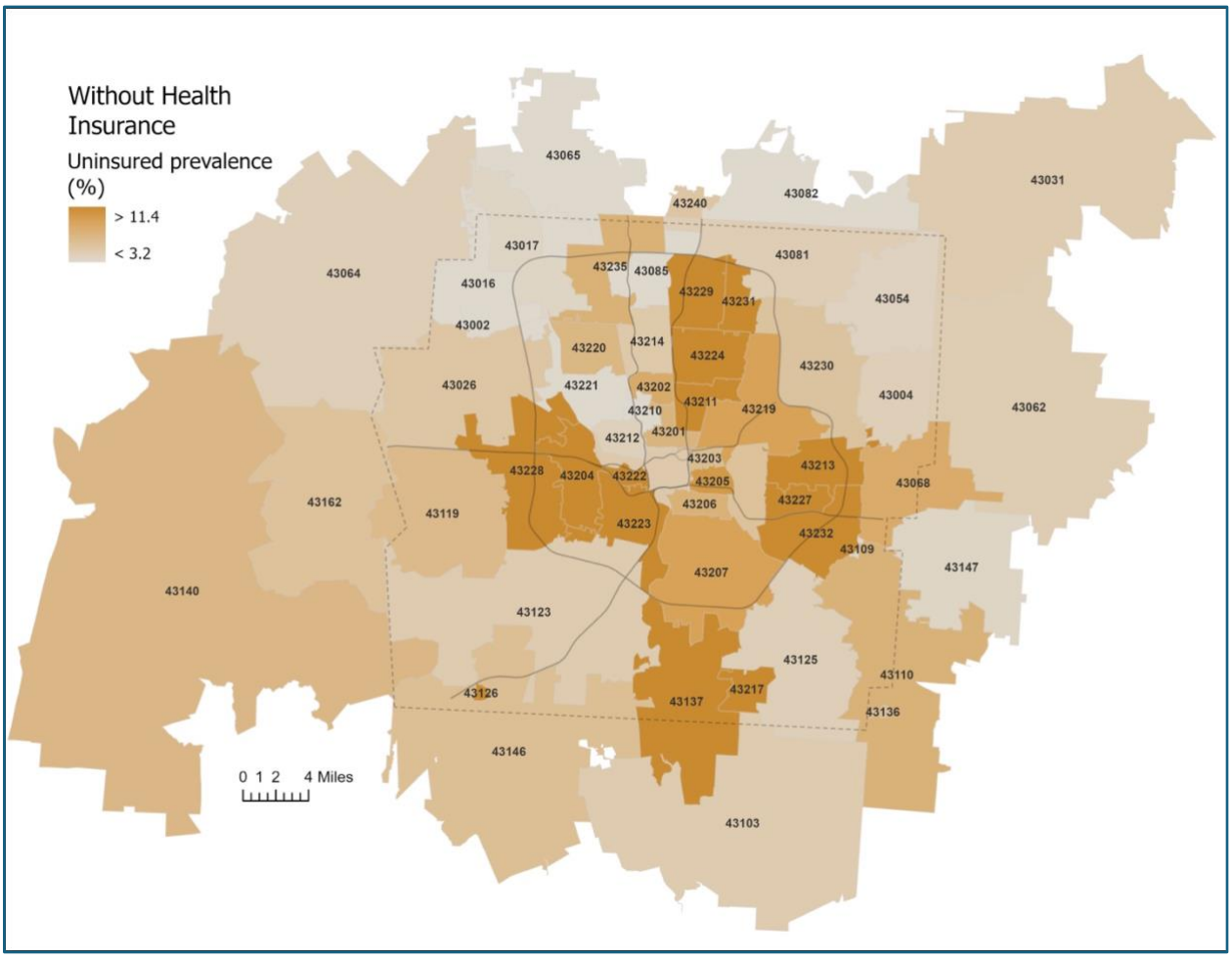
Healthy People 2030

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

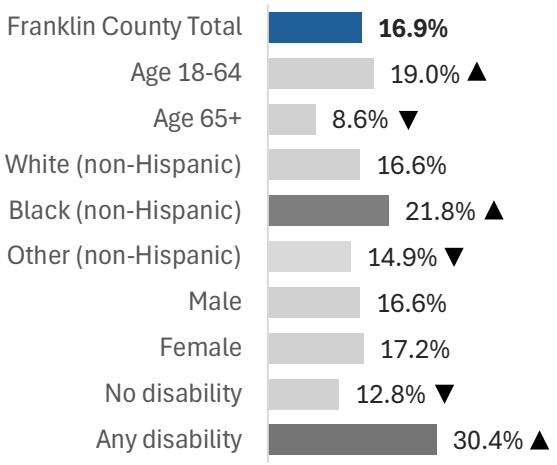
Disparities by selected social determinants of health

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.

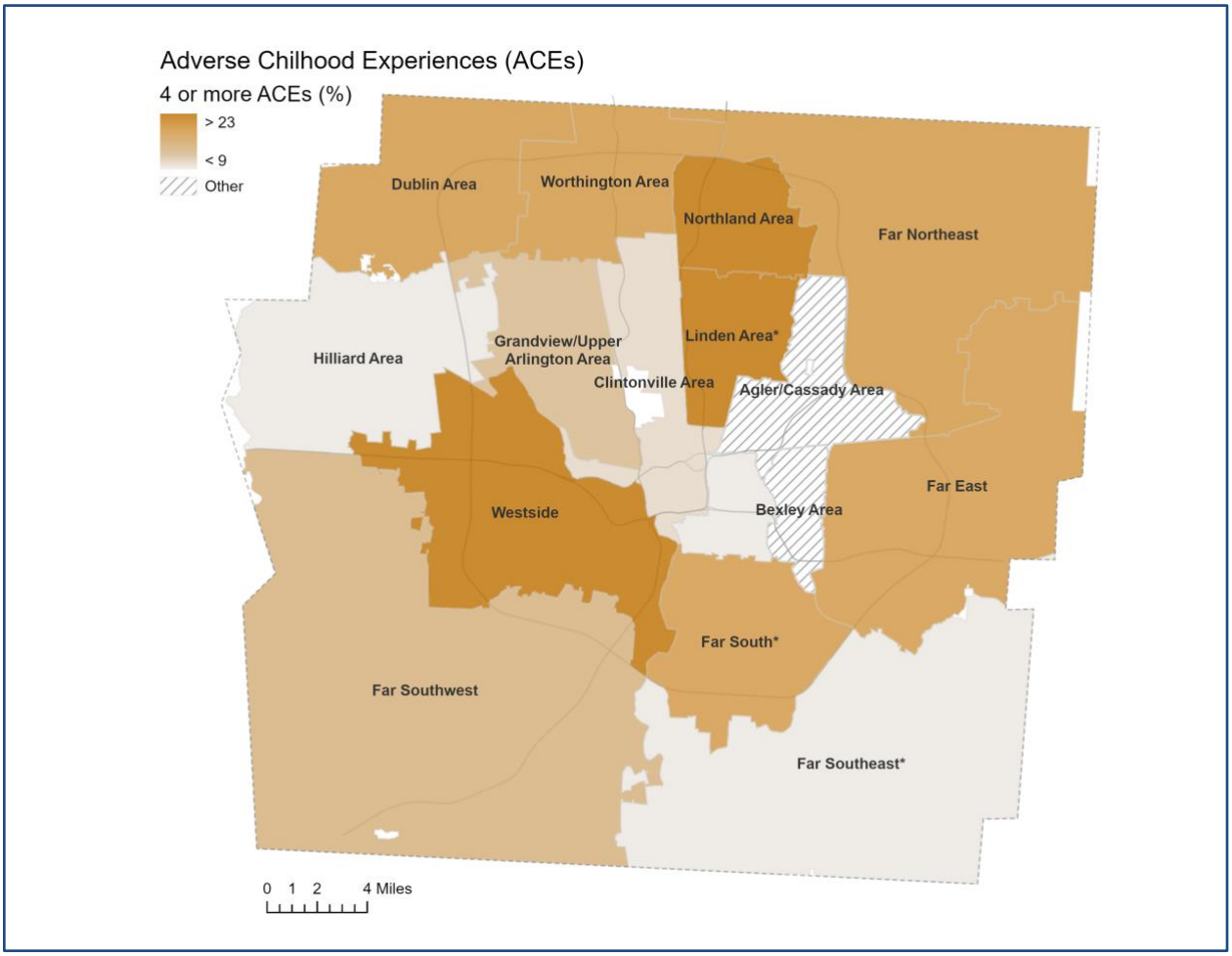
Four or more ACEs among adults 18+ in Franklin County



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**.

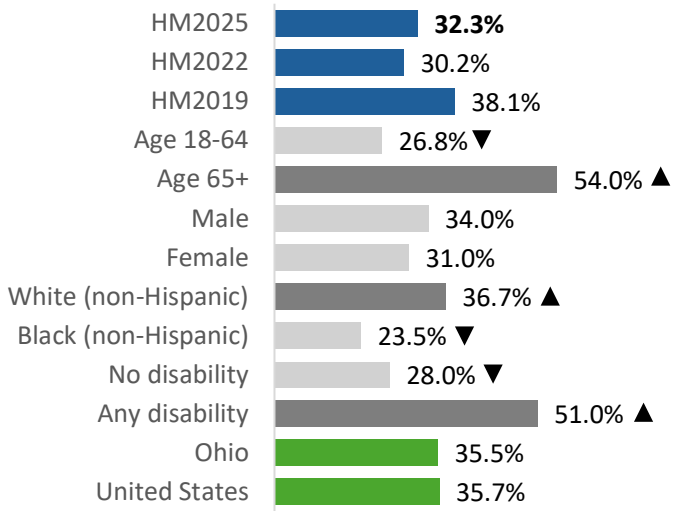
≈ Similar to HM2022 (10.6%)

Disparities by selected social determinants of health

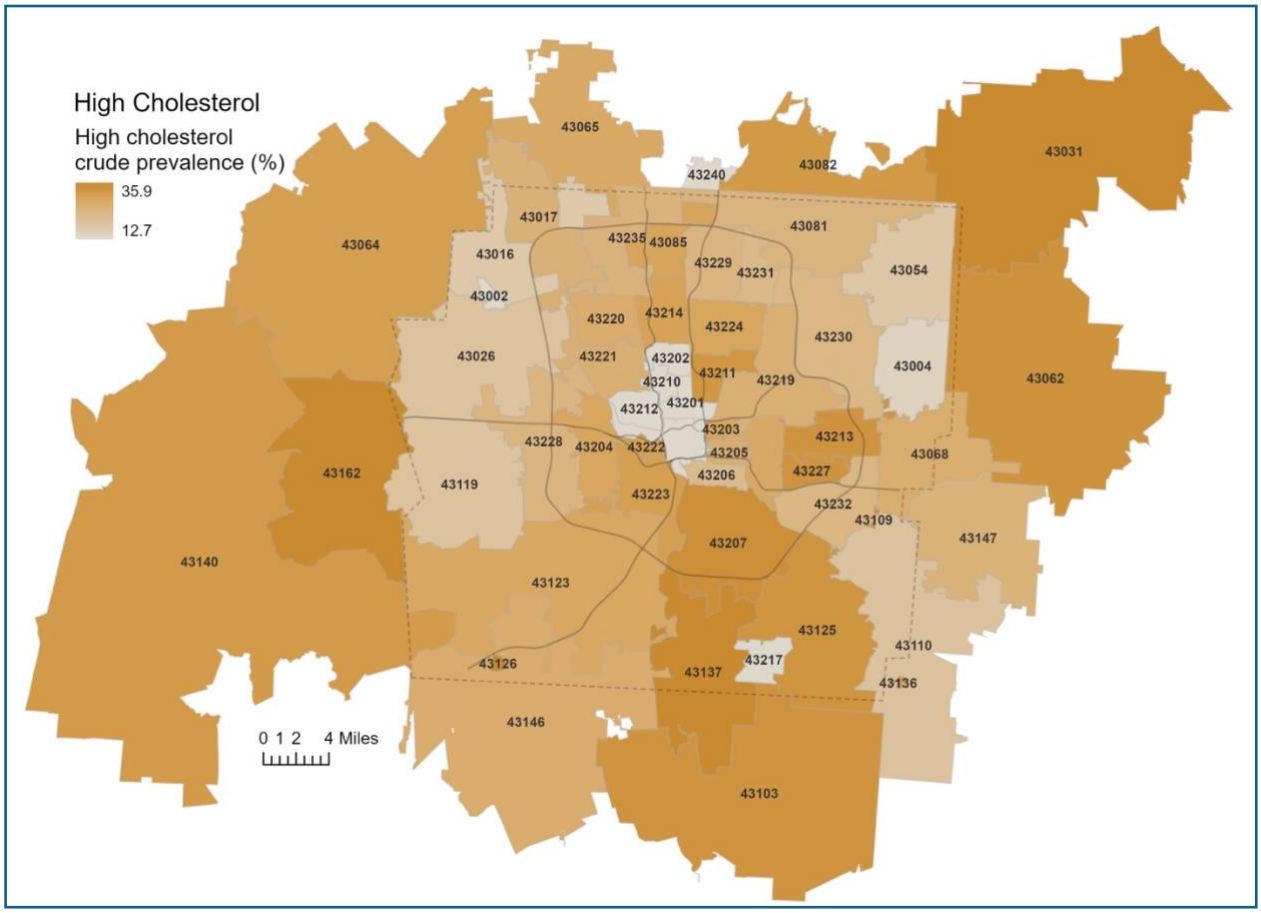
Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
65+ more likely	None observed	Black more likely	Observed (see map)

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.

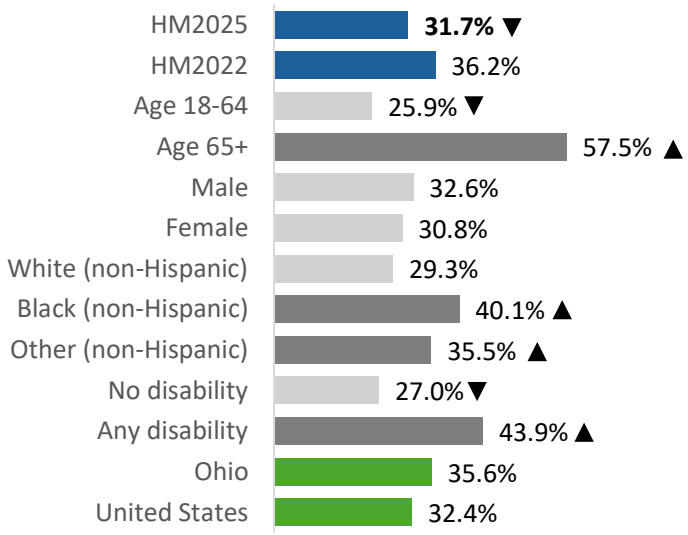


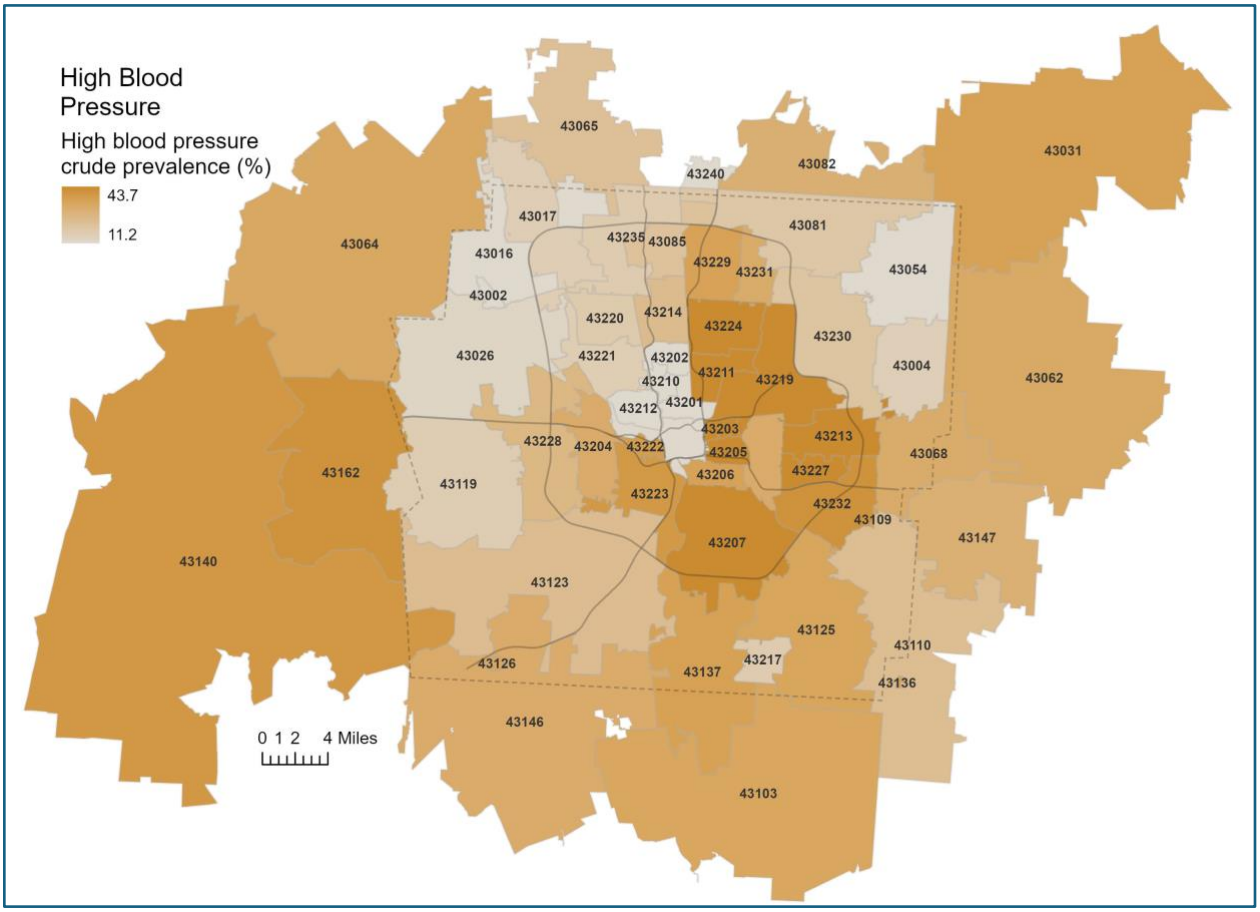
HIGH BLOOD PRESSURE

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

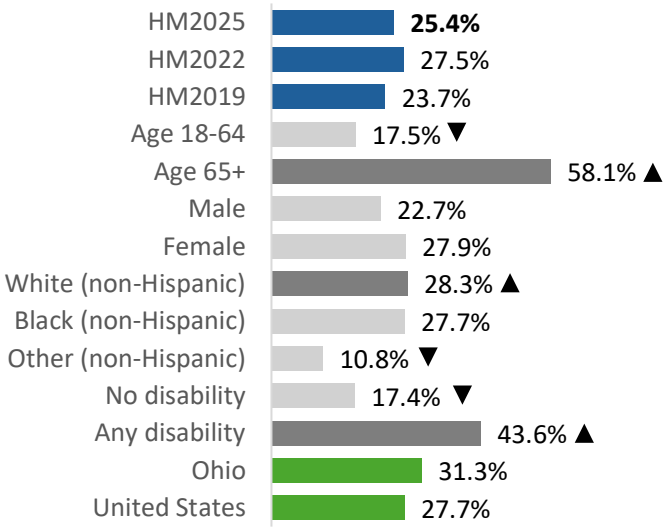


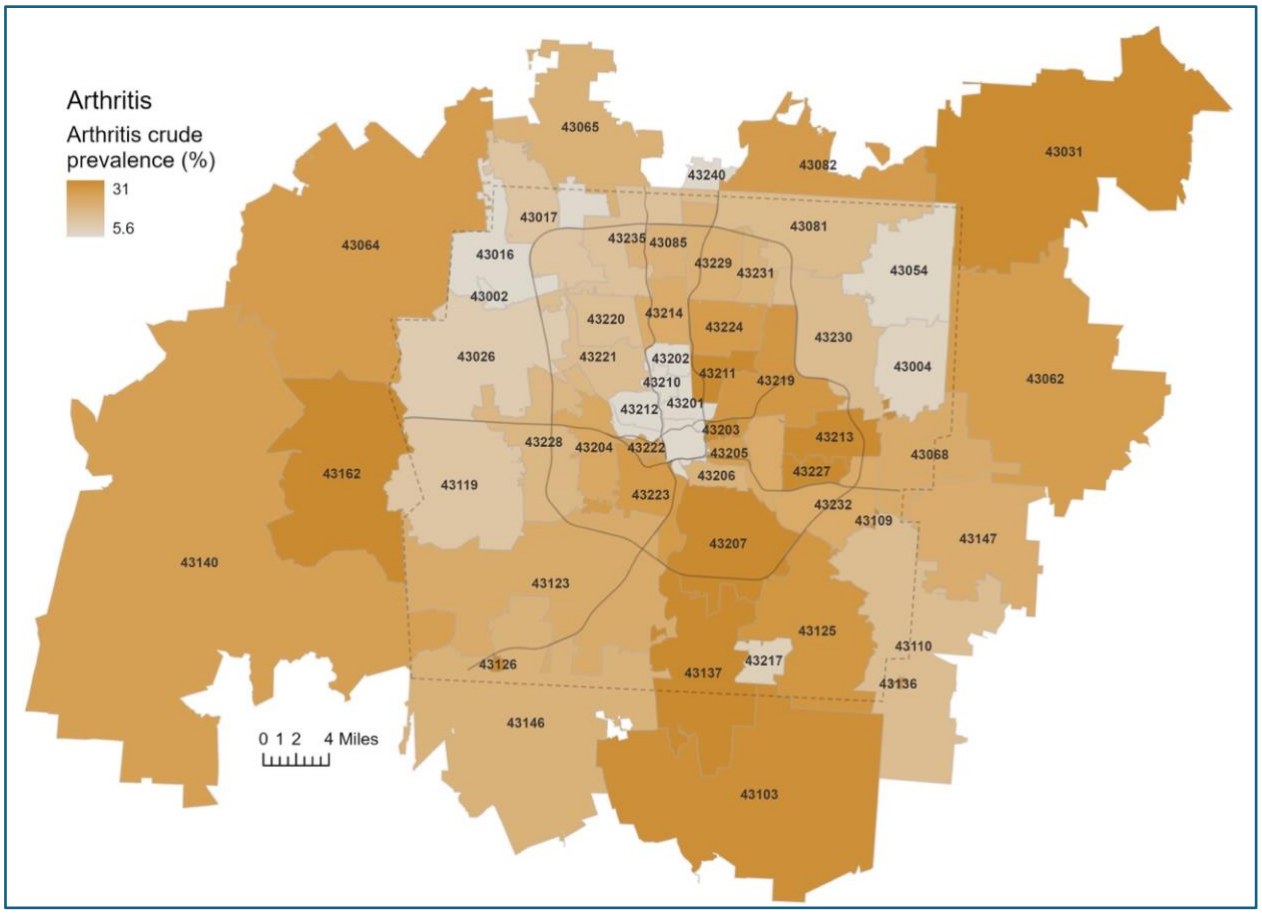


ARTHRITIS

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.

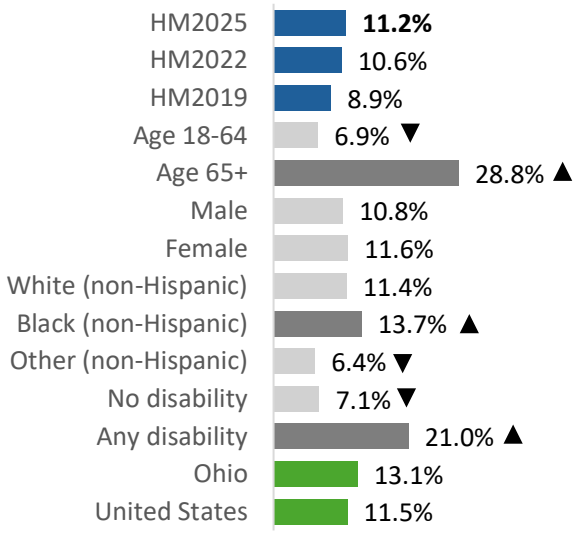


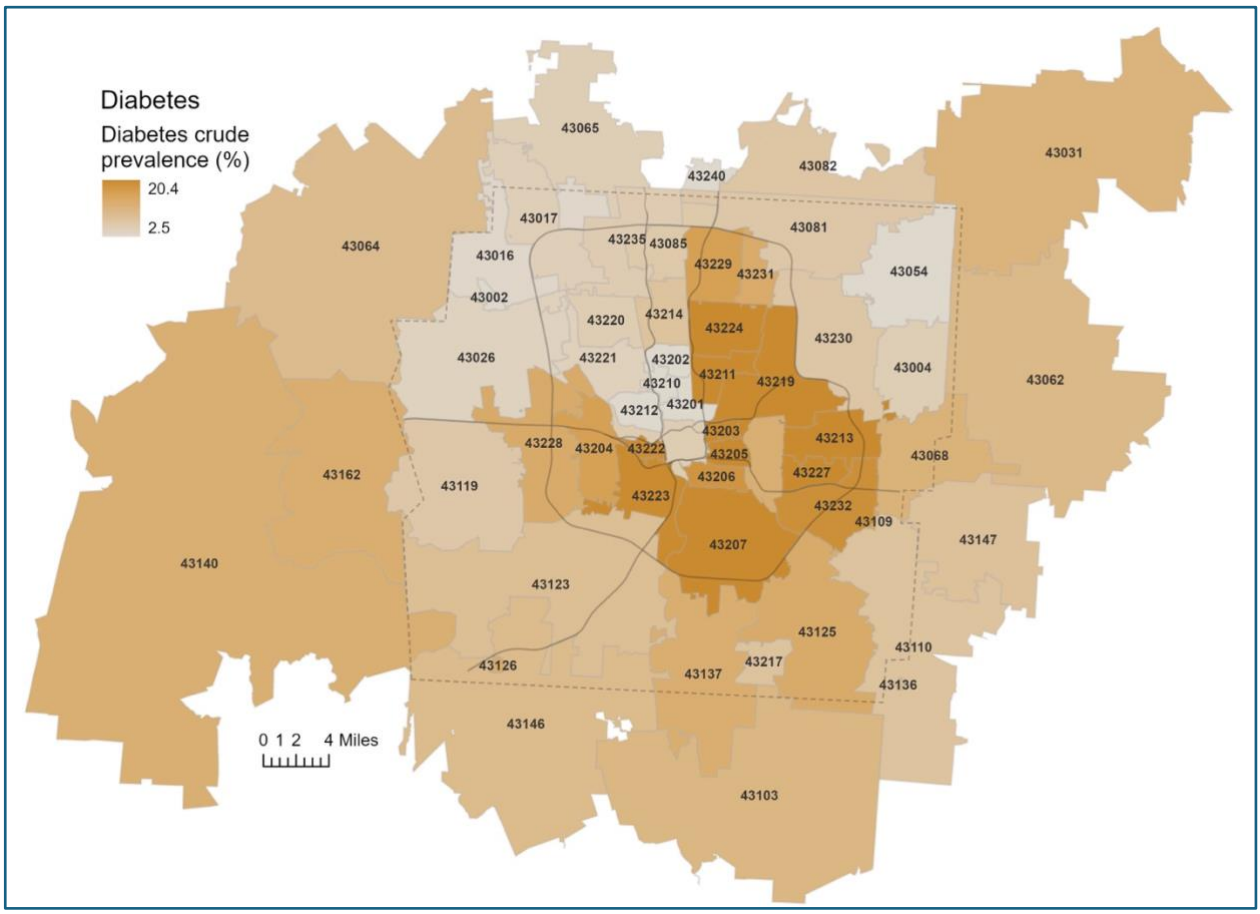


DIABETES

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

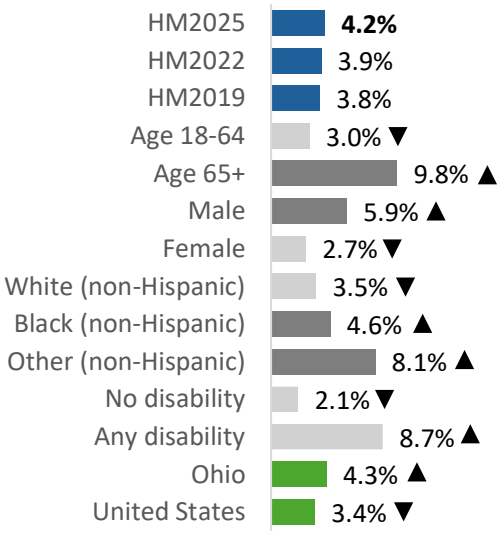
For community members, diabetes is at the forefront of their chronic condition concerns in the community. They perceive this condition to be increasing among the community's youth, and also noted how this condition co-occurs with other chronic conditions.

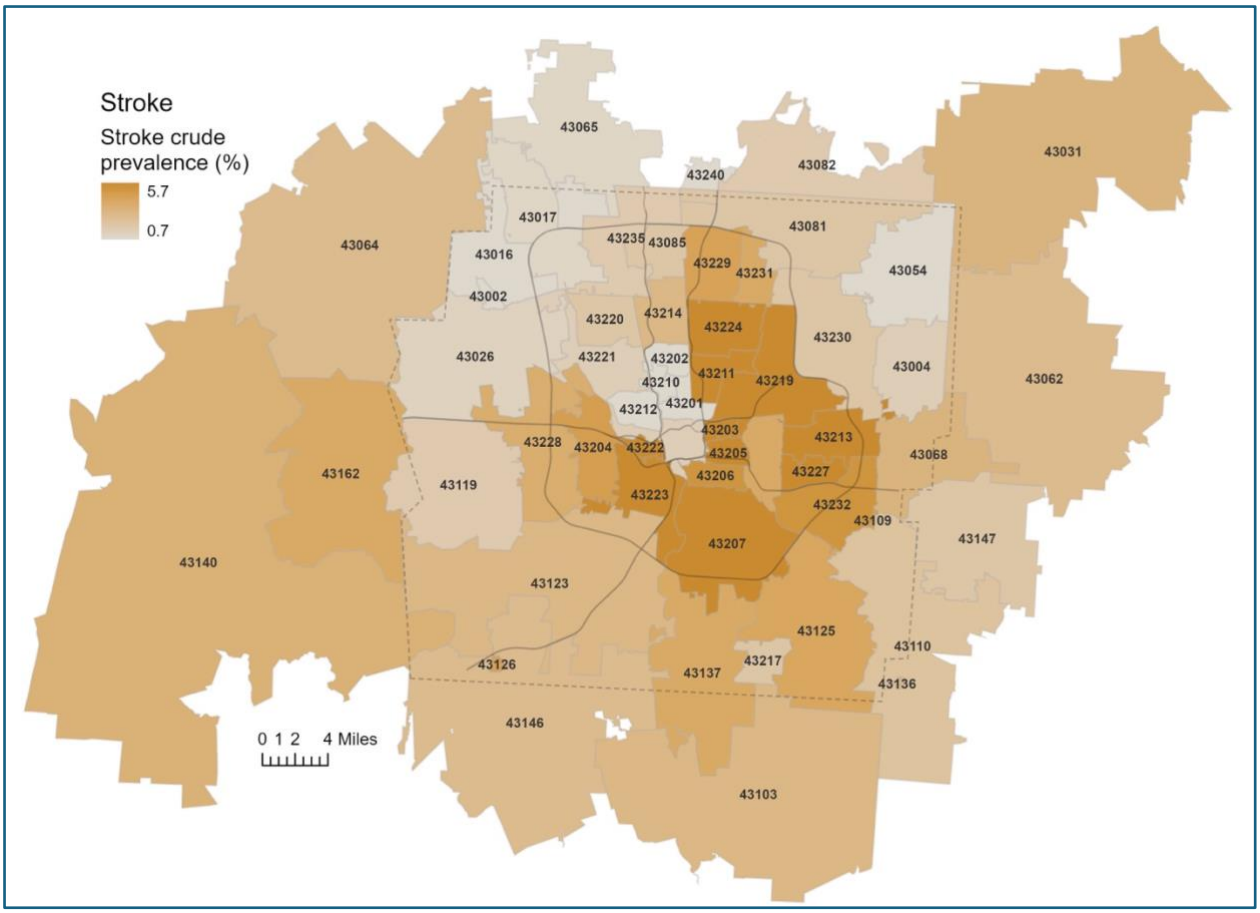
> *"Type two diabetes has become more prevalent than before…And insulin resistance can start younger. Even if type two is not there, we can have the metabolic syndrome. The hypertension strokes are even happening younger, and it seems that doctors will focus on an older population. A lot of kids won't 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.

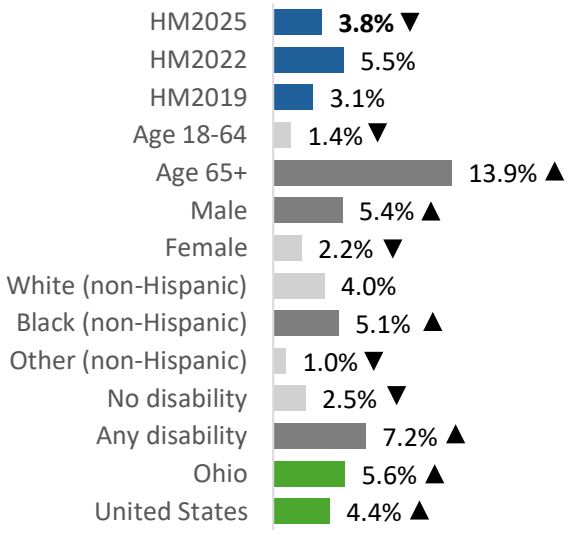


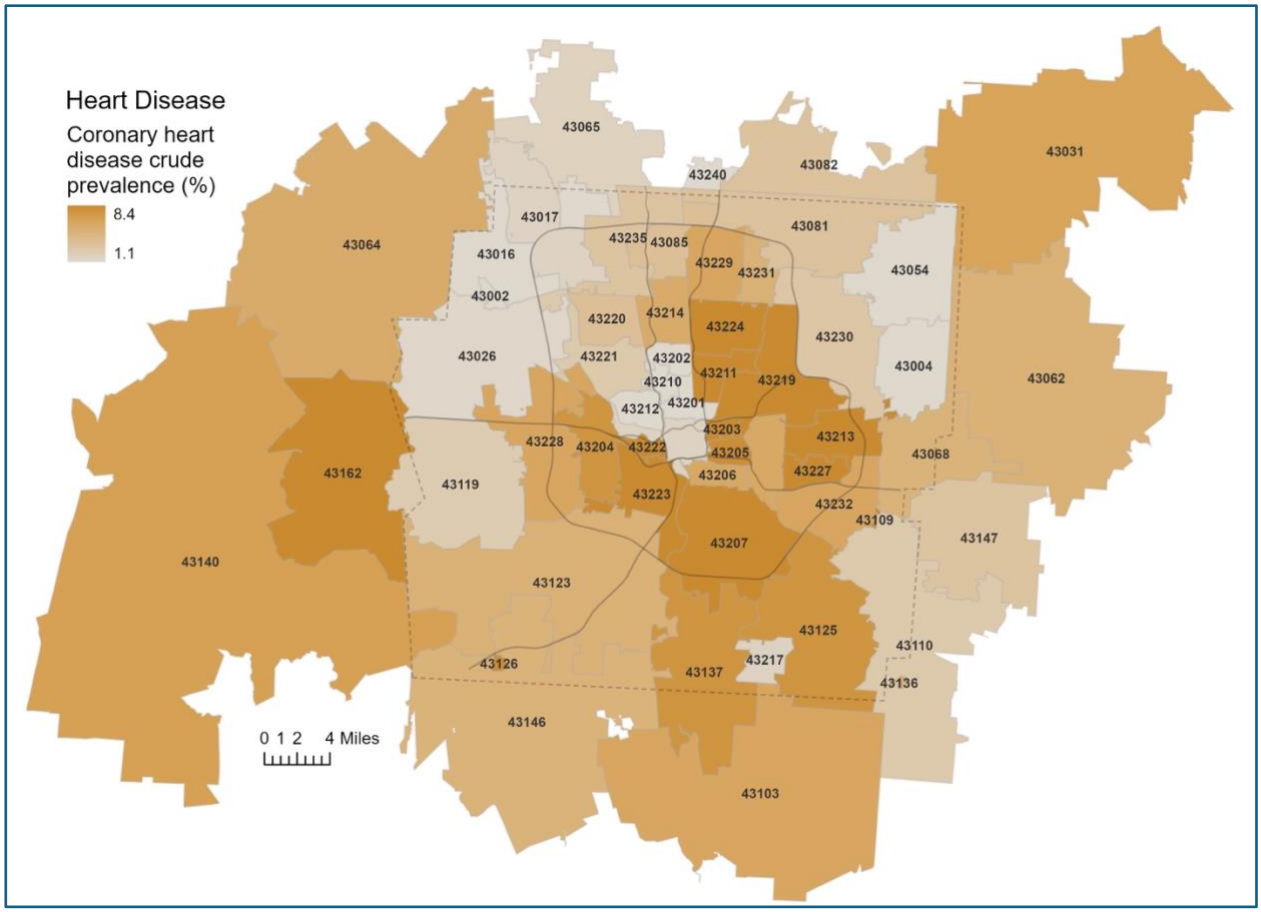


HEART DISEASE

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:

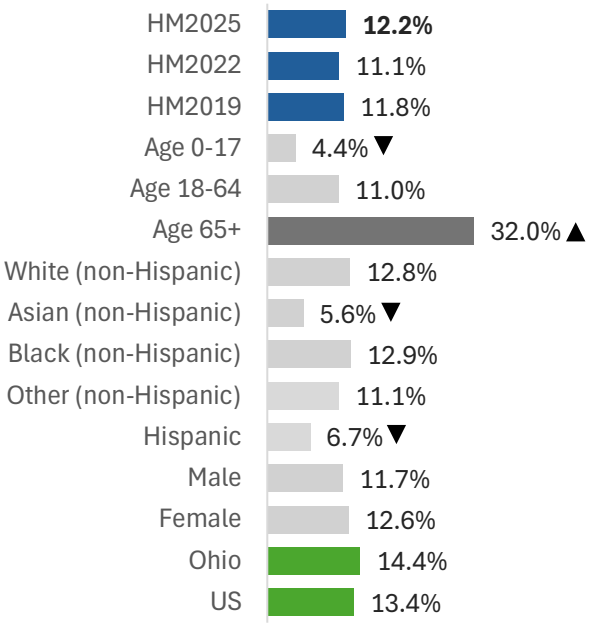
- *Hearing difficulty*, which is defined as "deaf or [having] serious hearing difficulty") and is measured among people of all ages;
- *Vision difficulty*, which is defined as "blind or [having] serious difficulty seeing even while wearing glasses" and is measured among people of all ages;
- *Cognitive 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.

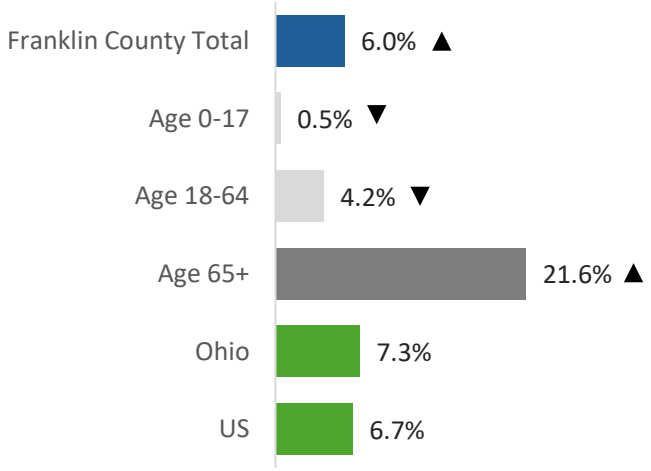
Those aged 65 or over have the highest percentage of residents with at least one disability, with ambulatory difficulties and independent living difficulties being most prevalent. Among children and younger adults, cognitive difficulties are more prevalent.

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

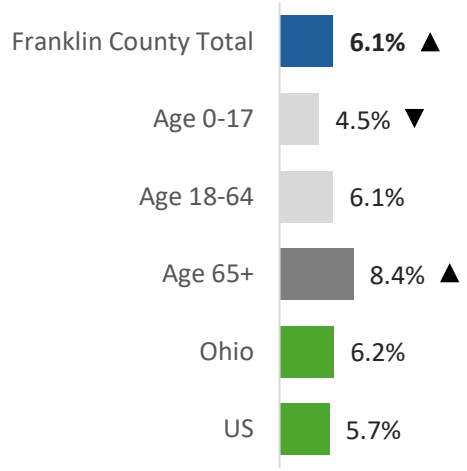
Disability Status Prevalence



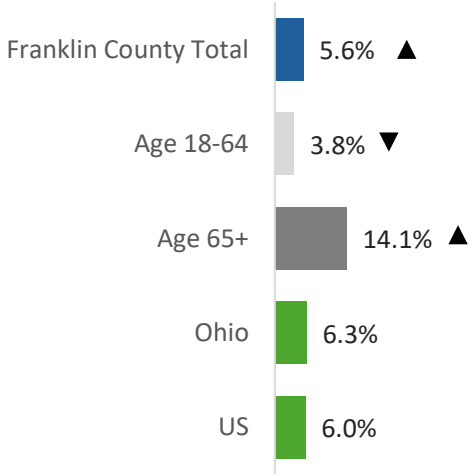
Ambulatory Difficulty



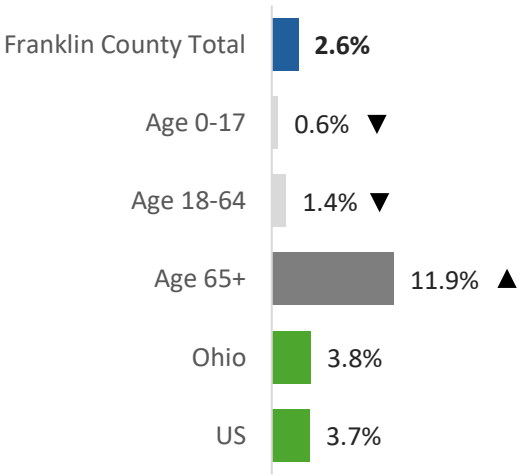
Cognitive Difficulty



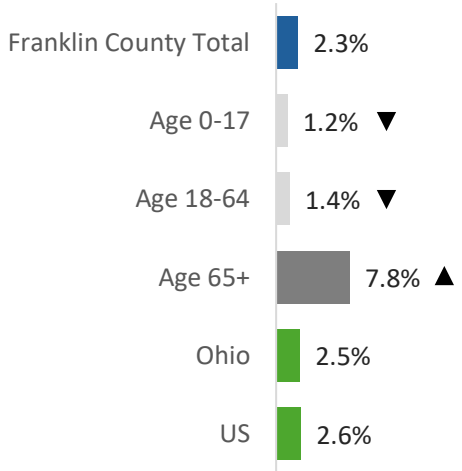
Independent Living Difficulty Age 18+



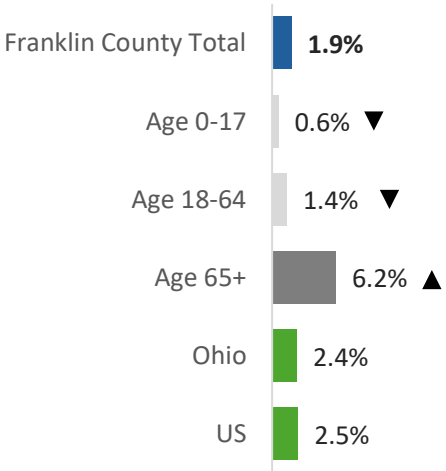
Hearing Difficulty



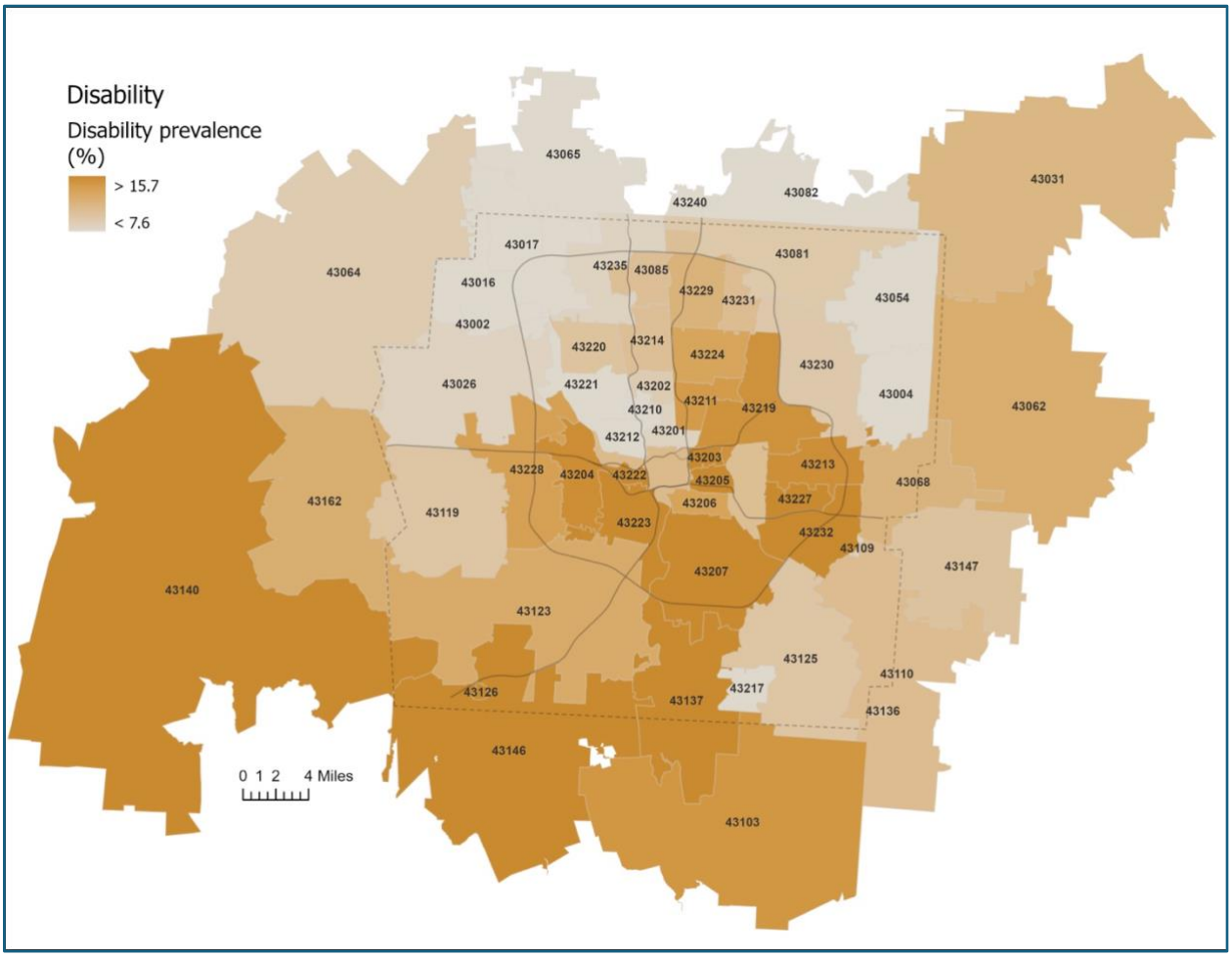
Self-Care Difficulty



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.

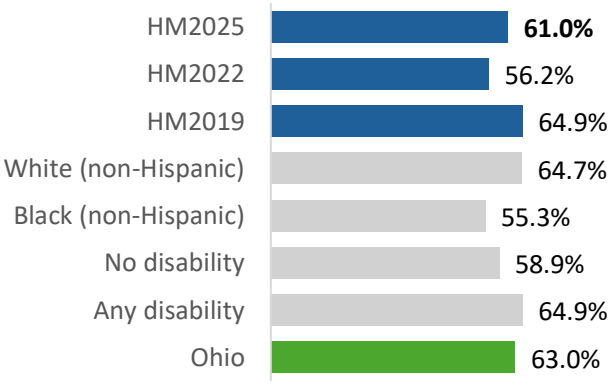
≈ Similar to HM2022 (74%)

Disparities by selected social determinants of health

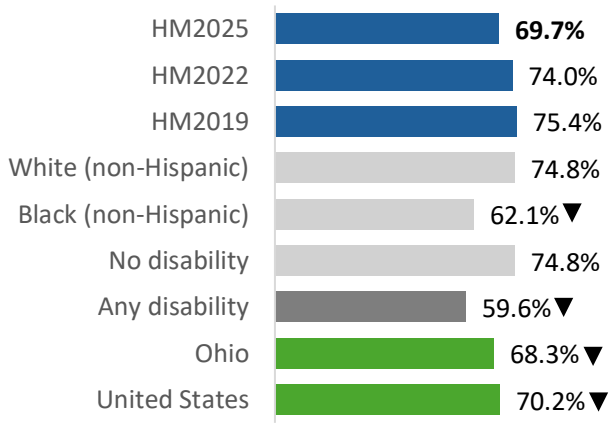
Age:	**Sex:**	**Race/Ethnicity:**	**Geography:**
Unavailable	N/A	Black less likely	Observed (see map)

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]

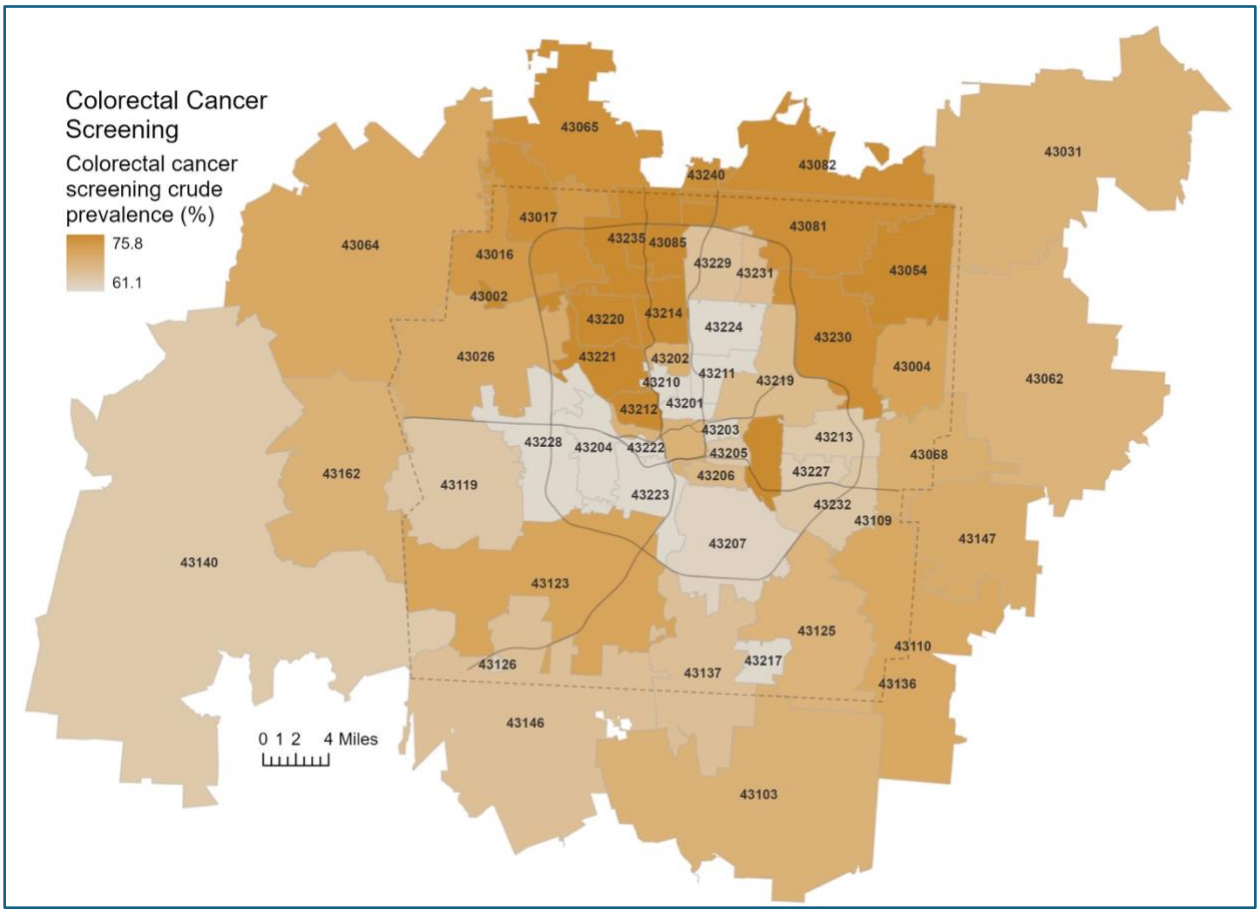
HP2030 objective for Colorectal Cancer Screening: Not met (but improving)

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

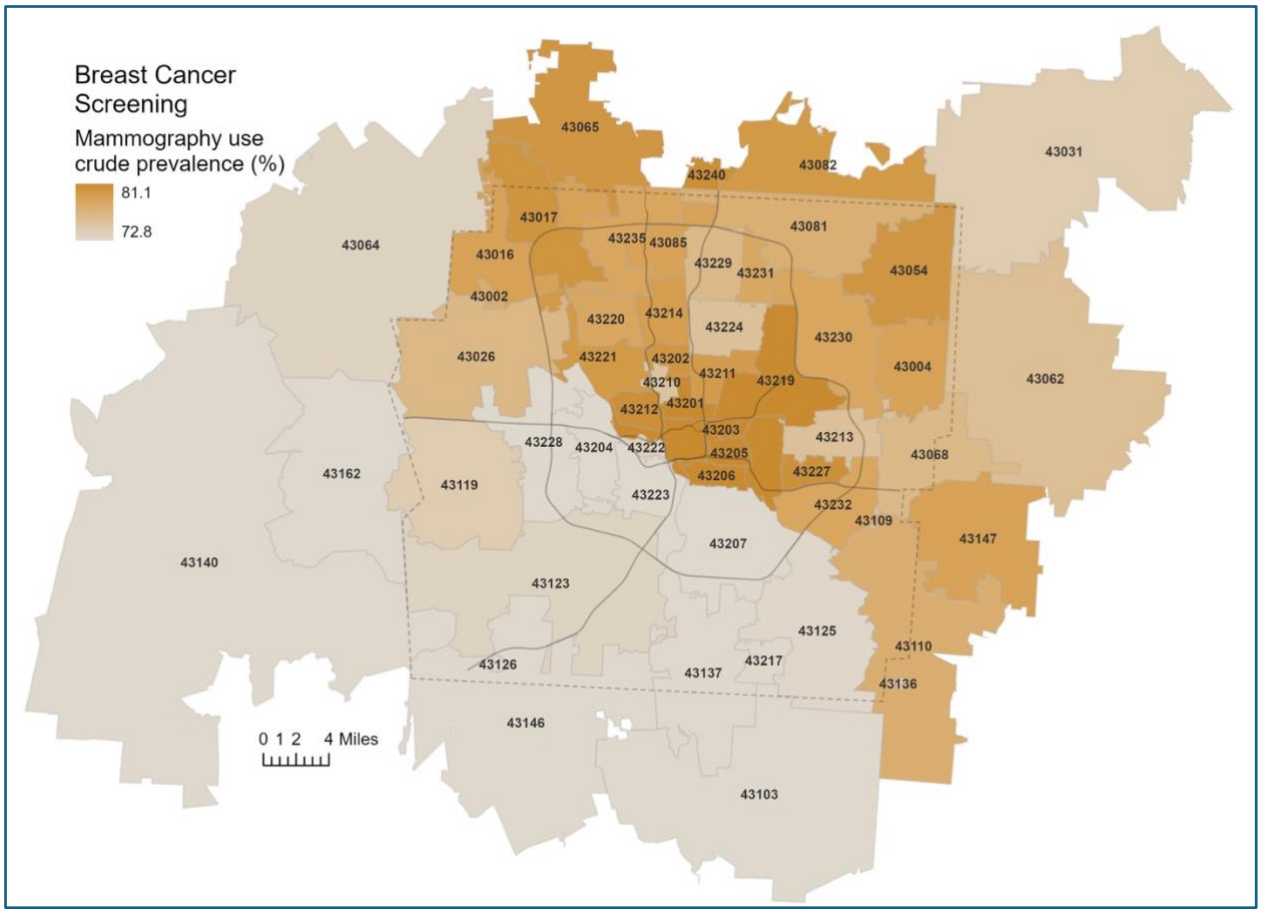
HP2030 objective for Breast Cancer Screening: Not met

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."*

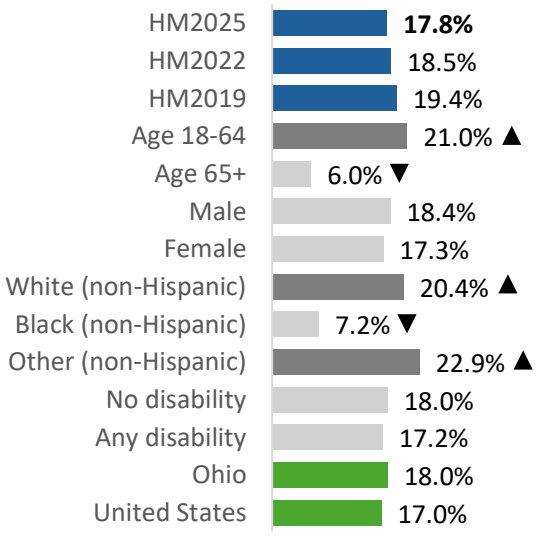
The negative effects of overconsuming alcohol mentioned by community members included worsened mental health and violence in the community.

> *"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."*

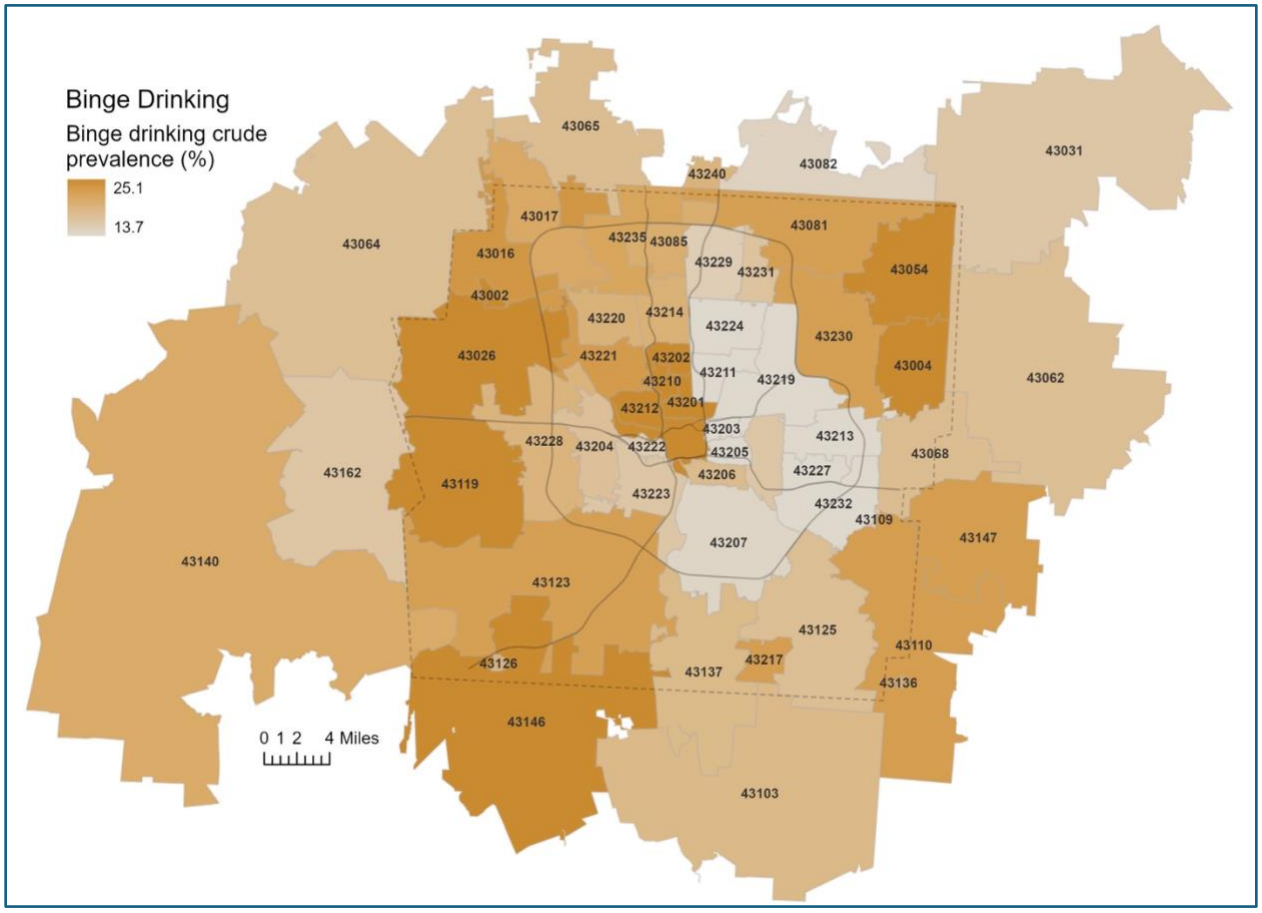
The prevalence of self-reported binge drinking has decreased slightly over time as compared to previous *HealthMaps*.

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.

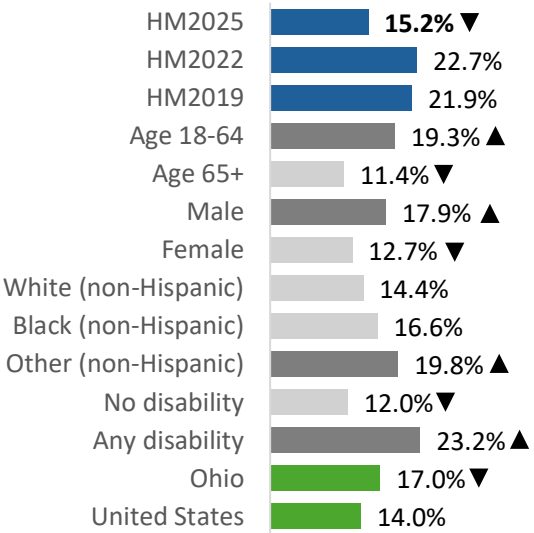
> *"It's the taste, you know, they don't feel as bad. It doesn't taste like a regular cigarette."*
>
> *"There's no social drawback of just vaping a mango kiwi."*
>
> *"I think the oversight is the piece that's slow. Technology is moving fast. The amount of nicotine that you're getting, the size of the 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.

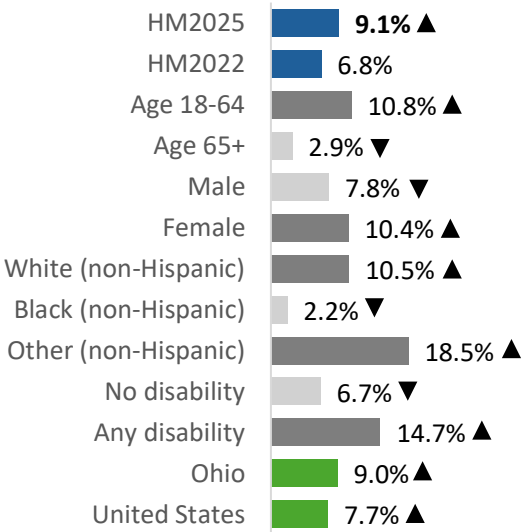
> *"It makes me so mad that our legislators are trying to deal with these issues by banning certain things or by dealing with the symptoms or the superficial. Like, they're gonna ban menthol cigarettes, but you're not really dealing with tobacco use. You're not taking on the big tobacco companies. You're 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.

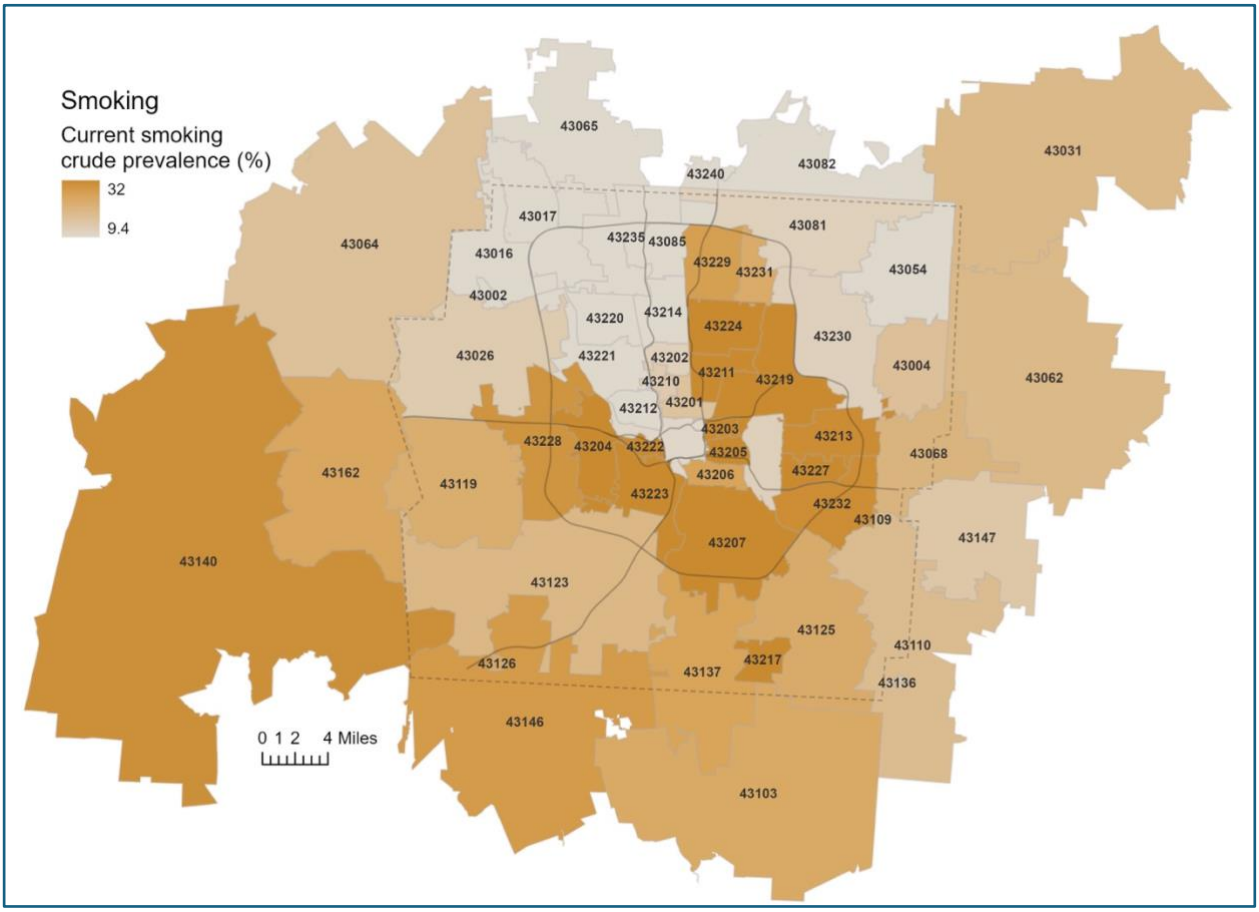
Healthy People 2030

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."

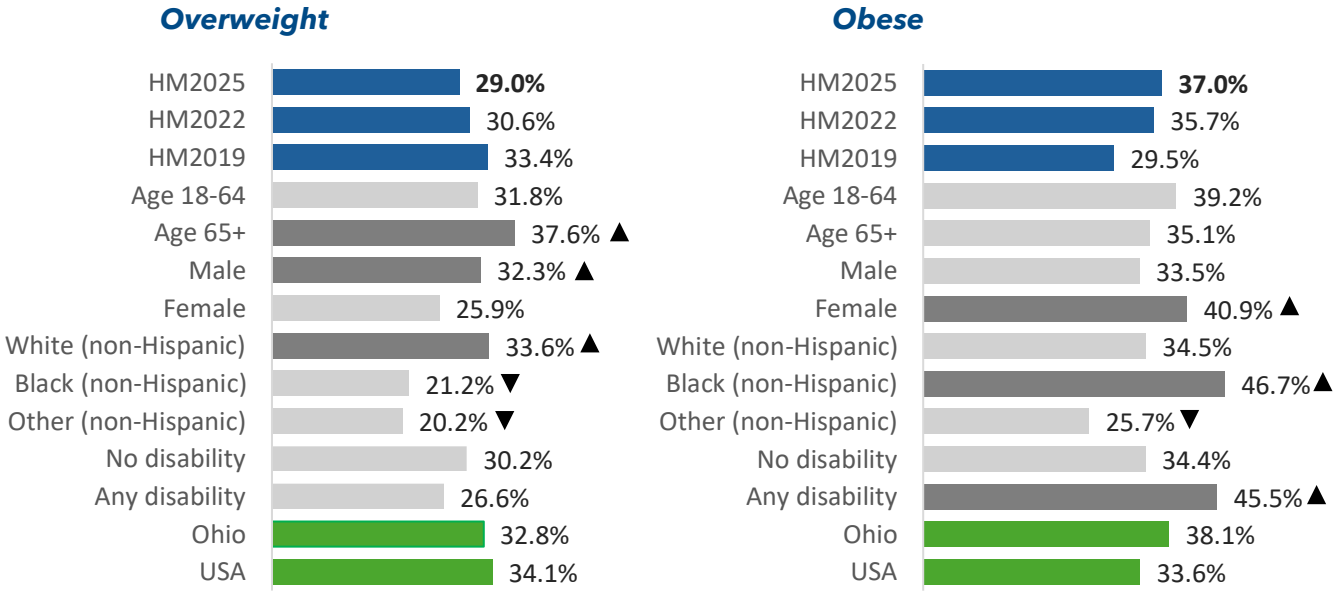
"My neighborhood stays quiet. There's a lot of kids, but I think most of the time they're either on their phones or in the house, playing video games…so it's creating a lazier, more unhealthier child that's [creating a cycle]…they'll have kids, and they just see their parents doing nothing."

"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.



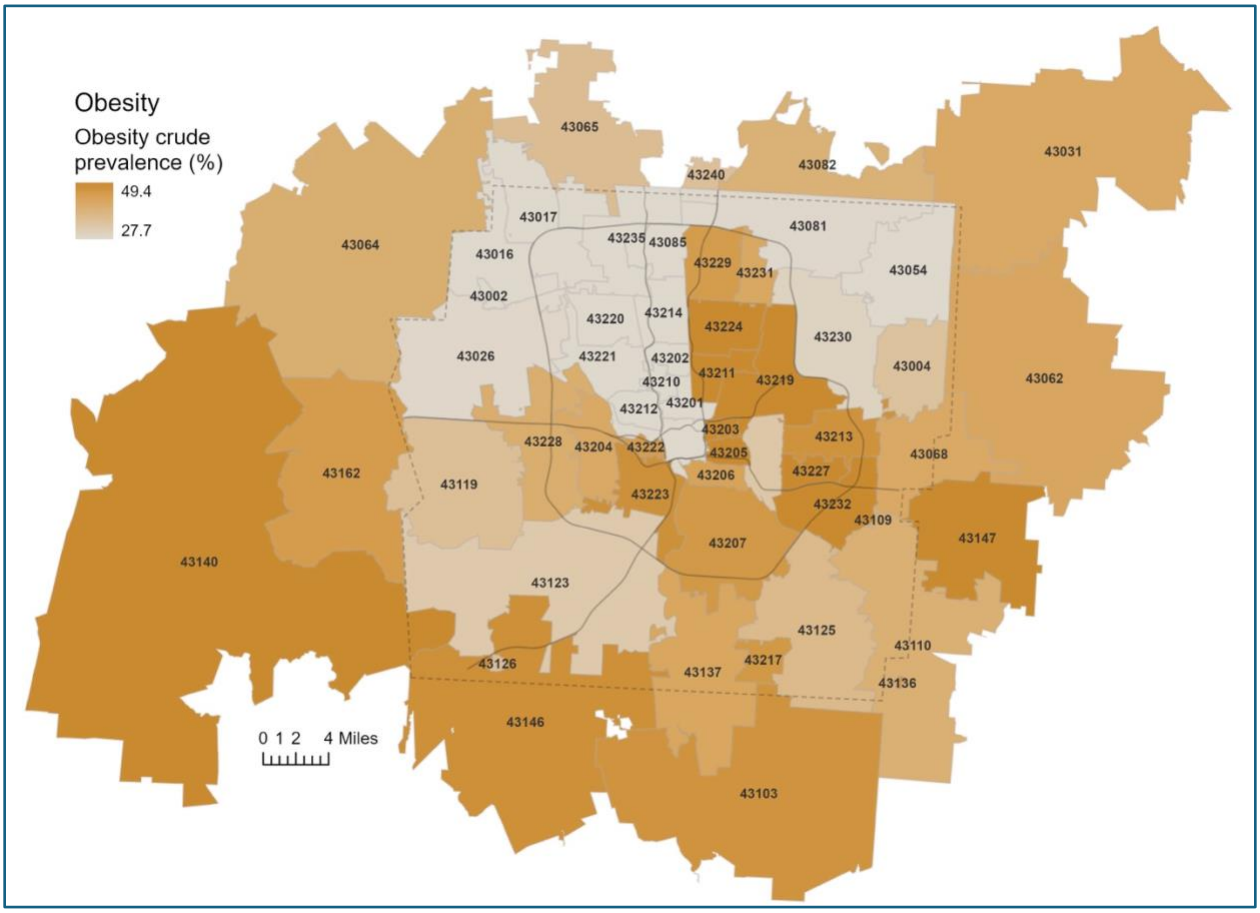
Healthy People 2030

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*

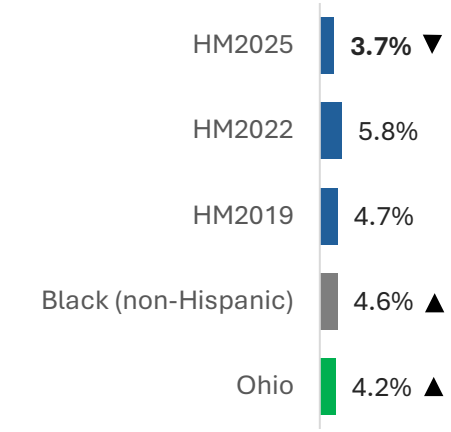
24.9% of live births were from **unintended pregnancies**.

≈ Similar to HM2022 (23.9%)

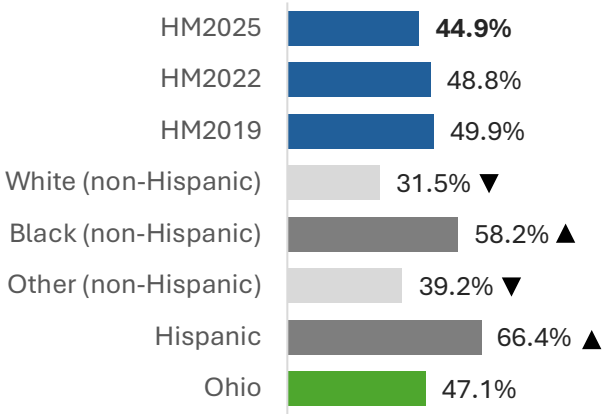
Disparities by selected social determinants of health: *Black, Hispanic more likely*

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.

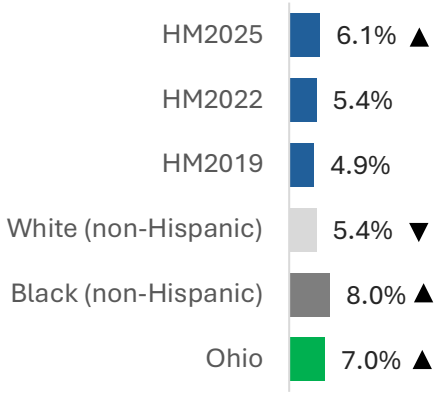
Pre-pregnancy Diabetes



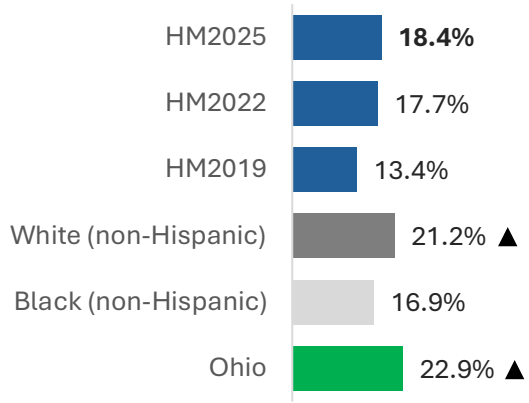
No Vitamins Pre-pregnancy



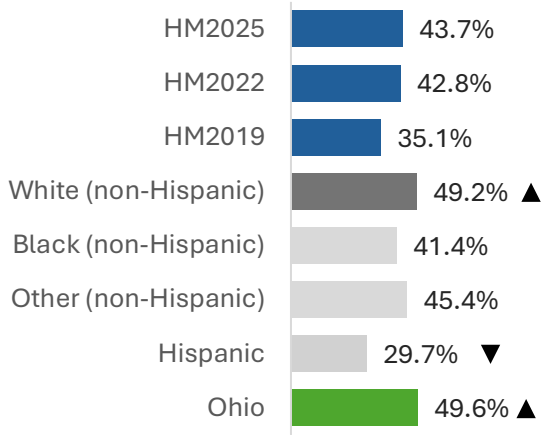
Pre-pregnancy Hypertension



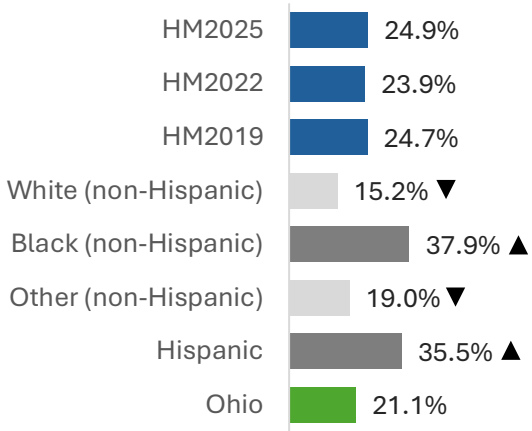
Pre-pregnancy Depression



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.

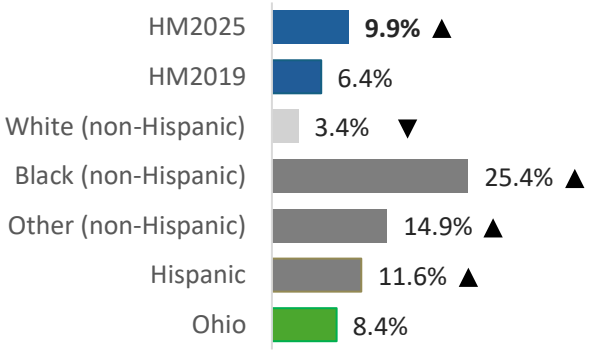
> *"It's obviously not true, but for the longest time in doula training, when you read the books, they were told that black women can accept more pain than a woman that's not black."*
>
> *"I've gone to a doctor and I've actually had them say, 'With you being an African American female, this is probably 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."*

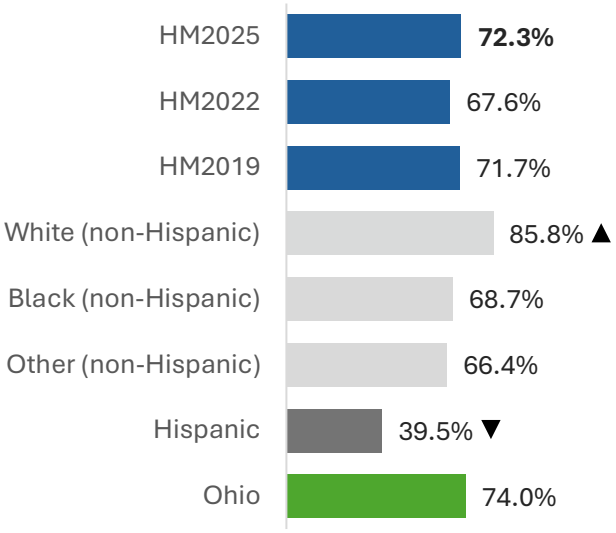
Community members mentioned that one of the reasons pregnant individuals don't seek health care is out of fear they will not receive adequate care. These fears appear to be especially prevalent in black communities.

"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."

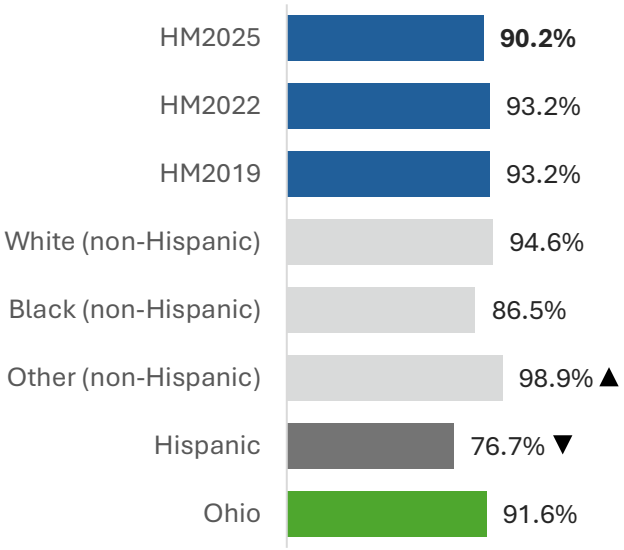
"There's just a lot of stories that you hear out here, where mostly black women are telling horror stories of how they're just not getting the proper care."

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

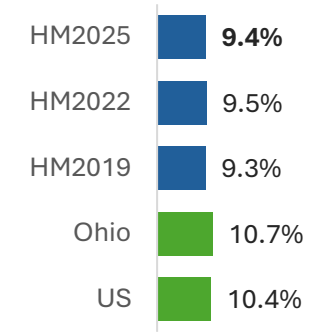
	Rate per 1,000 babies born
HM2025	**7.4**
HM2022	**6.9**
HM2019	**8.7**
White (non-Hispanic)	3.7 ▼
Black (non-Hispanic)	12.6 ▲
Hispanic	7.8
Ohio	**7.1**
US	**5.6**

Neonatal Abstinence Syndrome

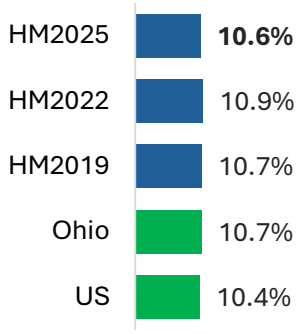
	Rate per 1,000 babies born
HM2025	**12.1**
HM2022	**11.4**
HM2019	**12.3**
Ohio	**10.1** ▼

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%

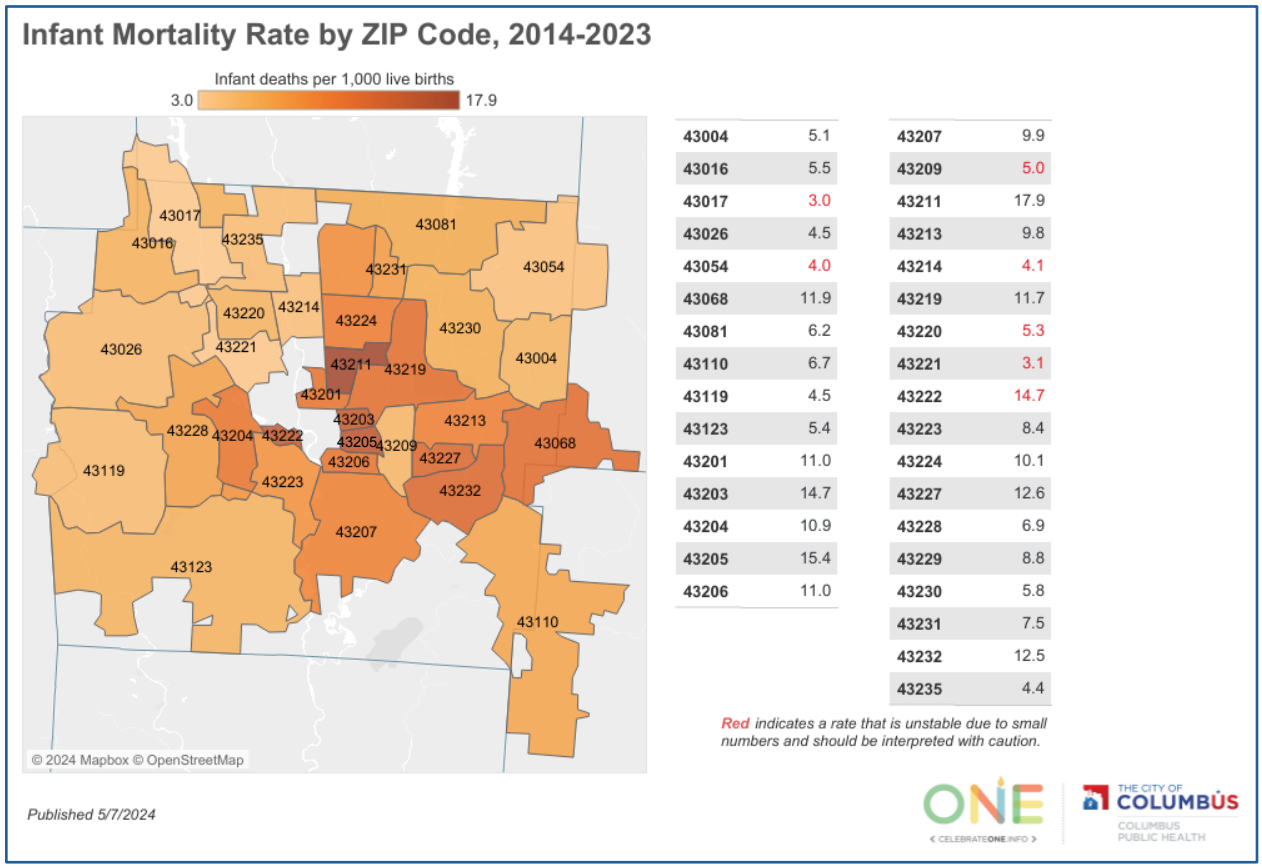
Most recent Franklin County data (HM2025)
10.6%

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**.



43004	5.1
43016	5.5
43017	3.0
43026	4.5
43054	4.0
43068	11.9
43081	6.2
43110	6.7
43119	4.5
43123	5.4
43201	11.0
43203	14.7
43204	10.9
43205	15.4
43206	11.0

43207	9.9
43209	5.0
43211	17.9
43213	9.8
43214	4.1
43219	11.7
43220	5.3
43221	3.1
43222	14.7
43223	8.4
43224	10.1
43227	12.6
43228	6.9
43229	8.8
43230	5.8
43231	7.5
43232	12.5
43235	4.4

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

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[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

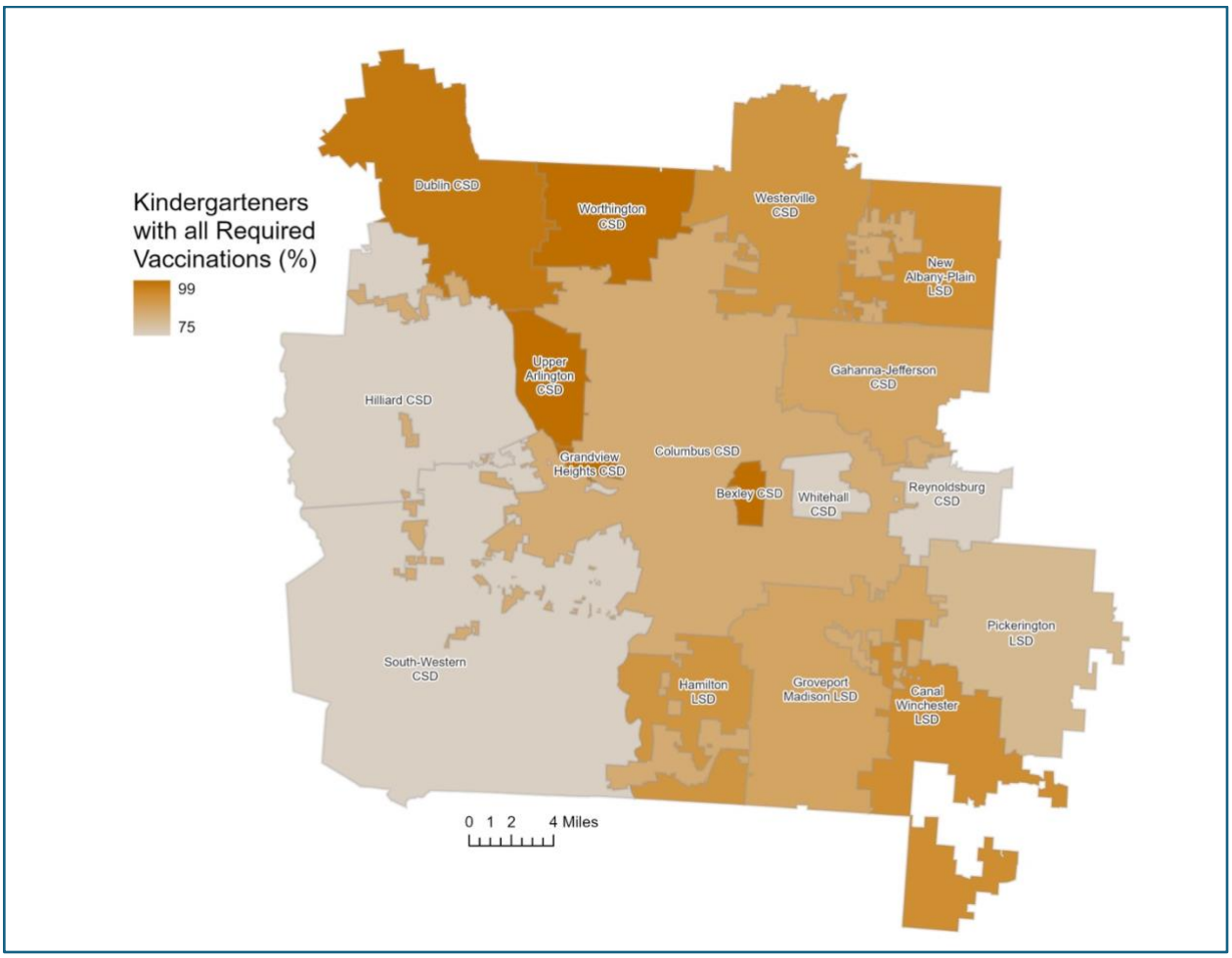
Kindergarten Vaccinations

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)

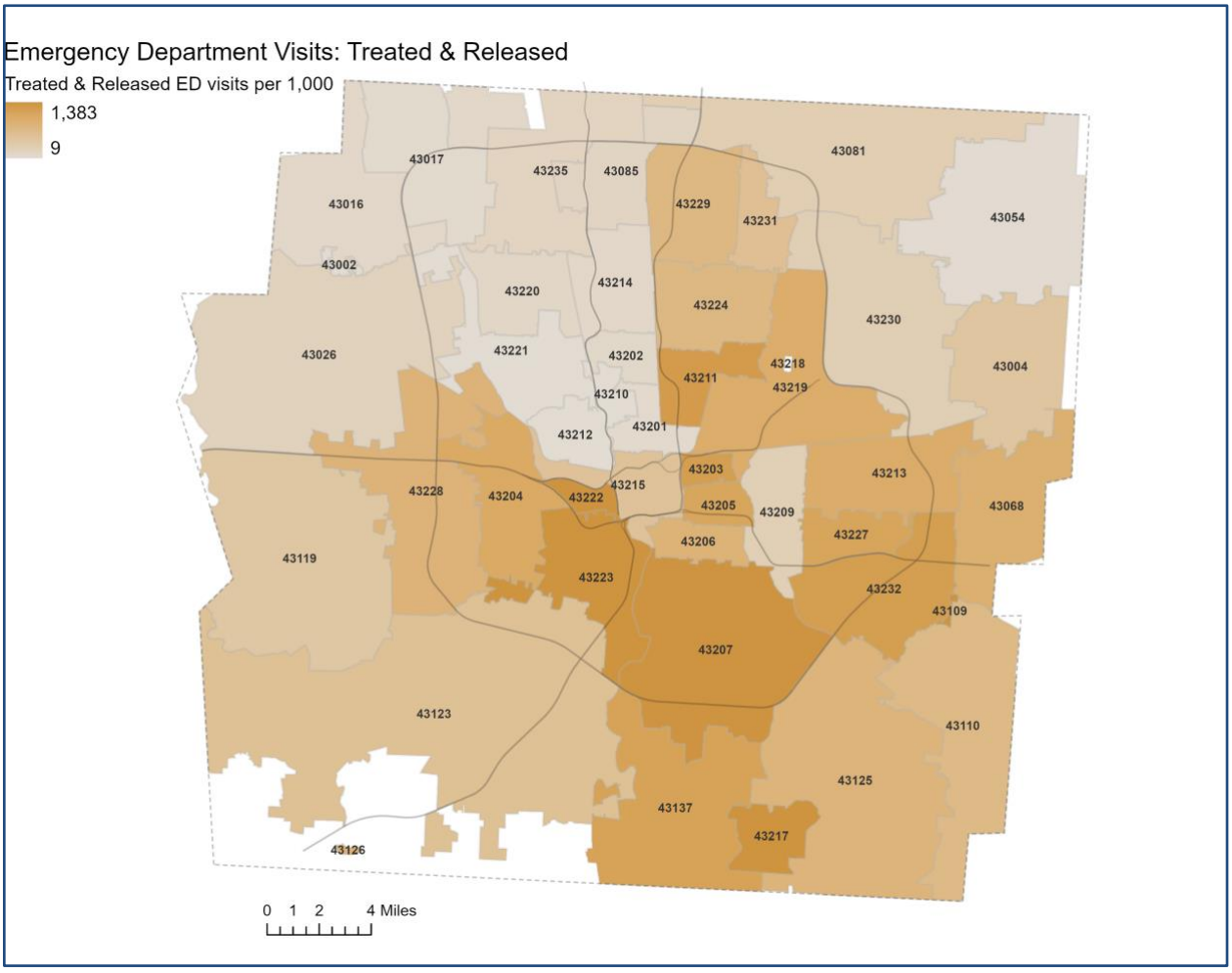
	HM2025	HM2022	Ohio
1st	Nose/throat infection (acute upper respiratory infection; unspecified): 19.1▼	Nose/throat infection (acute upper respiratory infection; unspecified): 24.7	Nose/throat infection (acute upper respiratory infection; unspecified): 21.7
2nd	Strep throat (streptococcal pharyngitis): 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)

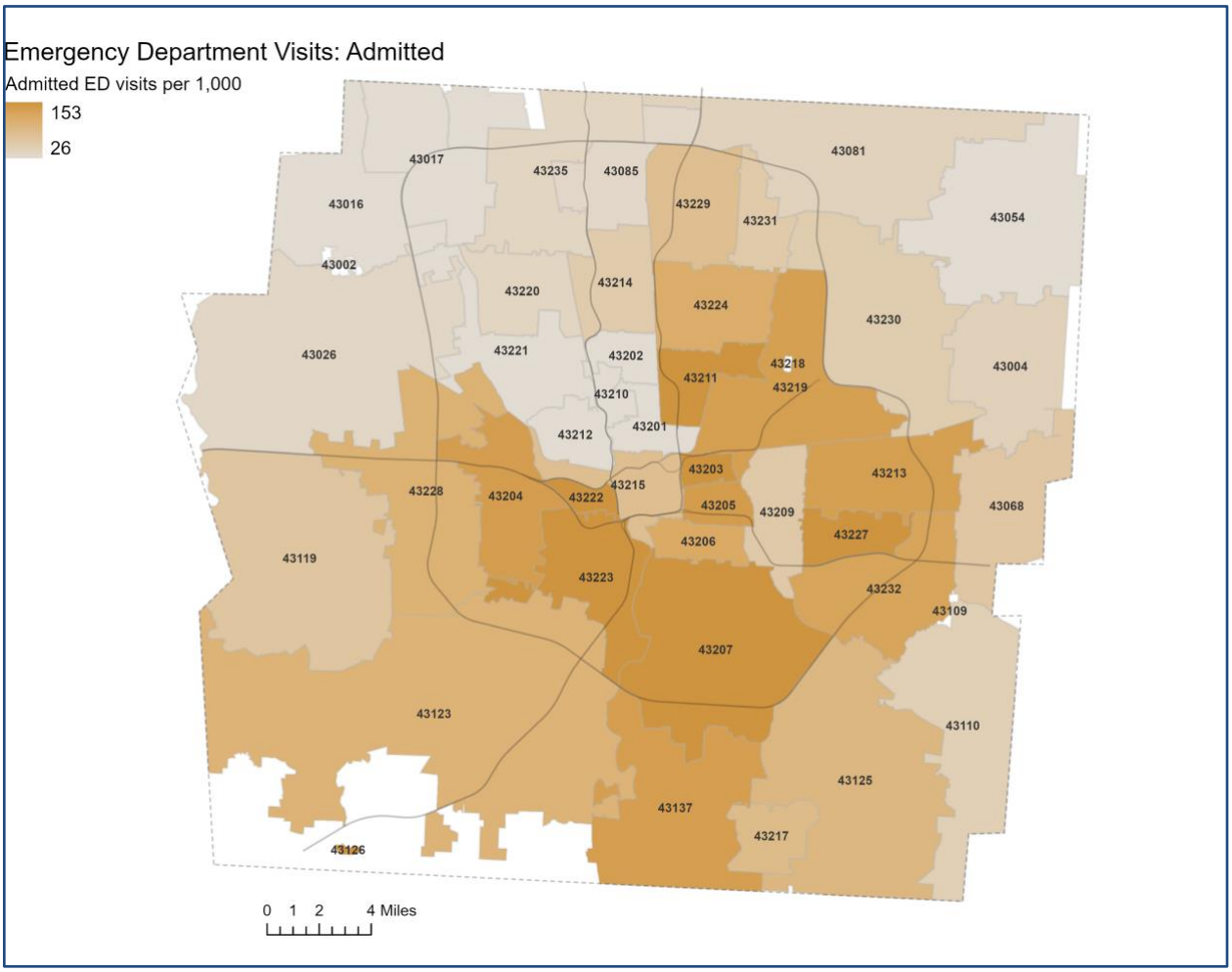
	HM2025	HM2022	Ohio
1st	Lung infection (acute bronchiolitis; RSV): 1.6	Lung infection (acute bronchiolitis; RSV): 1.5	Lung infection (acute bronchiolitis; RSV): 0.6
2nd	Recurrent major depression (without psychosis): 0.5	Dehydration: 1.4	Dehydration: 0.5
3rd	Lung infection (bronchiolitis; specified organism): 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.

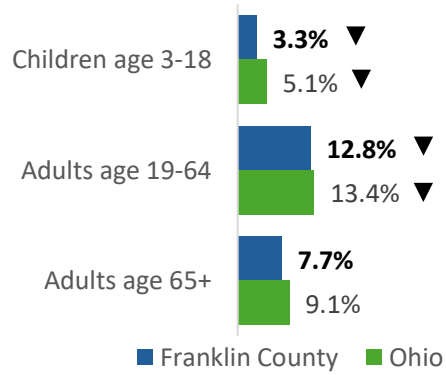
"[medical center] has emergency dental, but they only take the first ten people…So it's one of these, there is an emergency dental clinic, but again, if you're not right there when it first opens…"

"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.

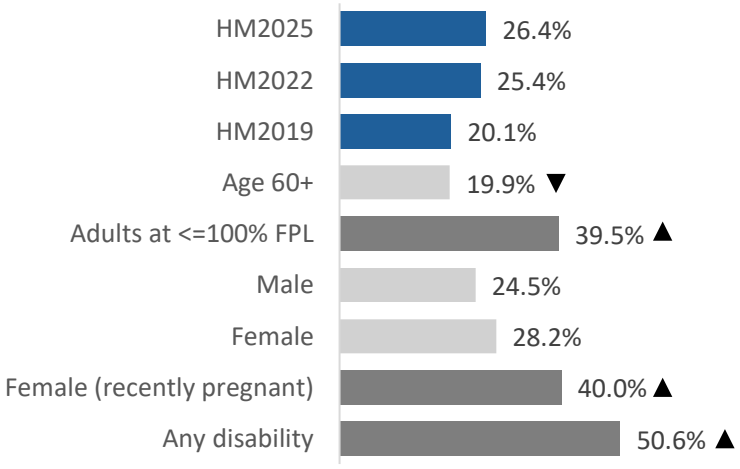
HP2030 objective for Suicide Deaths: Not met

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.

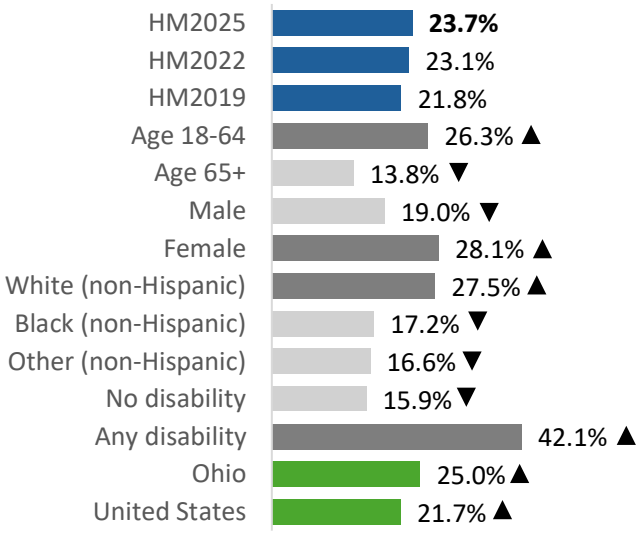
Loneliness

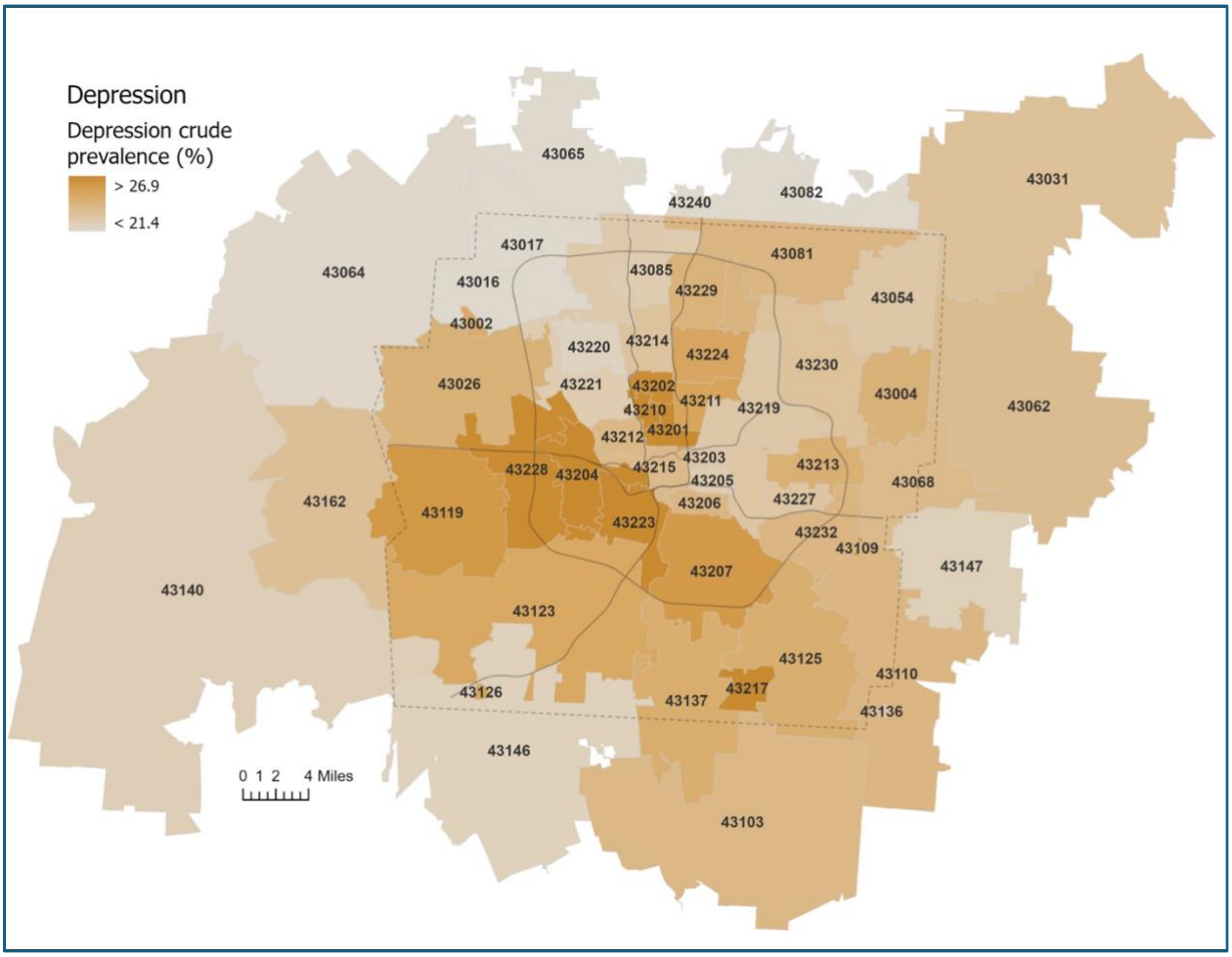


Females, white (non-Hispanic) individuals, adults under the age of 65, and individuals with a disability are more likely than other groups to report ever being told by a healthcare professional that they have a depressive disorder (e.g., depression).

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.

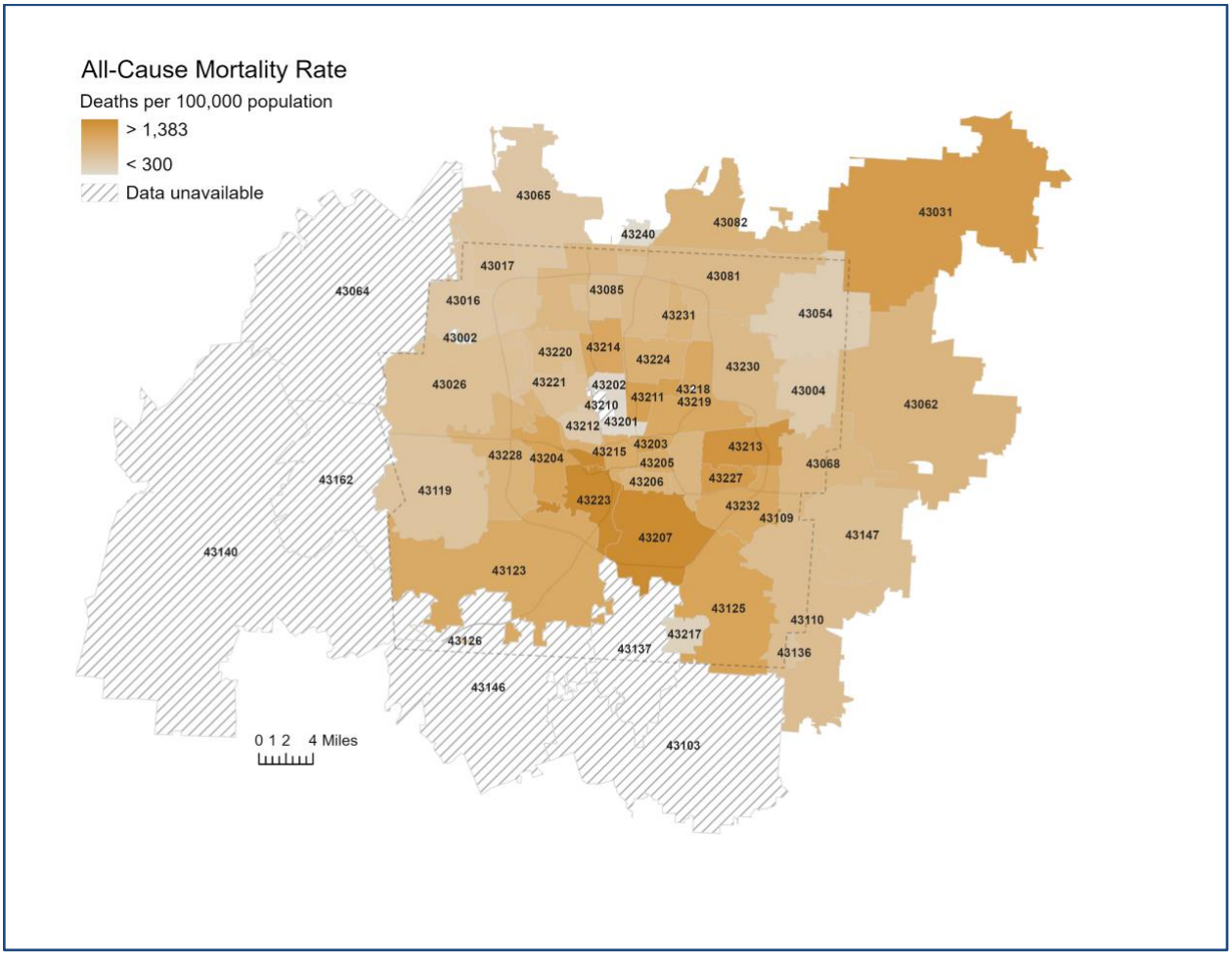
Life Expectancy at Birth

	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**

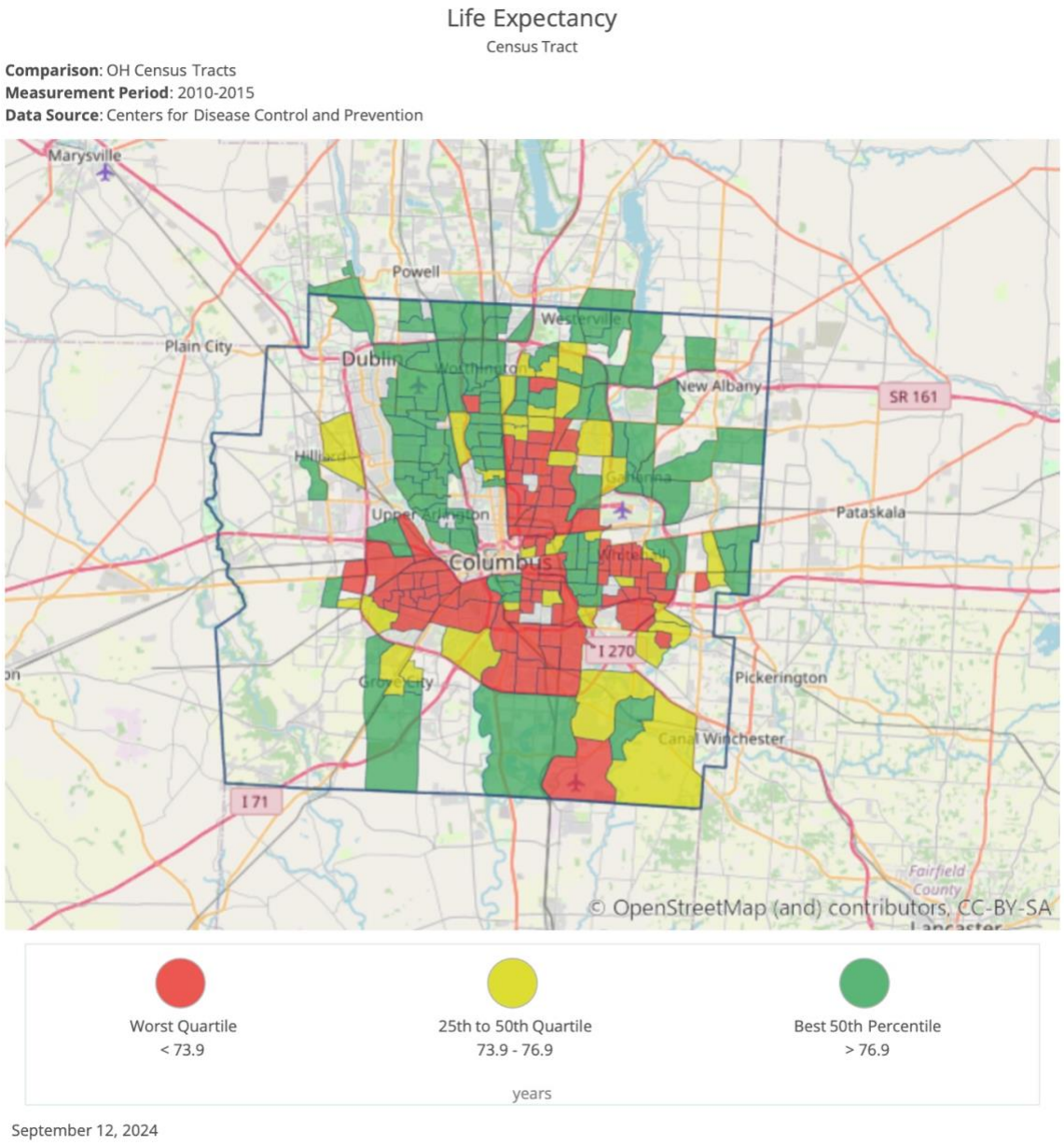
All-Cause Mortality Rate

	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.

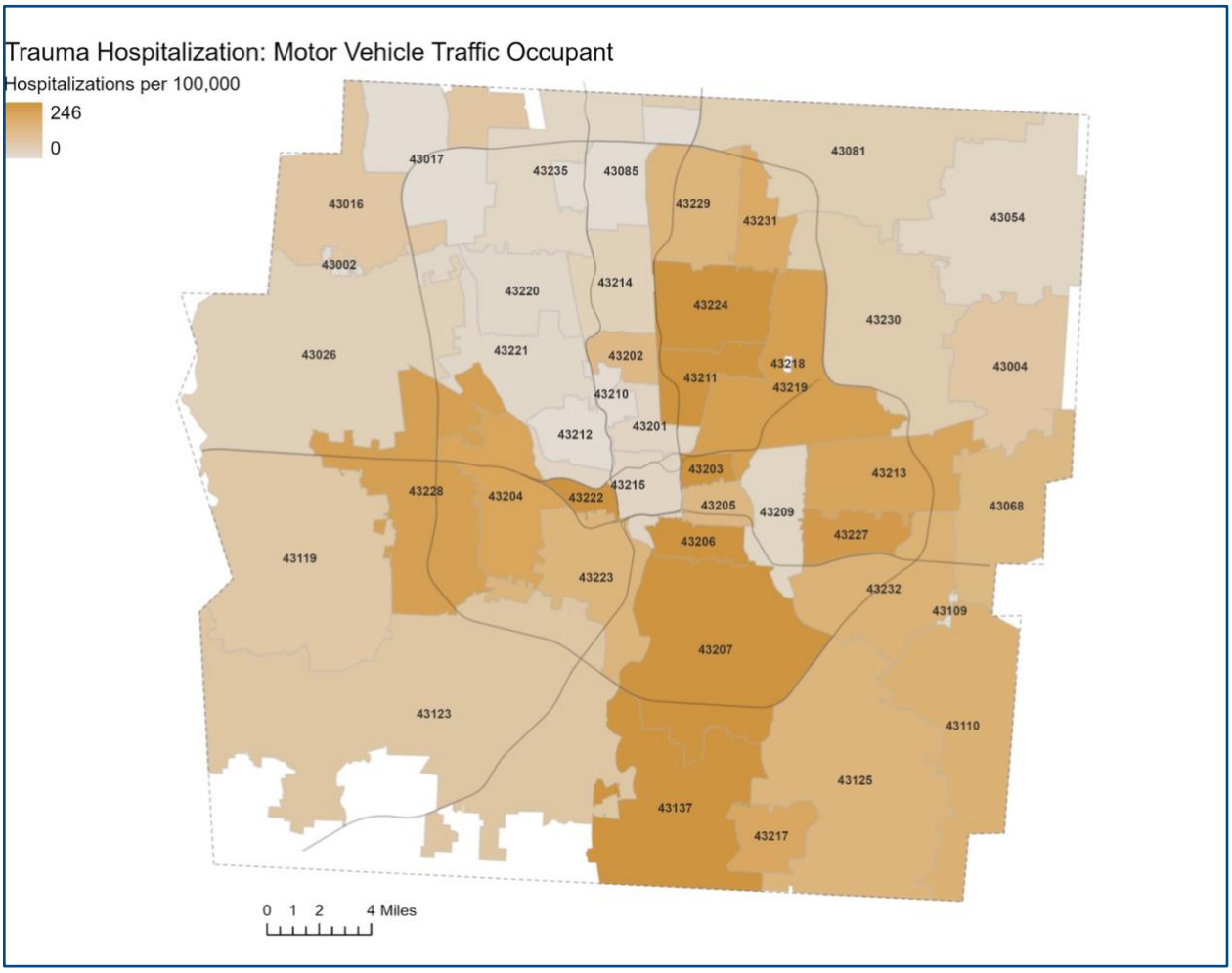
Injuries due to firearms, being struck (by or against something), or cutting/piercing that lead to hospitalization all occur more frequently among males than females. Injuries due to firearms that lead to hospitalization occur more frequently among black individuals.

Leading Causes of Trauma Hospitalizations (by Key Demographics)

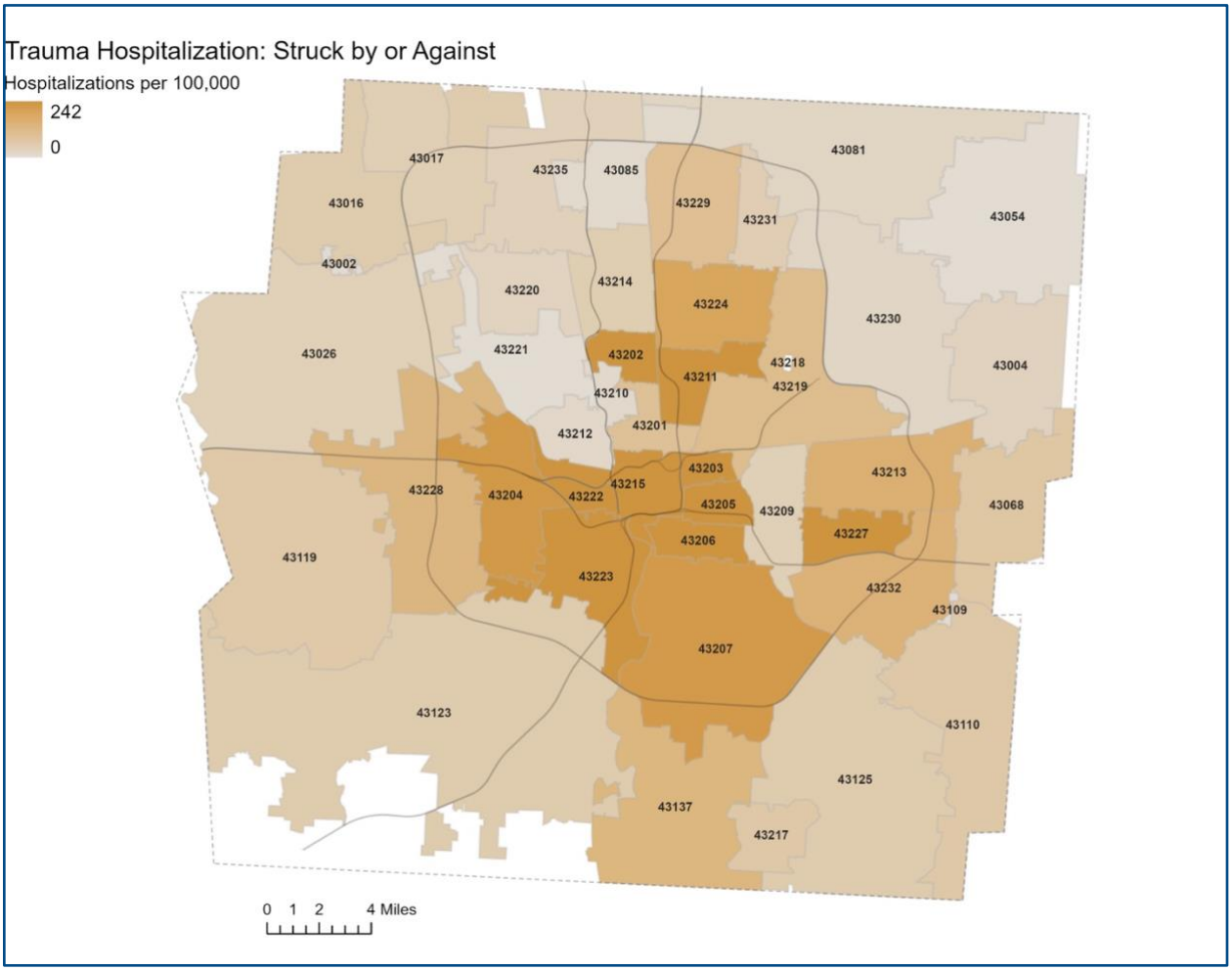
	Fall	Motor vehicle (occupant)	Struck by or against	Firearm	Cut or pierce	All others
Total	**5,766**	**1,245**	**805**	**521**	**266**	**1,577**
	56.6%	**12.2%**	**7.9%**	**5.1%**	**2.6%**	**15.5%**
Age						
0-17 Years	6.9%	7.4%	12.4%	14.8%	10.2%	
18-64 Years	30.8%	***75.8%***	***81.1%***	***83.5%***	***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.

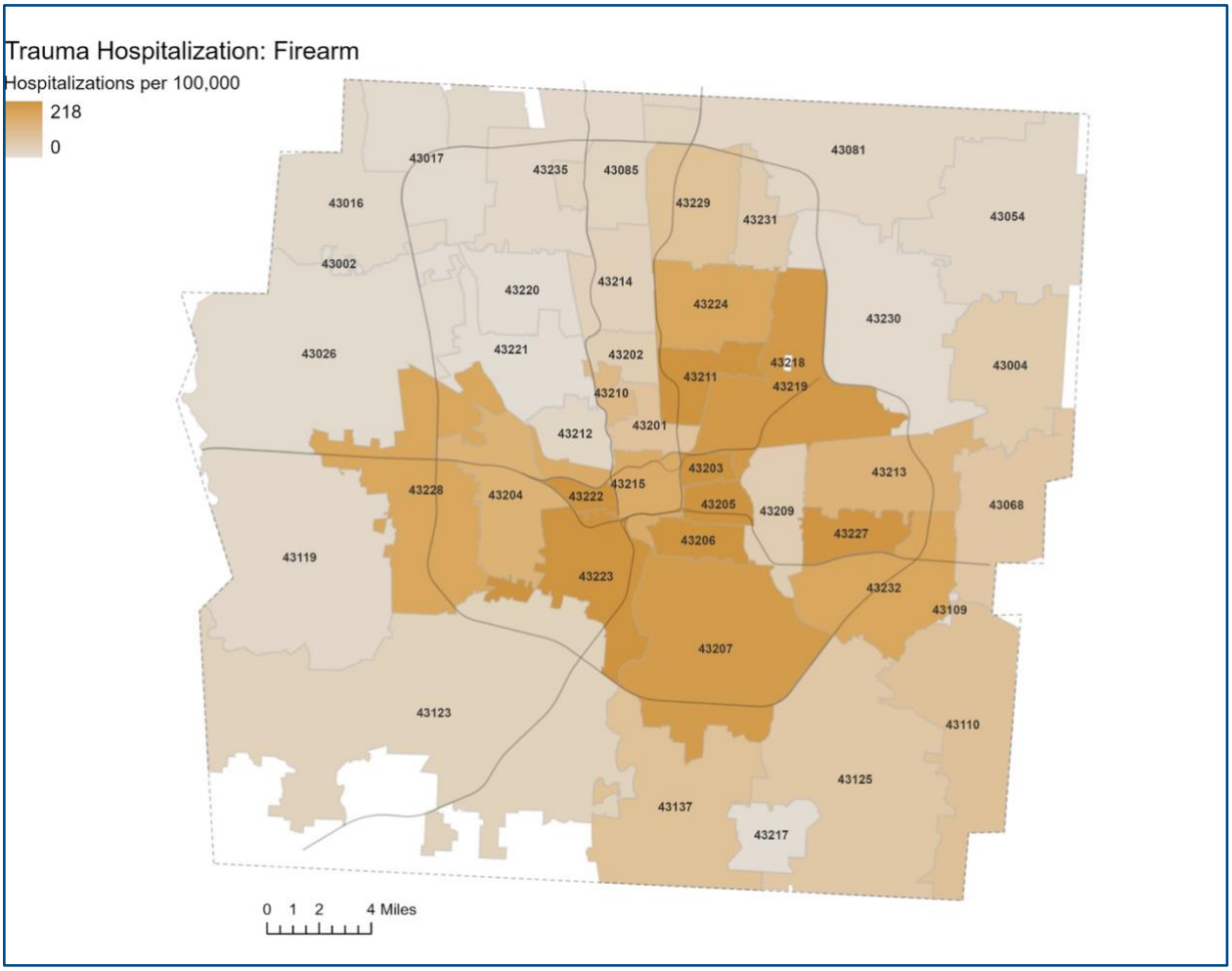
The rate of trauma hospitalizations involving an occupant of a motor vehicle that was in an accident is greater in north-central zip codes (43211, 43224), west-central zip codes (43222, 43204, 43228), and southern zip codes (43206, 43207).



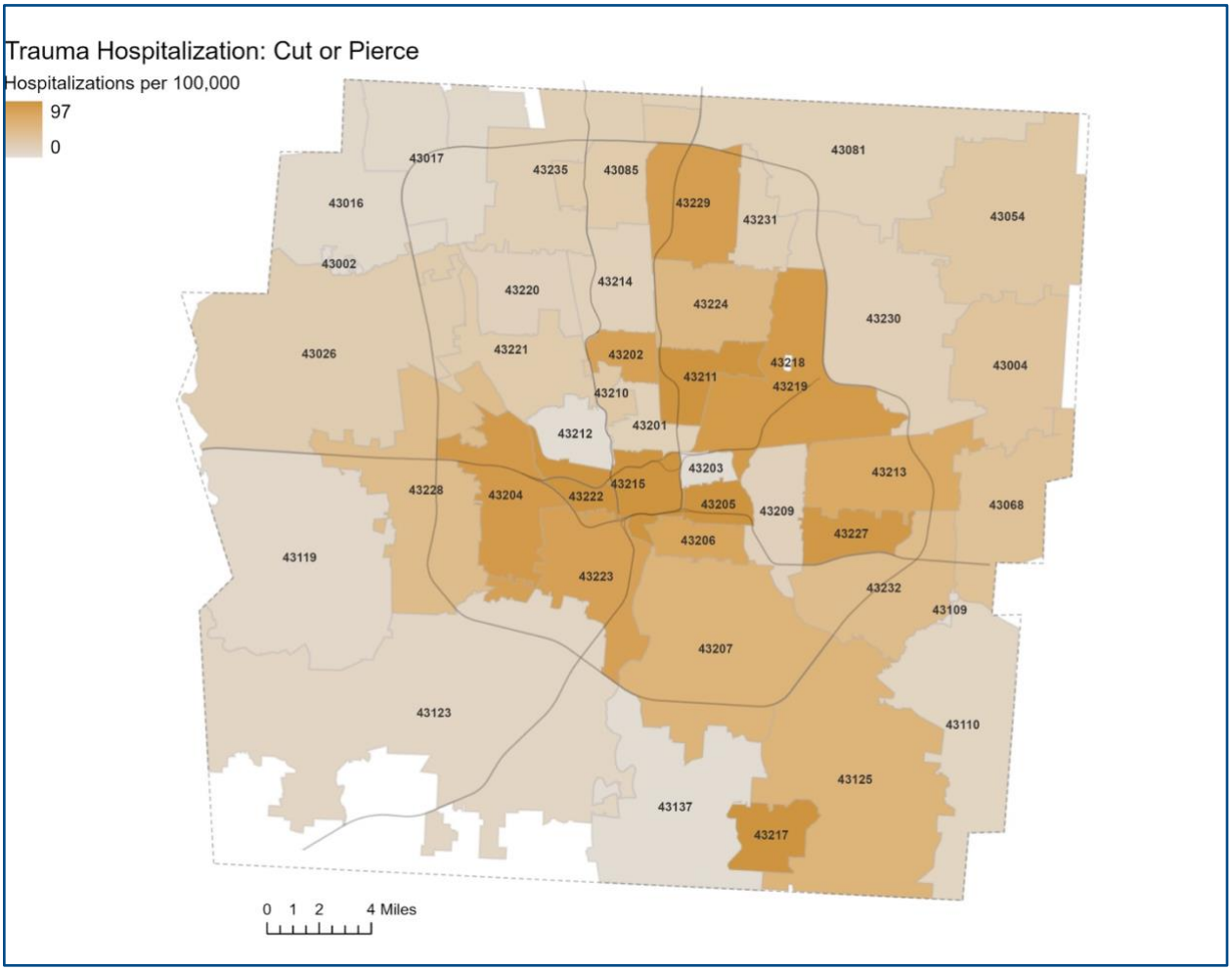
The rate of trauma hospitalizations due to being struck by or against something is greater in north-central zip codes (43202, 43211), central zip codes (43203, 43208, 43215, 43222, 43204, 43223), southern zip codes (43206, 43207), and the Whitehall area (43227).



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.

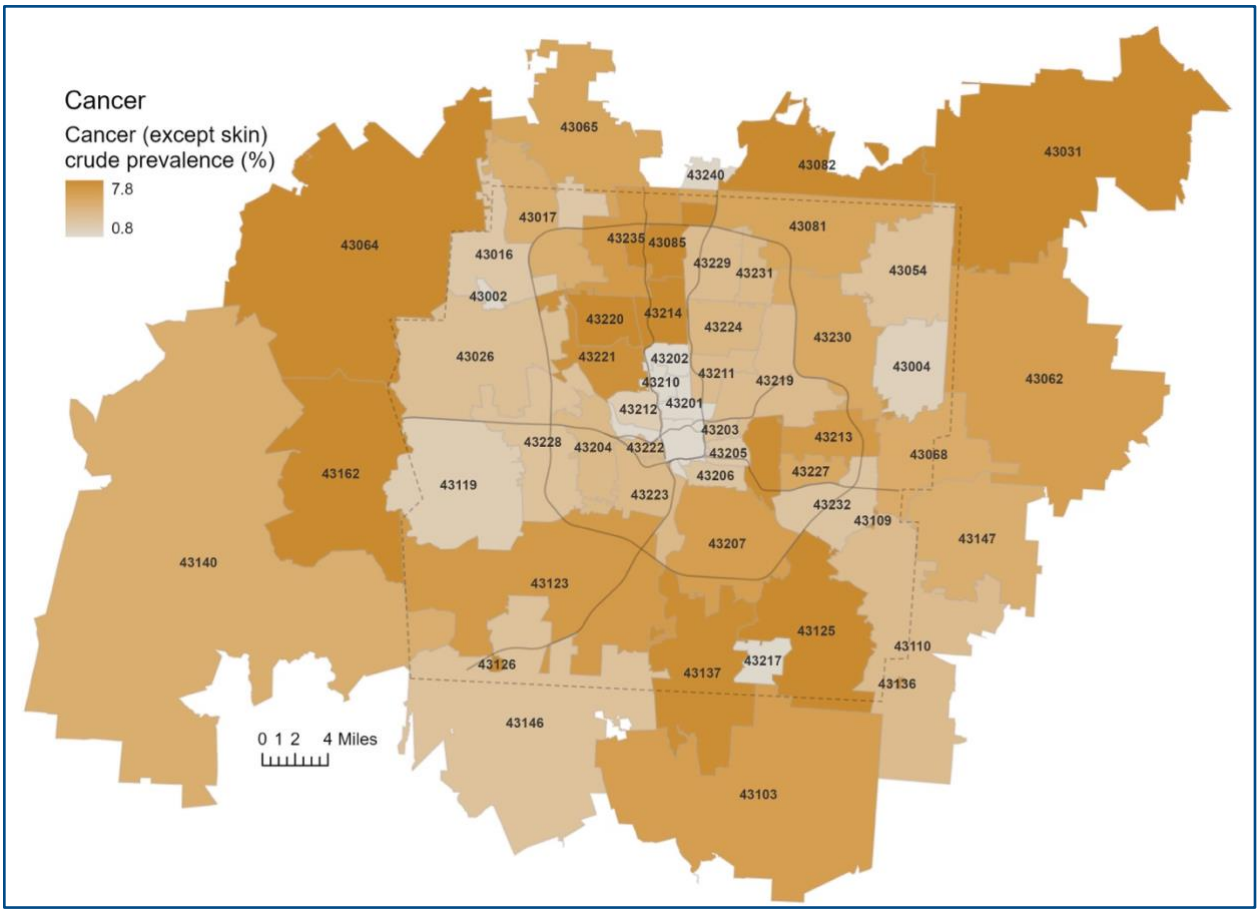
Cancer Mortality (age-adjusted rate per 100,000)

	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).

Healthy People 2030

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)

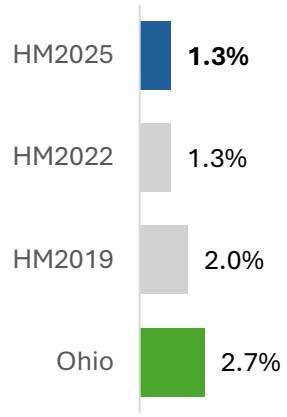
Although elevated blood lead levels (EBLL) are detrimental to all people, they are particularly harmful to children. Young children exposed to high levels of lead are at increased risk for brain damage and developmental delays, lower muscle function, and damage to the kidneys and other organs.[1] Children 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**.

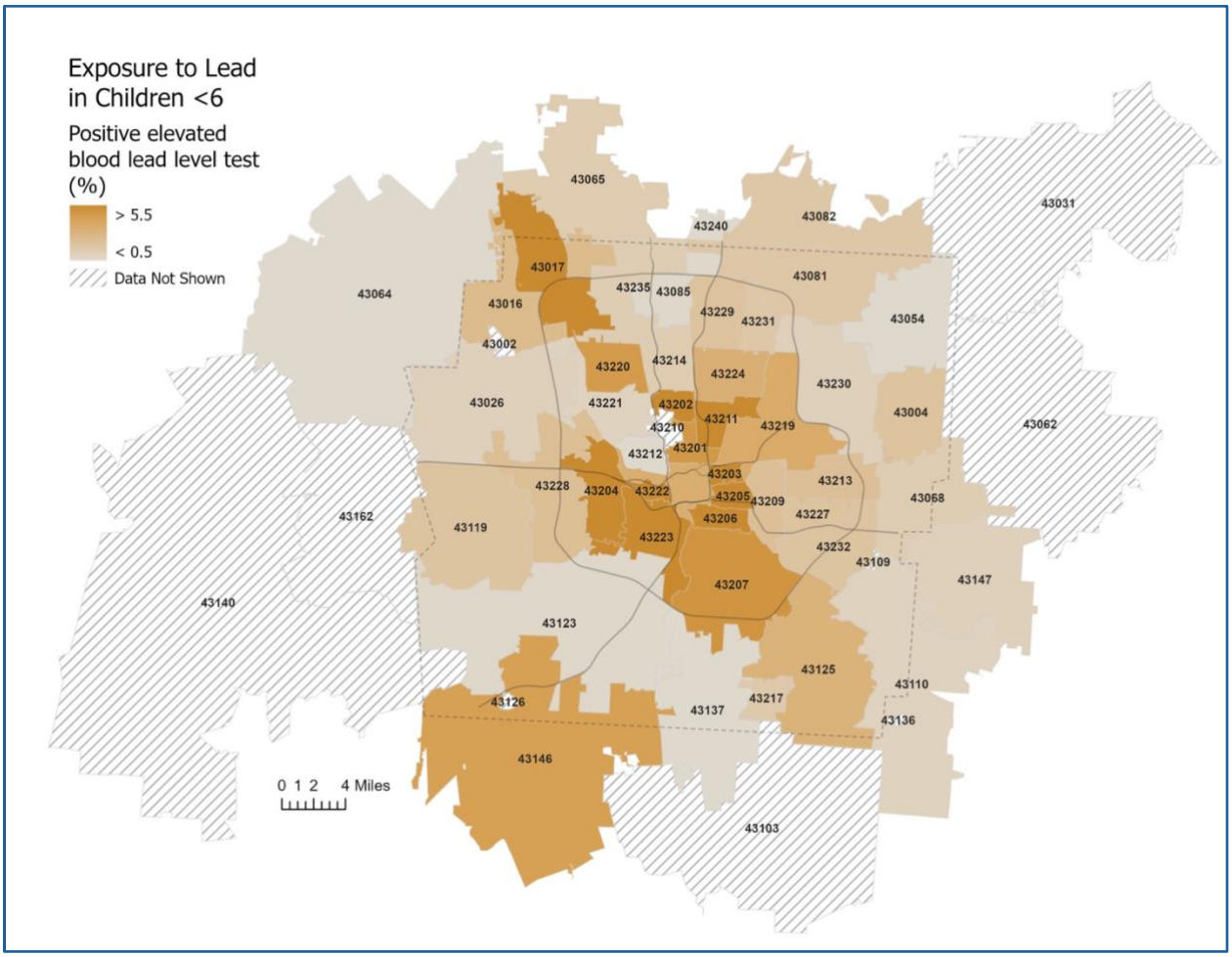
≈ Similar to HM2022 (1.3%)

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.

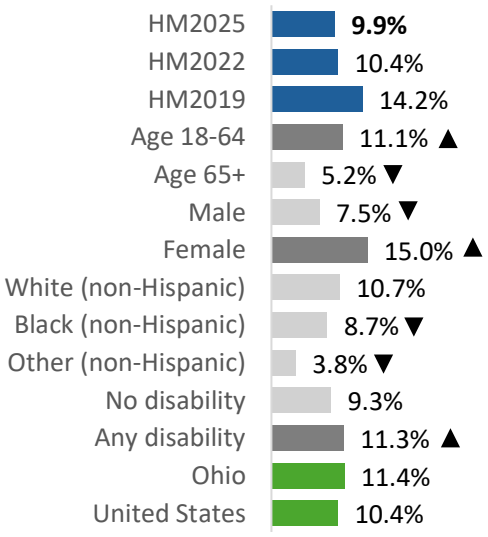
≈ Similar to HM2022 (10.4%)

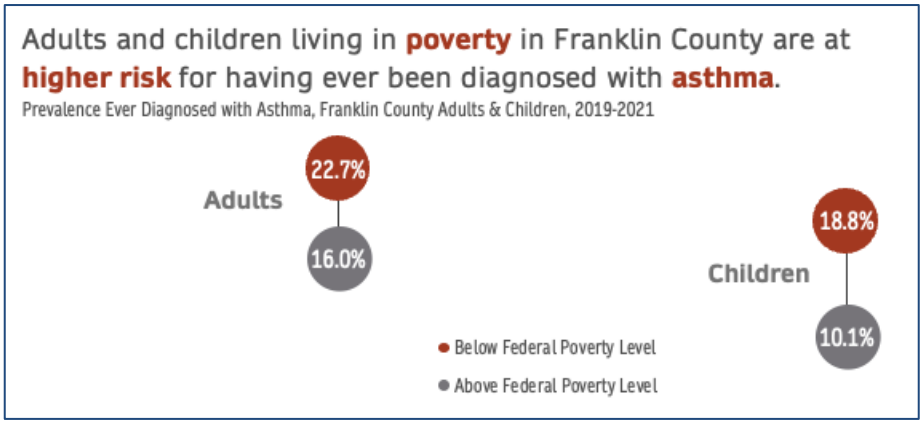
Disparities by selected social determinants of health

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

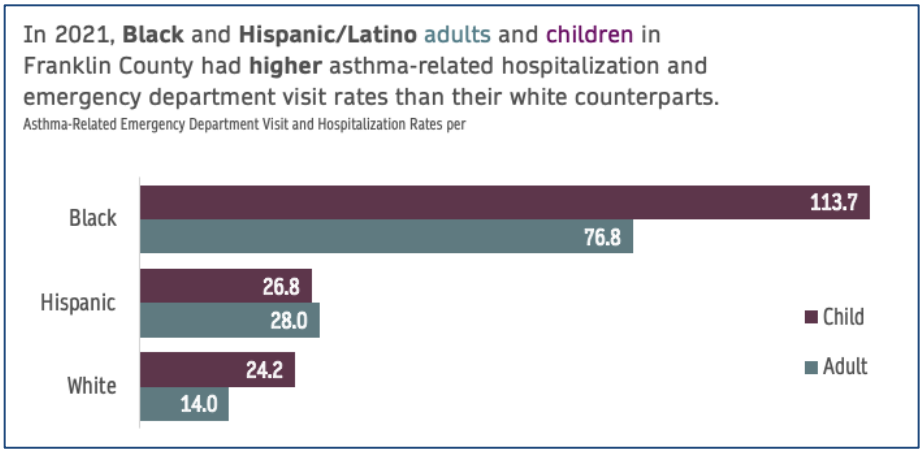
Asthma is lower among older adults than younger adults, which could be due to either changes in diagnoses or superseding respiratory diagnoses in the elderly (e.g., chronic obstructive pulmonary disease, or COPD). Females and individuals with disabilities are both more likely to report this health condition.

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).

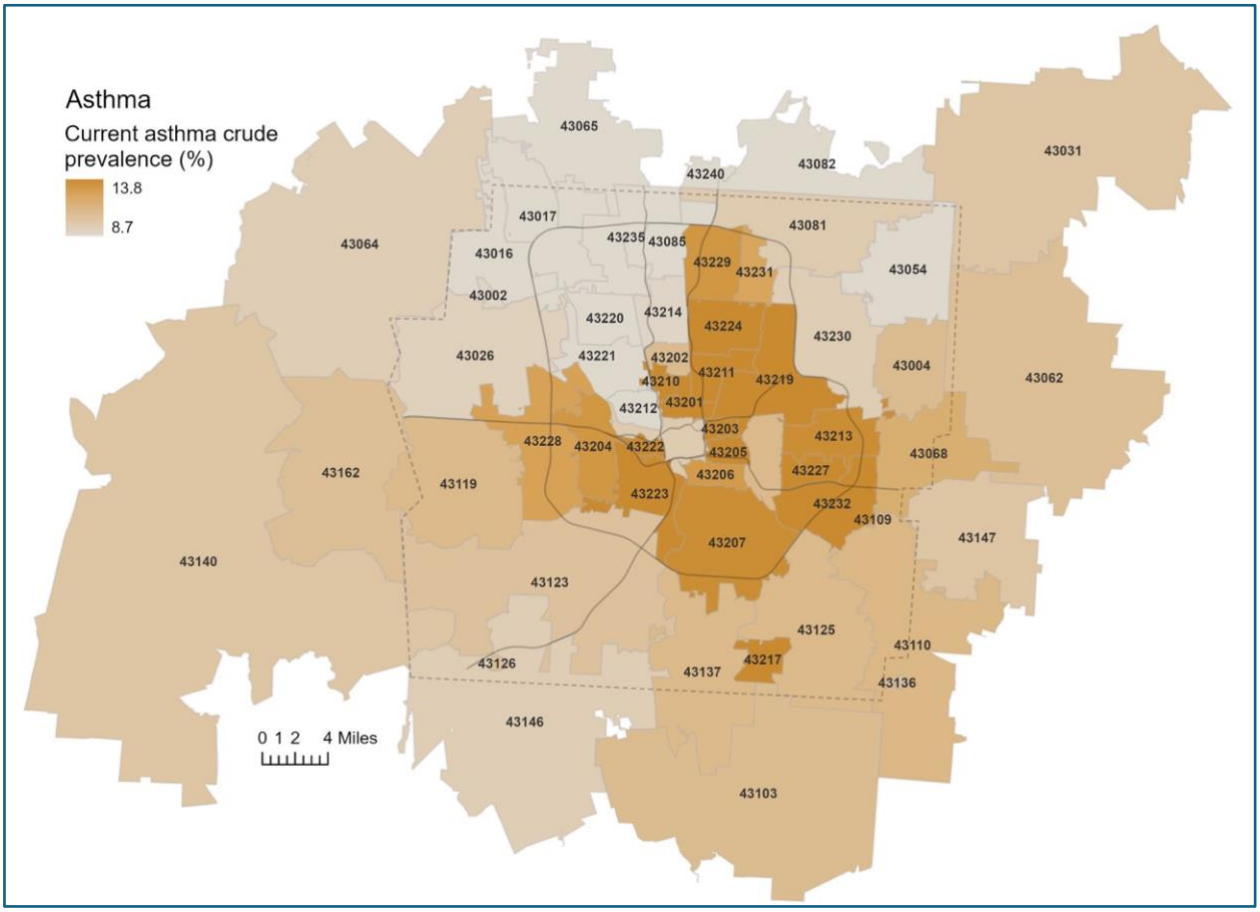




Additionally, a recent analysis revealed that black and Hispanic adults and children in Franklin County had much higher rates of asthma-related hospitalization and emergency department visits as compared to white individuals.



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

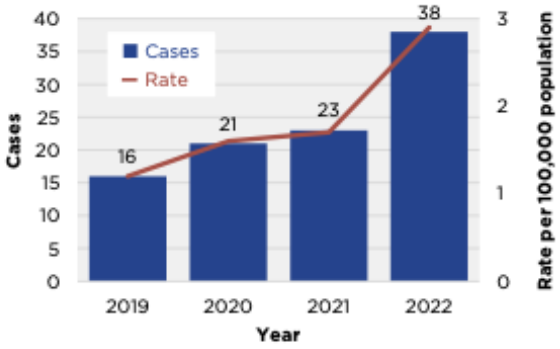
Case Definition: Please see the Ohio Infectious Disease Control Manual: Lyme Disease.

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.

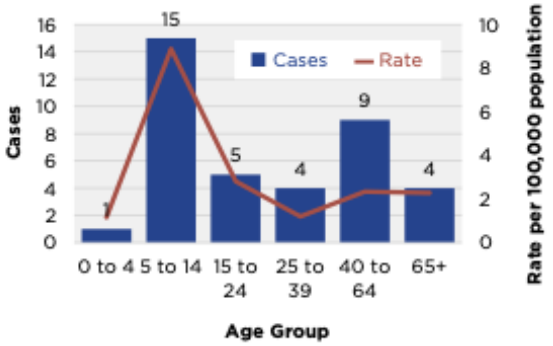
Incubation Period: Erythema migrans rash appears 3-32 days after tick bite (mean 7-10 days); early stages of the illness may be unapparent and the patient may present with later manifestations.

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

Community Impact Report

In 2022, Nationwide Children's set out to accomplish specific goals to improve the health of Franklin County's children and young adults. Since the majority of our patients live in Franklin County, we focused on indicators specific to these residents' needs. The following report is a review of the 2022 Nationwide Children's Implementation Strategy.

Goals for improvement were determined after review of morbidity and mortality data and a series of community meetings, which were designed to solicit feedback from residents on how Nationwide Children's could better serve them. The *HealthMap**2022*** was included in the 2022 to 2024 Nationwide Children's Hospital Community Health Needs Assessment. There were no public written comments for either the Community Health Needs Assessment or the Implementation Strategy.

Nationwide Children's succeeded in achieving many of its goals for improvement and will continue to be responsive to the community's health care needs by regularly evaluating each service provided.

The primary targets for Nationwide Children's efforts fell into the following categories, which were identified as areas of need by the Franklin County *HealthMap**2022***. Nationwide Children's added disease management and preventive care as pediatric health needs that required immediate attention.

- **Basic Needs**
  - Housing security
  - Financial stability
  - Neighborhood safety
  - Food security and increased access to nutritious foods
- **Racial Equity**
  - Effects on economic and housing stability
  - Effects on quality health care, mental health and safety
  - Effects on maternal and infant health outcomes
- **Behavioral Health**
  - Access to mental health care resources
  - Screening for mental health issues
  - Decreased unintentional drug and alcohol deaths
  - Youth mental health support
- **Maternal and Infant Health**
  - Infant mortality
  - Maternal pre-pregnancy health
- **Disease Management**
  - Asthma
  - Diabetes
  - Obesity
- **Preventive Care**
  - Well-child access and immunizations
  - Dental care access

Basic Needs

HOUSING, INCOME, SAFETY AND FOOD ACCESS

2022 Implementation Strategy Initiatives:

To help improve residents' access to basic needs including housing, income, neighborhood safety, food security and nutritious foods, Nationwide Children's and Healthy Neighborhoods Healthy Families committed to:

- Add 25 rental units to the South Side.
- Complete 40 home repairs on the South Side.
- Complete 200 home repairs in South and North Linden.
- Add 80 scattered-site rental units to South and North Linden.
- Add 60 homeownership units to South and North Linden through the Central Ohio Community Land Trust.
- Continue tenant success meetings to educate renters on best practices for safe and healthy homes as well as information on other Healthy Neighborhoods Healthy Families practices.
- Continue financial stability initiatives including My Bridge 2 Success and expand Volunteer Income Tax Assistance Program.
- Increase filings for the Earned Income Tax Credit, especially for Black, female-led households.
- Increase feelings of neighborhood safety through PlayStreets events.
- Serve more than 13,100 unduplicated families at the South Side Fresh Market by 2024.
- Expand Linden Fresh Market reach between 44,000 and 46,000 annual visits by 2024.

Basic needs were the highest priority based on the Franklin County *HealthMap**2022***. This comprised the following specific and interrelated indicators: housing security, financial stability, neighborhood safety, food security and increased access to nutritious foods.

In Franklin County, the median net household income was $64,713, which was higher than the median in Ohio, but slightly lower than the national figure. There was a higher percentage of families living below 100% of the federal poverty level (FPL) in Franklin County compared to Ohio and national rates.

Nationwide Children's and community partners worked together to improve access to safe, affordable housing; continue financial stability initiatives; increase neighborhood pride and feelings of safety; and expand access to nutritious foods.

HOUSING

Nationwide Children's Healthy Homes is dedicated to providing and preserving affordable housing through the provision of homeownership, rental and home repair services in two Columbus communities, the South Side and Linden. Healthy Homes is the affordable housing prong of Nationwide Children's Healthy Neighborhoods Healthy Families initiative. Since inception, Healthy Homes has impacted more than 900 properties on Columbus's South Side and Linden neighborhoods. Healthy Homes invested $52 million in affordable housing in South Side and Linden between 2022 and 2024.

Add 25 rental units to the South Side

From 2022 to 2044, Healthy Homes surpassed the goal and added 44 rental units to the South Side. Among the new units were four new duplexes along Reeb Avenue, providing convenient and affordable housing options for families supported by The Reeb Center on Columbus's South Side. The new rental units offer more than 1,300 square feet of space, three bedrooms and 1½ baths per home. The rent averages $920 per month, compared to the average rental for similar properties around $1,400 per month.

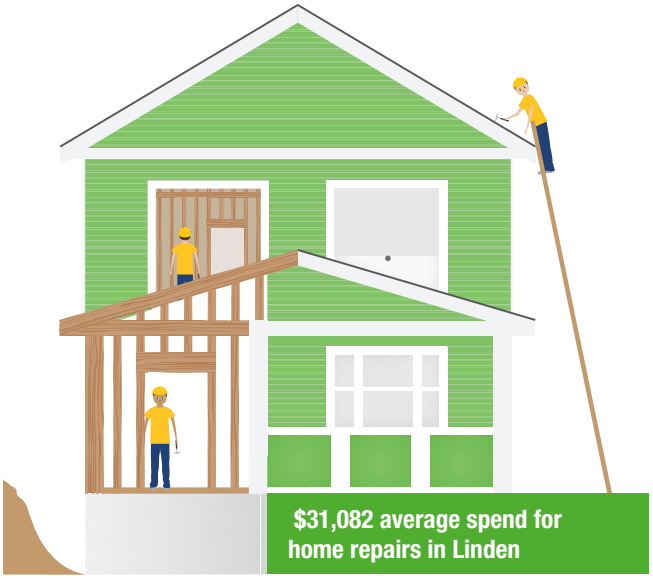
Complete 40 home repairs on the South Side

Home repairs are crucial for family safety and community development. Safe, well-maintained homes are essential for health, security and long-term residency. From 2022 to 2024, Healthy Homes completed 41 home repairs on the South Side. One home repair equals one house, representing a household that could remain in place, avoiding displacement and contributing to neighborhood stability.

A Healthy Homes' exterior home renovation that included a new roof, siding, windows, doors and porch railings.

Complete 200 home repairs in South and North Linden

Healthy Homes completed 170 home repairs in South and North Linden between 2022 and 2024. The repairs consisted of full exterior facelifts, which often included new roofs, windows, doors, porch railings, siding and more per property. These repairs are more than cosmetic — they are critical updates that allow residents to remain in their homes and avoid the risks of unsafe living conditions or forced relocation. While multiple repairs were happening for each home, one house was equal to one project. The amount of work required on each property maxed out grant funding before 200 properties could be completed. A large portion of the home repair projects in Linden required a full scope of repair, including a roof, siding and new windows. This maxed out the grant for each property, increasing the average spend per home, which was $31,082.



Add 80 scattered-site rental units to South and North Linden

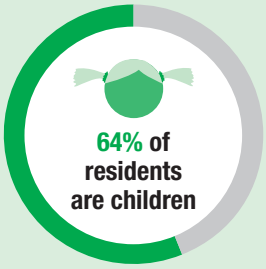
According to U.S. Department of Housing and Urban Development (HUD), scattered-site housing is a model of public housing where units are dispersed throughout different neighborhoods rather than concentrated in a single location. This provides several benefits, including reduced stigma associated with public housing and greater opportunities for residents to participate in community life. Scattered-site low-income housing may include single-family homes, duplexes, townhouse and small apartment buildings.

From 2022 to 2024, Healthy Homes added 80 scattered-site rental units to Linden.

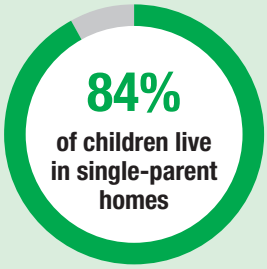
The average rent on a three-bedroom was $880. Most Healthy Homes properties are two- or three-bedroom single family homes with some duplexes and multi-family buildings.

Average Renter Profile:

Total Children:
308



Total Residents:
500



Median Household Income:

Healthy Homes Household:
$28,821

Average Healthy Homes Rent 3BR:
$875

Columbus Household:
$75,482

Average Columbus Rent 3BR:
$1,593

Families must meet certain qualifications to be eligible:

- Household income may not exceed 80% of area median income.
- Household income must be at least three times the asking rent. If the rent is $880 per month, then the household must make (pre-tax) $2,640/month. This represents a full-time worker who makes $16.50/hour.
- Section 8 housing vouchers are accepted. The household must have at least $300/month in income.
- No evictions within three years
- No past due balances owed to previous landlords or utilities
- No felonies or property crime

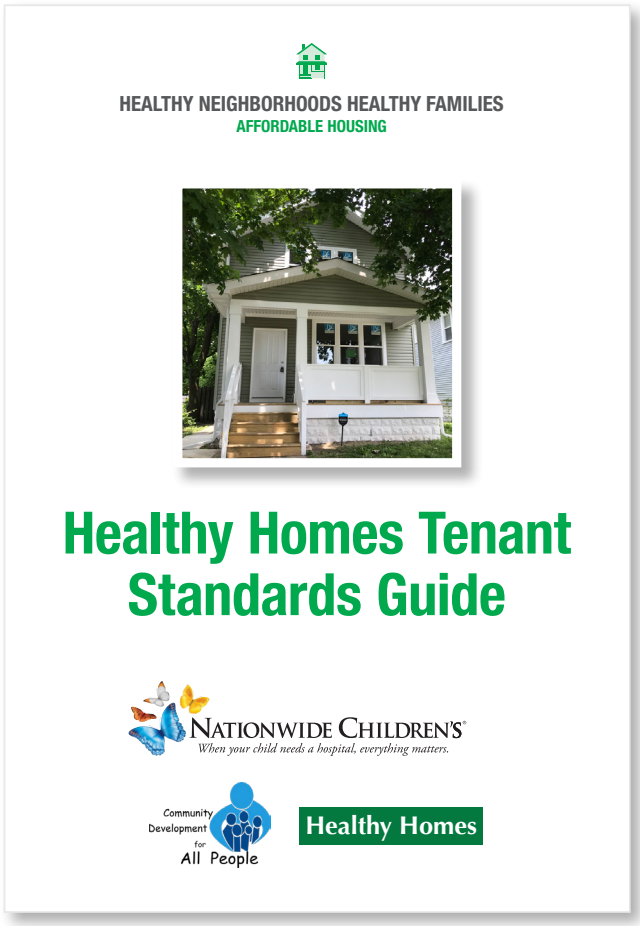
Add 60 homeownership units to South and North Linden through the Central Ohio Community Land Trust (COCLT)

Healthy Homes entered into an agreement with the Central Ohio Community Land Trust (COCLT). The COCLT works with developers like Healthy Homes to provide new construction homes on currently owned land bank lots in areas with high housing costs. COCLT holds the land in perpetuity and provides homes to income-eligible buyers, earning up to 120% of HUD-area median income, through a 99-year land lease. Community land trusts (CLT) are designed to provide community stewardship of land. They are primarily used to ensure long-term housing affordability. To do so, the land trust maintains ownership of the acquired land permanently.

This model creates permanent affordable homeownership opportunities. When a house is built on the land, only the house is sold, and the home buyer enters a long-term, renewable lease of the land. When the house is resold, the CLT and the homeowner share the increased equity using a market rate, appraisal-based resale formula. This allows the buyer to build wealth and the house to remain affordable for the subsequent home buyers.

Prior to Healthy Homes' partnership with the land trust, which started in 2019, homes were sold to income-eligible households. When those homes were resold, they were sold at market rate. In other words, the housing was only affordable for the first buyer. Under this partnership, Healthy Homes built 28 homes for homeownership in Linden through the COCLT. The homes were built in quick succession, so the plan pivoted to ensure all the available homes sold before more were built.

Continue tenant success meetings to educate renters on best practices for safe and healthy homes as well as information on other Healthy Neighborhoods Healthy Families services

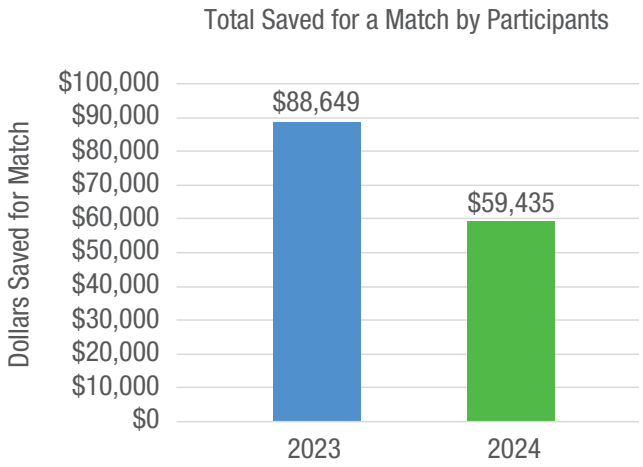


Healthy Homes previously offered resources to support rental home tenants. The Healthy Homes Tenant Standards Guide outlined interior and exterior maintenance expectations for renters and offered tips to ensure the homes remained neat, clean, compliant and in good repair. Tenant success meetings were held to educate renters on best practices for a safe and healthy home as well as information on other Healthy Neighborhoods Healthy Families services. In 2023, to better meet residents' needs, a tenant resource coordinator was hired. The tenant resource coordinator began reaching out directly to residents who needed assistance. In addition, the tenant resource coordinator began providing mentoring/coaching through the Nationwide Children's matched-savings program.

Continue financial stability initiatives including My Bridge 2 Success and expand Volunteer Income Tax Assistance Program (VITA)

As the Healthy Neighborhoods Healthy Families initiative at Nationwide Children's works to address concerns like stable housing and educational opportunities, it is also accelerating its efforts to get at a more basic concern: poverty. The initiative's career development and free tax preparation programs have made a difference for hundreds of families over the last five years. My Bridge 2 Success supports adults to become more economically mobile and even provides funds for families to overcome obstacles. Those funds can be put toward a vehicle, tuition or any number of other "bridges" that could ultimately break a family out of poverty. Between 2023 and 2024, a total of $148,084 was saved for a match by 60 participants.

My Bridge 2 Success Supports and Funds to Help Families Break the Cycle of Poverty



The hospital also partners with the United Way of Central Ohio to offer free tax preparation services. In 2024, Nationwide Children's and its volunteers completed more than 1,000 tax forms, helped return $1.8 million in refunds to Ohio families, and assisted many of those families in accessing tax credits they didn't know they could receive. Since the Tax Time partnership with Nationwide Children's began in 2019, volunteers have helped prepare taxes for more than 2,700 families and returned over $5.4 million in refunds.

Free Tax Preparation Clinics Help Over 2,700 Families Return More than $5 Million in Refunds

Increase filings for the Earned Income Tax Credit (EITC), especially for Black, female-led households

Some of the most important outcomes of increasing filings for the Earned Income Tax Credit (EITC) are related to improved maternal and child health. And yet, low rates of Black women who are pregnant or with young children seek tax preparation help or are aware of EITC and other tax credits as measured by attendance at tax sites, filings and awareness in maternal-child health settings in Columbus. An innovative partnership among central Ohio's infant mortality collaborative (CelebrateOne), the regional United Way VITA collaborative (Tax Time) and Nationwide Children's enhanced EITC filings and improved maternal-child outcomes.

CelebrateOne staff and agencies were trained in referral, outreach and the value of EITC and related tax credits, while Tax Time staff were trained in adverse childhood experiences (ACEs), risk and protective factors, and community referrals. Nationwide Children's managed the outreach and coordination activities, conducted an independent evaluation through its Center for Innovation, hosted project management staff, provided five new VITA tax preparation sites focused on women with young children from CelebrateOne neighborhoods, and monitored birth outcomes, maternal depression and child maltreatment reports.

There has been a particular focus on helping families claim Child Tax Credits and Earned Income Credits, which can be complicated for tax filers trying to complete returns on their own (or expensive for filers who are paying others for help). In 2024, families using the Nationwide Children's free tax service claimed more than $1.1 million in those credits.

Increase feelings of neighborhood safety through PlayStreets events

PlayStreets events are part of Nationwide Children's efforts to address and improve social determinants of health in local communities. These non-medical factors, which include neighborhood environments and social and community context, account for 80% of a person's health outcomes. PlayStreets events promote outdoor play and social interaction in communities. PlayStreets are block parties with recreational activities designed to encourage kids within the community to be physically active. Residents reported that the events made them feel connected to the community, and that PlayStreets made the neighborhood feel safer.

PlayStreets events have grown through the years. From 2022 to 2024, PlayStreets scheduled 12 events each year across Linden and South Side neighborhoods, including two new event locations, for a total of four locations.

In 2022, PlayStreets reached three attendance milestones. On August 20, 105 participants attended the South Side

event, signifying the first South Side event with over 100 child/youth participants. On August 27, 117 participants attended Linden, marking the largest child/youth count in the history of PlayStreets. In 2023, 2,372 people enjoyed PlayStreets events. By 2024, participation rose 21%, with 2,875 people attending.

PlayStreets Reach New Attendance Milestones

PlayStreets expanded from 2 to 4 locations from 2022 to 2024

Participation rose 21% in 2024

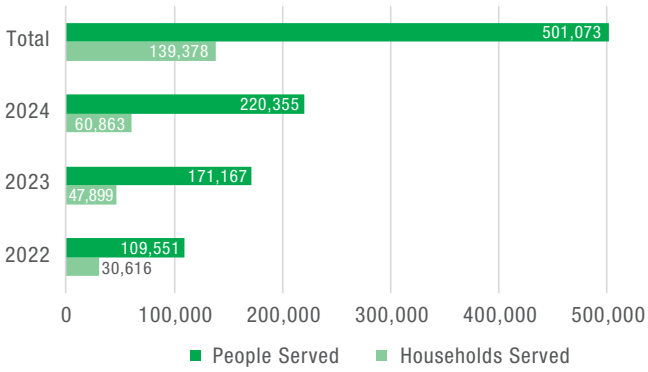
Serve more than 13,100 unduplicated families at the South Side Fresh Market by 2024

One of the most important factors for good health is access to fresh, nutritious food. Over 40% of Franklin County residents eat fruit less than once per day. Community members stated that having access to grocery stores is essential to eating healthily. However, grocery stores are not accessible enough, particularly in low-income neighborhoods. By contrast, corner stores often don't have nutritious foods, and restaurants cannot guarantee affordable prices. Because of access barriers to healthy food, Healthy Neighborhoods Healthy Families, Nationwide Children's and Community Development for All People created the All People's Fresh Market. Started in 2018, the free food market serves 40,000 people per year on the South Side of Columbus. In collaboration with the Mid-Ohio Food Collective, it's now the largest point of free fresh food distribution in the entire state of Ohio. Between 2022 and 2024, All People's Fresh Market in the South Side provided services to 758,486, representing 105,630 unique individuals. This superseded all goals set for families and individuals served.

Expand Linden Fresh Market reach between 44,000 and 46,000 annual visits by 2024

After years of planning, partnership and investment, the Linden Fresh Market opened in September 2021, providing fresh food in an area that was a food desert. The Linden Market partners with Mid-Ohio Food Collective to distribute free food in Ohio. The market focuses on health and provides market members with free, fresh produce to any household earning less than 200% of the federal poverty guidelines. People in the community who qualify can become members by stopping by the market during open hours and bringing photo identification. Between 2022 and 2024, the Linden Fresh Market served 139,378 households and 501,073 people. The Linden Fresh Market was able to drastically outperform all goals set for households and people served by the end of 2024.

Families and Households Served by the Linden Fresh Market



Racial Equity

EFFECTS ON ECONOMIC AND HOUSING STABILITY

2022 Implementation Strategy Initiatives:

To help improve racial disparities in economic and housing stability, Nationwide Children's committed to:

- Create or preserve 1,000 units total (from when work began in 2008) of affordable housing on the South Side.
- Create goals in collaboration with stakeholders for developing affordable housing in Linden by 2025 and by improving 100 to 150 homes and developing 20 to 30 homes and 50 rental units by 2025.
- Increase the number of underrepresented minority community members who participate in workforce development programs and obtain a living wage career pathway as a result.
- Increase the number of jobs and businesses created within the community.
- Increase the underrepresented minority youth employment rate in the community.
- Increase the percentage of Nationwide Children's purchases from local underrepresented minority businesses.
- Increase kindergarten readiness of underrepresented minority children in Linden and the South Side.
- Reduce chronic absenteeism by underrepresented minority children in Linden and the South Side.
- Increase high school graduation of underrepresented minority children in Linden and the South Side.
- Improve the sense of community and engagement as reported through neighborhood programming.

In *HealthMap**2022***, racial equity tied with behavioral health as the second highest priority in Franklin County. Practices of racial and ethnic discrimination, including redlining, preclude residents' access to economic stability, quality health care services, and optimal maternal and infant health outcomes, among other health needs.

Create or preserve 1,000 units total (from when work began in 2008) of affordable housing on the South Side

Safe, affordable housing can bring stability to a family unit, allowing the family to focus on the children's education, the parents' employment and the family's health and safety. Since 2008, Healthy Homes, the affordable housing arm of Nationwide Children's Healthy Neighborhoods Healthy Families initiative, has created or preserved 950 units of affordable housing on the South Side. Healthy Neighborhoods Healthy Families has now expanded to the Linden area, where it continues affordable housing work.

Create goals in collaboration with stakeholders for developing affordable housing in Linden by 2025 and by improving 100 to 150 homes and developing 20 to 30 homes and 50 rental units by 2025

Healthy Homes worked with several central Ohio partners to develop and improve homes and rental properties. Community partners included Central Ohio Community Land Trust, City of Columbus, Community Development for All People, Nationwide Insurance, Ohio Capital Finance Corporation and Turner Construction. Some of the projects included affordable housing initiatives in Linden, home repair programs in Linden, redeveloping a former hardware store site in North Linden into affordable apartment units and homes, adding new duplexes on Reeb Avenue on the South Side, and new accessory dwelling units (ADU) on the South Side. An ADU is a separate living space on a person's property that can be rented out or used by family members.

Healthy Homes Accomplishments from 2022 to 2024

Homes Built for Homeownership
28

Homes Improved in Linden
170

Rental Units Added
80

Increase the number of underrepresented minority community members who participate in workforce development programs and obtain a living wage career pathway as a result

Healthy Neighborhoods Healthy Families' Youth Engagement programs and career pathways are designed to connect young professionals to their career goals while positively impacting high school graduation rates through its Summer Youth Employment Program and High School Career Academy. This is achieved through career exploration and opportunities to obtain certifications using a hands-on, engaging approach. The desired outcome is to build relationships with young professionals, ultimately becoming an employer of choice.

This initiative was successfully achieved through enhanced engagement and a stronger presence in local schools. Additionally, collaboration opportunities with key community partners — including Partnership4Success, Franklin County Job and Family Services, the Department of Education and Workforce and the Educational Service Center of Central Ohio — played a vital role in its success. Active participation on career center and high school advisory boards also contributed to this accomplishment. Throughout 2022 to 2024, 273 young adults participated in the program, with 32 participants accepting employment offers at Nationwide Children's after completing the program. Of those 32 participants, 13 of them reside in Healthy Neighborhoods Healthy Families zip codes.

2022 to 2024: Youth Engagement and Workforce Development Programs

273
PARTICIPANTS in programs

32 ACCEPTED employment offers at Nationwide Children's

BOOST is a free work readiness training and coaching program for community residents, ages 18 and older, designed to help them get a job and grow their career. Classes are offered monthly, successfully preparing residents for full-time employment with starting wage at $18/hour. Sixty-two residents from South Side graduated from the BOOST program. Thirty six graduates landed jobs in 2024, and eight of those hires joined Nationwide Children's. Forty-four residents from Linden graduated from the BOOST program in 2024, and 37 graduates landed jobs.

Increase the number of jobs and businesses created within the community

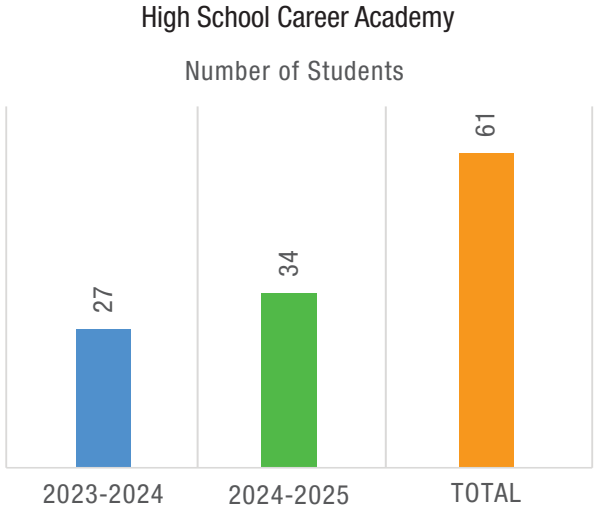
Nationwide Children's has assisted in establishing the Community Impact Council and the Community Impact Fund. This initiative is designed to acquire small businesses in low- to moderate-income communities and convert them into employee-owned enterprises. This movement helps create jobs, build sustainable careers and fosters generational wealth. Transitioning ownership to employees helps preserve local businesses, uplift neighborhoods and build pathways to wealth-building for families who have historically been excluded from ownership opportunities.

In addition, through workforce development and hiring initiatives, 100 Linden residents have been hired at Nationwide Children's and 21 residents have been hired by partner employers in 2024. A total of 202 South Side residents have been hired at Nationwide Children's, and 22 residents have been hired by partner employers as a result of the workforce development and hiring initiatives throughout 2024.

Increase the underrepresented minority youth employment rate in the community

Nationwide Children's hosts youth and young adults (ages 16 to 24) for paid summer work learning experiences through its Summer Youth Employment Program. Students learn, build their skills and gain valuable work experience within a health care setting.

In addition, Nationwide Children's hosts the High School Career Academy for 11th and 12th-grade students enrolled in the Columbus City and Reynoldsburg school districts. This six-month program introduces students to various health care professional tracks through paid shadowing experiences, with the opportunity to obtain industry-recognized credentials. The High School Career Academy provides students with opportunities to gain hands-on experience in an environment that develops leadership character and confidence toward navigating a successful health care career. Students receive training and education on CPR, HIPAA and protecting patient health information, medical terminology, financial literacy, interview skills, resume writing, networking and more.

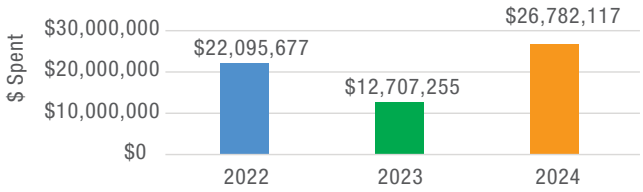


Students practice CPR at Career Academy at Nationwide Children's.

Increase the percentage of Nationwide Children's purchases from local underrepresented minority businesses

As an anchor institution in the community, Nationwide Children's continues to invest in the community and lead in creating safe and healthy spaces where individuals can work, live and thrive in their neighborhoods. Working, living and volunteering in communities around Nationwide Children's all contribute to the economic development program. For some projects, a lot of spend includes furniture from King Business Interiors, a woman-owned business which can add a few million in year over year variation. The decrease in 2023 was most likely due to fluctuations in furniture spend on new construction projects. There was a 21.2% increase in purchases from local underrepresented minority businesses from 2022 to 2024.

Tier 1 Diversity Spend



Increase kindergarten readiness of underrepresented minority children in Linden and the South Side

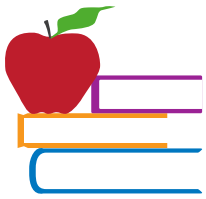
According to *HealthMap**2022***, Columbus City Schools District was among the school districts in Franklin County with the lowest rates of kindergarten readiness. Graduation rates and future educational attainment can be impacted by a child's proficiency in school, measured as early as kindergarten. We know that education is the foundation for lifelong success. That's why Nationwide Children's and Healthy Neighborhoods Healthy Families initiative supports a number of programs to improve educational outcomes focused on school readiness and mentorship. Supporting Partnerships to Assure Ready Kids (SPARK) helps prepare children for kindergarten by working with families, schools and the community to engage up to 80 preschool-age children per year. Through a home visit each month, children receive a new book, an activity and educational supplies, and participate in learning opportunities — all with the goal of increasing the child's success in school and life. The program also helps develop parents as children's first — and best — teachers.

Children who have been in the SPARK program do better on school tests than children who have not been in SPARK. Two important components of SPARK include Get Ready to Read! and Preschool Early Numeracy Screener. Get Ready to Read! is a screening tool used to determine if a child has the early reading and writing skills necessary to enter kindergarten. The Preschool Early Numeracy Screener (PENS) measures the numeracy skills of children ages 3 through 5. From 2022 to 2024, 299 children were enrolled in SPARK and 214 successfully transitioned from SPARK to kindergarten.

SPARK Enrollment

214 STUDENTS
Transitioned From SPARK to Kindergarten (2022 to 2024)

299 STUDENTS
Enrolled in SPARK (2022 to 2024)

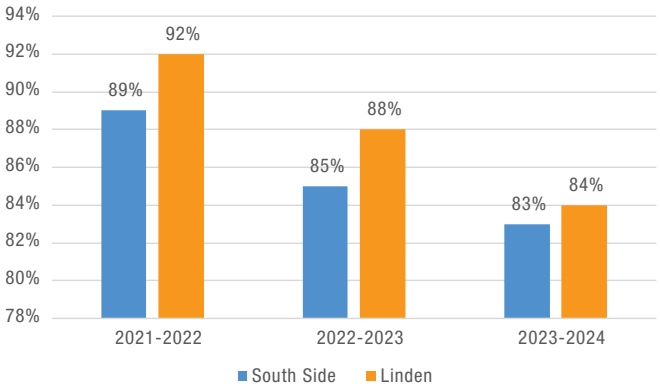


Supporting Partnerships to Assure Ready Kids (SPARK)

Percentage of chronic absenteeism by underrepresented minority children in Linden and the South Side

Several factors contribute to a student's school attendance and their ability to graduate on time. Although chronic absenteeism is decreasing, there are still fewer students graduating from schools in focus neighborhoods. People who receive a high school diploma have better health and economic outcomes.

Percentage of Chronic Absenteeism in Linden and South Side Students



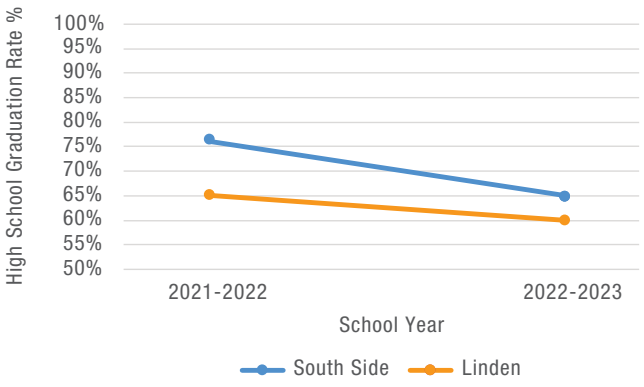
Increase high school graduation of underrepresented minority children in Linden and the South Side

There are several factors that contribute to a student's school attendance and their ability to graduate on time. Although chronic absenteeism is decreasing, fewer students are graduating from schools in Healthy Neighborhoods Healthy Families focus neighborhoods. Part of this can be explained by the open enrollment policy within Columbus City Schools, which allows students to choose a school outside of their neighborhood. Many programs, such as Upward Bound Math and Science and the Youth Employment programs, enroll students who live in the catchment areas of these focus neighborhoods, but attend schools outside of the South Side or Linden. Consequently, their progress isn't reflected in the graduation and attendance goals tied specifically to these neighborhood schools.

Students who participated in Be The One at Linden-McKinley STEM Academy and Upward Bound Math and Science are more likely to graduate. Be The One focuses on students who may be at risk for not graduating, often because they have experienced family trauma, are unhoused, or had other adverse childhood experiences, or ACEs. The program has led to increases in graduation rates, fewer suspensions, less frequently missed classes and other successes.

In the last year, Healthy Neighborhoods Healthy Families became more intentional about recruiting students who attend South Side and Linden schools directly for these programs, to better align with the original goals.

High School Graduation Rates for Linden and South Side Students



Improve the sense of community and engagement as reported through neighborhood programming

To build a sense of community and neighborhood pride, in 2023, Nationwide Children's hosted the first annual Linden Fall Festival at the Linden Fresh Market. The event drew 800 community members and 11 community partners. The team distributed 646 free meals, 150 resource bags and $6,000 in winter accessory giveaways by the Linden Primary Care Center. In 2024, the event grew to 1,400 attendees, 1,400 resources distributed and 900 meals served. The festival featured performances from the Linden-McKinley High School band and cheerleaders, free haircuts, bounce houses and fall-themed activities to celebrate the Linden community and bring partners together.

Select Nationwide Children's Primary Care Centers throughout Franklin County hosted annual summer festivals, back-to-school bashes, fall coat events and more for hundreds of families to increase community involvement while providing a safe and fun community environment for families.

Another way Nationwide Children's is building community is through the Proud Linden Parent Program, launched in 2022. This free program is for parents and caregivers living in the Linden neighborhood. The 11-week program allows parents and caregivers to connect with each other and learn skills and techniques for raising strong, healthy children. Between 2022 and 2024, eight cohorts of parents graduated from the program. Each cohort averaged 10 to 12 adults, with three to four children per adult, thereby affecting over 300 children.

To maintain strong community ties beyond the program, facilitators keep in touch with alumni through regular communication and invitations to special events such as graduation ceremonies and the annual holiday party. Many alumni share their experiences through testimonials and word of mouth, helping to recruit new participants and expand the program's positive impact throughout the Linden community. Since its inception, the program has impacted 140 families and counting.

EFFECTS ON QUALITY HEALTH CARE, MENTAL HEALTH AND SAFETY

2022 Implementation Strategy Initiatives:

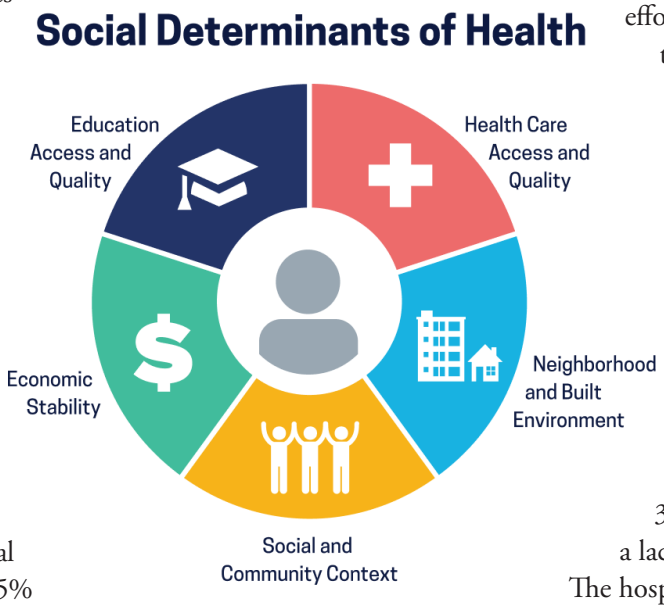
To help improve racial disparities in quality health care, mental health and safety, Nationwide Children's committed to:

- Increase the percentage of Nationwide Children's patients receiving a social determinants of health screen.
- Reduce visits of children with incarcerated parents, ages 2 to 18, seen at Nationwide Children's for a well-child check with behavioral health concern from 50% to 25% by 2023.
- Create a coordinated health care response for detained youth as measured by a 50% increase in the number of youths, and youths of color, who receive provider-recommended health care during detention and at three months after release by the end of 2022 and sustain for one year.

There's increasing consensus that health care providers can improve children's lives by paying attention to social determinants of health, or what are sometimes called health-related social needs. Social determinants of health are non-medical factors that affect health outcomes, such as food security, stable housing and similar concerns. All of these can make a big difference to a child's well-being.

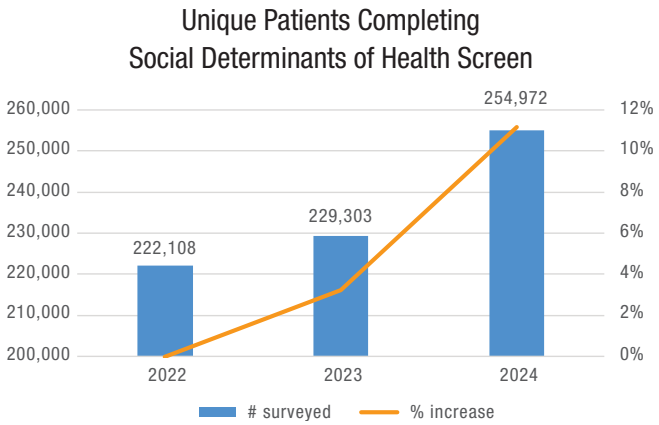
Increase the percentage of Nationwide Children's patients receiving a social determinants of health (SDoH) screen

Nationwide Children's has implemented the SDoH screen to the majority of outpatient settings, screening more than 250,000 families in 2024. Plans for expansion include (1) implementation of the SDoH screening in the Behavioral Health outpatient service areas and (2) implementation of the SDoH screening via MyChart in one pilot location.



A recent study from Nationwide Children's examined the hospital's efforts to improve screening through electronic medical records, to keep screening levels high once they were improved, and to connect families to help they needed.

Among many other findings, researchers discovered that nearly 10% of families screened did have at least one social need, and 3% had an urgent need (like a lack of a safe place to sleep). The hospital was able to complete social work consultations with 85% of families in need within seven days.



Reduce visits of children with incarcerated parents, ages 2 to 18, seen at Nationwide Children's for a well-child check with behavioral health concern from 50% to 25% by 2023

There are national shortages in the behavioral health space, and Nationwide Children's often sees that demand outweighs capacity. This goal shifted focus from well-child checks to prioritize bringing together children and families affected by incarcerated fathers in Franklin County. Intentional child time and parent-child relationships are important protective factors in building a child's mental health and wellness.

The Office of Justice Policy and Programs was the recipient of the Second Chance Act Grant, addressing the needs of incarcerated parents and their children. Nationwide Children's is a subrecipient of this Department of Justice grant to link social and health services to the families of incarcerated fathers who are being actively detained at a community-based correctional facility.

Through PACT (Parents and Children Together), the goal was to serve 50 fathers, 25 caregivers and up to 125 children per grant year. Nationwide Children's administers a social determinants of health screening to families to understand and address the medical and non-medical factors that influence the child's well-being. Providing a wraparound service, program administrators track and monitor families' progress and adjust as needed. Resources like gift cards (e.g., gas cards, grocery cards), laptops and books about parental incarceration are provided to families to help encourage program involvement and build trust with the families following the household needs assessment. Based on the needs identified during the assessment, families and children are referred to a range of supportive services and programs, including behavioral health and family therapy.

Simultaneously, the men receive a curriculum rooted in evidence-based practices. The fatherhood program helps fathers confirm or establish reasonable and healthy beliefs regarding personal and family alcohol/drug use or non-use based on their personal experience. The Developing Positive Parental Influences curriculum helps fathers recognize how children with substance-misusing parents are affected. This course helps participants develop a healthy and informed understanding of alcoholism by learning to recognize it as a disease that has early, middle and late stages, with recognizable effects on family, friends and other relationships.

Upon completing the program, fathers receive a graduation letter highlighting the skills they learned and practiced becoming better fathers. The PACT program focuses on reflective thinking, co-parenting, substance misuse and information on how to connect their child to supportive services.

Nationwide Children's also created a Family Engagement Day that offers fathers and their children a chance to spend quality time together, fostering positive relationships and strengthening bonds. This is a safe, non-judgmental atmosphere where families can interact, communicate and express emotions freely while enjoying food, music and games. This day has contributed to the emotional well-being of both fathers and their children. Since the program's inception, 188 children have participated in Family Engagement Day.

Create a coordinated health care response for detained youth as measured by a 50% increase in the number of youth, and youth of color, who receive provider-recommended health care during detention and at three months after release by the end of 2022 and sustain for one year

Nearly 70% of young people in juvenile detention centers have an unmet health care need. These centers are designed for short stays while a case is adjudicated or other arrangements are found, but some stay weeks, months or years. Nationwide Children's and the Franklin County Juvenile Intervention Center have developed a partnership to create a primary care clinic inside the center.

Due to the difficulty of measuring provider recommended care while in detention because of the unknown release date and tracking follow-up care once re-entering society, the team revised the aim to be "Increase the completion of care goals closed done for youth detained in the Juvenile Intervention Center (JIC) and enrolled in Partners For Kids' Care Coordination Program from 49% to 70% by December 2024 and sustain for a year." The revised aim eliminated reference

to provider-recommended care, which was essentially impossible to measure, given the uncertainty of length of stay and follow-up once released from the JIC.

The revised aim is now measured by monthly quality improvement meetings and tracking ICD-10 codes.

Between 2022 and 2024, 582 Care Coordination referrals were made for youth at the JIC.

Throughout 2023 and 2024, more than 7,000 health care visits were completed at the JIC, ranging from well visits, behavioral health needs, care for chronic conditions, STI testing and treatment, contraception access and more.

EFFECTS ON MATERNAL AND INFANT HEALTH OUTCOMES

2022 Implementation Strategy Initiatives:

To help improve racial disparities in maternal and infant health outcomes, Nationwide Children's committed to:

- Improve pediatric health outcomes in underrepresented minority children by increasing prevention measures including well child visits, immunizations, students exposed to evidence-based health education and teen pregnancy prevention.
- Evaluate behavioral health access including depression screening and links to behavioral health care services.
- Increase the percentage of Nationwide Children's patients receiving a social determinants of health (SDoH) screen.
- Implement one intervention aimed specifically at reducing racial disparity in each pediatric vital sign measure.

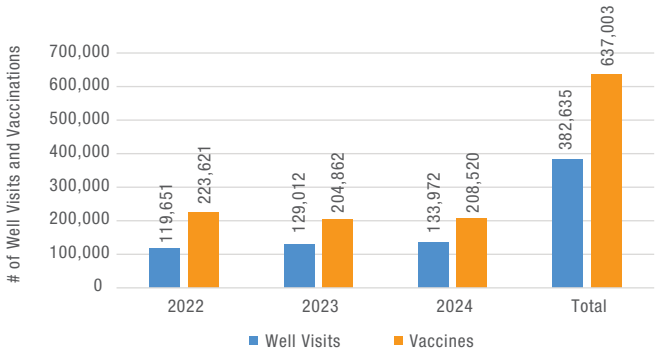
The infant mortality rate among Black infants had decreased from 2022 since the 2019 *HealthMap* (from 15.2 to 11.4 per 1,000 live births) but remained considerably higher than White infants (4.3 per 1,000 live births). Rates of infant mortality among Black infants remained significantly higher than other racial and ethnic groups. Since 2015, CelebrateOne, OBBO, Nationwide Children's and other partners have implemented action steps in safe sleep education, prematurity prevention and early access to prenatal care. This work has resulted in a reduction of the Franklin County infant mortality rate by 20%. Despite this progress, the unacceptable racial disparity still exists. The new phase of the CelebrateOne 2021 to 2026 strategic plan is aimed at accelerating the decrease in Black infant mortality.

Improve pediatric health outcomes in underrepresented minority children by increasing prevention measures including well child visits, immunizations, students exposed to evidence-based health education and teen pregnancy prevention

Between 2022 and 2024, Nationwide Children's Primary Care Network experienced progress in well child visits and immunizations. These are both foundational components of preventive health care for children, providing opportunities for early detection of developmental, behavioral and physical health issues, allowing for timely intervention and support. Immunizations administered during these visits are essential for protecting children from vaccine-preventable diseases and maintaining community-wide herd immunity.

There was a consistent increase in well child visits, reflecting improved access to care. Although immunization rates declined from 2022 to 2023 — likely attributed to targeted "catch-up" vaccination efforts in 2022 after the COVID-19 pandemic — there was a rebound in 2024.

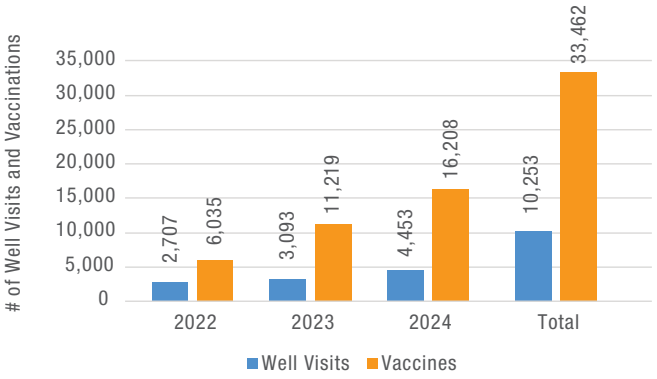
Primary Care Network Well Visits and Vaccinations



Nationwide Children's operates one of the most comprehensive school-based health programs in the United States, which has an important, positive impact on the children of central Ohio. The school-based health centers offer health care to students, families and

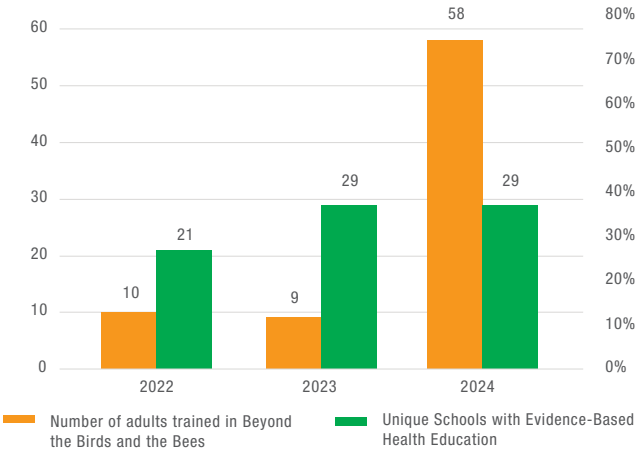
community members. Providers work on-site to provide primary care services, mental health counseling, asthma therapy care and more. Throughout 2022 to 2024, the amount of well visits and immunizations provided at school-based health centers has increased significantly, reflecting its expanding reach. By embedding these services directly within schools, the program removes several critical barriers to care, meeting students where they are, to ensure their health needs are addressed in a timely and supportive environment.

School-based Health Well Visits and Vaccinations



In Franklin County, 29 schools offer evidence-based health education, a 38% increase since 2021. The School Health Education team delivered evidence-based curriculum, Making Proud Choices, at 30 schools in 2024, as well as four development sessions offered to Columbus City Schools teachers. The curriculum aims to empower adolescents to make positive behavior changes to reduce their risk of an unplanned pregnancy and protect themselves from sexually transmitted infections (STIs).

Teen Pregnancy Scorecard



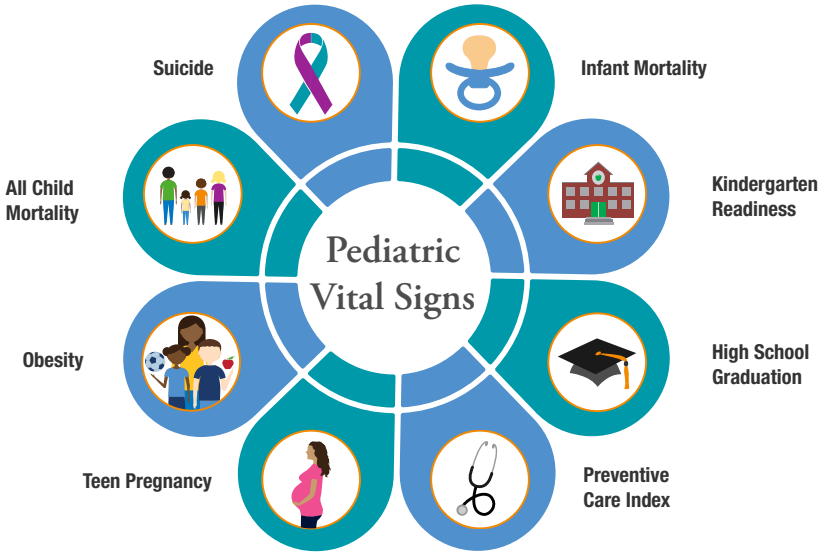
Evaluate behavioral health access including depression screening and links to behavioral health care services

Postpartum depression (PPD) screenings during pediatric well-baby visits are essential for supporting both parent and child health. If left untreated, PPD can interfere with a parent's ability to bond with and care for their baby, which may lead to lower breastfeeding rates and increase the risk of toxic stress. Nationwide Children's Primary Care Network is in a unique position to identify signs of depression early by screening and connecting parents to care at the 1-, 2-, 4- and 6-month well-infant visits. After starting the screening process on iPads, the percentage of completed screenings increased from 59% at the end of 2021, to 87% by the end of 2023.

Increase the percentage of Nationwide Children's patients receiving a social determinants of health (SDoH) screen

In 2020, Nationwide Children's began a first-of-its-kind initiative to measure and improve the well-being of an entire population of children, called Pediatric Vital Signs. The hospital and a coalition of community partners identified eight metrics, or Vital Signs, throughout the span of childhood — from infant mortality rate to high school graduation rates — that could be proxies for child health in Franklin County, Ohio.

Using that data, the coalition could work to improve health for every child. The goals were certain of clear improvements in the metrics by 2030. Nationwide Children's has implemented the SDoH screen to the majority of outpatient settings, screening more than 240,000 families in 2024. Plans for expansion include (1) implementation of the SDoH screening in the Behavioral Health outpatient service areas and (2) implementation of the SDoH screening via MyChart in one pilot location.



Implement one intervention aimed specifically at reducing racial disparity in each pediatric vital sign measure

Infant mortality

In Ohio, Black infants are three times as likely to die as White infants. Continuing education across the continuum of care is crucial to combat racial disparities and improve health outcomes for Black women and their families. As a result, a new continuing education series, titled *Addressing Health Equity in Maternal and Infant Health*, was launched in 2023. Since the conception of this free community-wide education, there has been a steady increase in participation, including health care partners from prenatal care to labor and delivery to perinatal support providers. Topics include Intersectionality and Cultural Humility, Investigating Your Relationship to Black Pain, Why Health Equity Should Matter to You and more.

Kindergarten readiness

Addressing book access is a vital aspect of the work. Dolly Parton's Imagination Library of Ohio mails children one free book each month until their fifth birthday. Research shows that a child's brain is 80% developed before turning three. The Imagination Library's high-quality, age-appropriate books help children develop critical early literacy skills before starting kindergarten. Imagination Library helped 44,378 (53%) children enrolled in Franklin County, with 43% enrollment in Healthy Neighborhoods Healthy Families neighborhoods of South Side and Linden. There is also a focus on layering interventions in some neighborhoods such as Linden where there are lower kindergarten readiness assessment (KRA) scores.

Nationwide Children's Linden Primary Care Center completed 818 kindergarten readiness assessments for children ages 3 to 4 throughout 2022 to 2024. This assessment evaluates mathematics, language and literacy, as well as physical well-being, motor development and social foundations like emotional development and approaches to learning. This tool is valuable to pass along to students' teachers to help them understand their individual students' unique needs.

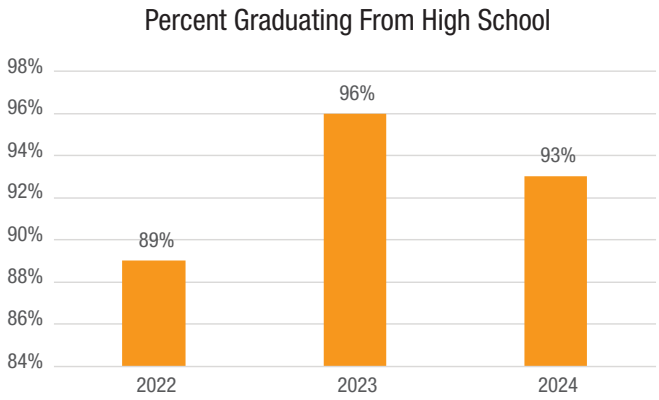
Local Layering | Linden Example

- Whitehall, Reynoldsburg, and Linden communities have low kindergarten readiness assessment (KRA) scores – 5,975 0–5-year-olds in Linden (2020 U.S. Census)
- In 2023, 725 kindergartners were enrolled across 11 Linden elementaries – 150 (21%) were ready and 575 (79%) were not ready

Nationwide Children's Care Sites	SPARK	Proud Linden Parent Program	Apprenticeships
• 2,292 6-month-olds to 5-year-olds seen at Linden Primary Care Center in 2024 • Kindergarten readiness coordinator, community health worker and parent coach at Linden Primary Care Center • Reach Out and Read/ Imagination Library • 488 0–5-year-olds seen across Behavioral Health	• 35 graduates in 2024	• 9th cohort started in March • 60 graduates and more than 120 children reached	• 4 new child development associate professionals and 4 in training

High school graduation

The Nationwide Children's TRIO Upward Bound Math & Science (UBMS) grant provides free, year-round, college and career readiness programs to first-generation, low-income high school students. Nationwide Children's UBMS is designed to enhance the academic and personal skills of students while preparing for college admission, retention and graduation. With a STEM foundation and curriculum, Nationwide Children's UBMS aims to increase

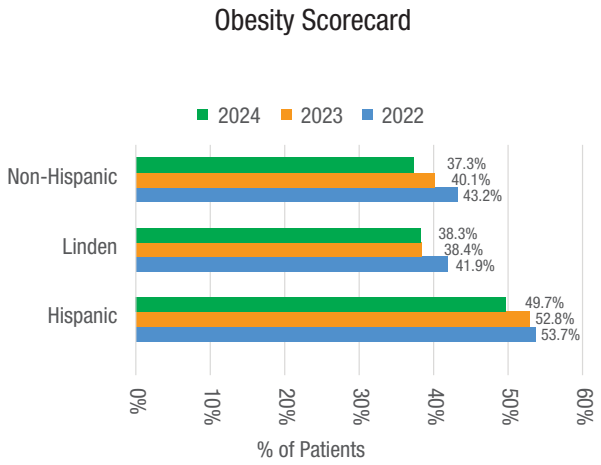


the number of students who pursue postsecondary career opportunities in math and science fields. These figures show the percentage of seniors connected to high-impact interventions who graduated.

Obesity

The high prevalence of obesity; the disparities in the risk of obesity based on race, ethnicity and socioeconomic status; and the serious short- and long-term effects of childhood obesity led to the selection of obesity as a Pediatric Vital Signs (PVS) indicator.

When considering interventions for underrepresented minorities, some focus has been paid to both Linden and the Hispanic communities:



In 2022, some interventions specific to the Linden community included the Be The One project and a cooking class at Linden McKinley, monthly community cooking classes at Linden Community Center and a physical activity step challenge in Linden schools. In 2023, programs included Safety City and the Fresh Connect pilot program. In 2024, MyPlate placemats were added in schools. These free placemats from myplate.gov offer healthy eating tips, nutrition guidelines and physical activity suggestions. That same year, school gardening started at Marion Franklin on the South Side.

Teenage pregnancy

One of the ways Nationwide Children's has been working to combat unintended teen pregnancy is through the Contraceptive Access Collaborative (CAC), which is a multidisciplinary group including voices from Rheumatology, Neurology, Pediatric Adolescent Gynecology, Hospital Pediatrics, School Health and more.

The percentage of teens ages 15-19 on a prescribed contraceptive at time of a Nationwide Children's visit has stayed relatively the same throughout 2022 to 2024. The Collaborative has also created pathways for providers to help them in prescribing birth control and consumer facing materials to help teens and parents and caregivers.

Provider education continues to be a key strategy in preventing teen pregnancy. The Personal Responsibility Education Program (PREP) conducted several on-site trainings with regional and local providers. Between April and July 2024, PREP facilitated implant training and privileging with an advanced practice nurse at Star House, a drop-in center for unhoused youth. In July and December, they hosted Adolescent Sexual and Reproductive Health Best Practices sessions with Partners For Kids. In August, they offered an on-demand training titled *Coercion-Free Contraception* for providers at Federally Qualified Health Center Lower Lights. September featured a Reproductive Choices Workshop with the Center for Healthy Families' Peer Group, and in December, they delivered a training on the birth control implant Nexplanon®. The team remains actively involved in implementing a community engagement plan and continues to incorporate youth voices into future plans.

> **In 2023, 30 schools completed the Making Proud Choices evidence-based curriculum.**

> **In 2024, youth participation in Ohio Personal Responsibility Education Program (PREP) increased by 65%.**

Suicide

Expanding partnerships in Franklin County will help to identify and support vulnerable populations (e.g., Black youth, LGBTQ+ youth, immigrant/refugee youth, youth in foster care, youth in the juvenile justice system,

youth in low income/resource families and rural youth). Boys and Girls Clubs in Franklin County received standardized suicide prevention training with curriculum developed by the Center for Suicide Prevention and Research (CSPR) at Nationwide Children's. Youth received the 10-session curriculum focusing on awareness, coping and reduction of suicidal behavior with demonstration of increased knowledge and staff preparedness to support youth in crisis.

From 2022 to 2024, CSPR provided over 126 trainings to more than 3,500 trusted adults in the community. Examples of nuanced trainings include general trusted adults, foster and adoptive care providers, postvention, trauma informed, faith-based communities, LGBTQ+ youth, Latino youth, youth with physical disabilities, first responders working with youth and transition age youth. Community organizations can request custom trainings with a suicide prevention focus as well.

All-cause child mortality

The child mortality rate in Franklin County has decreased from nearly 36 per 100,000 in 2021 to 29.4 per 100,000 in 2024. While about half of these deaths were from medical causes, a significant number of deaths were caused by preventable injuries.

In response to alarming child mortality rates in Franklin County, Nationwide Children's and the City of Columbus reintroduced Safety City in 2022. This free injury-prevention program is designed to reach young children ages 5 to 7 with life-saving education. Originally popular in suburban communities, Safety City was brought into Columbus neighborhoods (Hilltop, Linden, Franklinton and more) to increase equitable access. With support from Columbus firefighters, police officers and public health professionals, children learn about bike safety, water safety, firearm safety, poison prevention and more — all in a fun, engaging environment. The four-day curriculum has reached hundreds of children over the past few years, and the work continues.

Children practice crosswalk safety at Safety City

Preventive services delivery

The preventive services delivery aim is considered a hybrid measure. It consists of increasing the composite score of recommended preventive services including breastfeeding and maternal depression screening, primary vaccination series, fluoride varnish application, lead screening, adolescent depression screening and sexually transmitted infections screening. This Pediatric Vital Sign remains in the early stages, so there are not yet metrics to report on. However, several initiatives have been implemented to address preventive services delivery:

Breastfeeding and maternal depression screening

- Integrating lactation consultants into Primary Care Centers to provide breastfeeding education and assistance into routine pediatric visits
- Offering peer counseling, lactation consultations and breastfeeding supplies to low-income families at Nationwide Children's WIC (Women, Infants and Children) clinic
- Completing maternal depression screenings at every well-baby visit from birth to 6 months

Primary vaccination series

- Partnering with schools and public health departments to offer vaccines in accessible settings
- Using reminder systems in MyChart at Primary Care Centers to ensure patients stay on schedule with immunizations

Fluoride varnish application

- Offering at each cleaning. In 2024, Nationwide Children's Dental Clinic saw 33,081 patients
- Offering at School-Based Health Dental Centers. Throughout 2022 and 2024, there were 5,164 dentistry visits

Lead screening

- Offering community education to families about the dangers of lead and how to reduce exposure
- Screening children living in older housing or high-risk neighborhood at primary care visits

Adolescent depression screening

- Providing routine mental health checks at Primary Care Centers during well visits for youth ages 12 to 18
- Integrating behavioral health into Primary Care Centers: 12 out of 14 centers have on-site psychologists to offer immediate support and referrals when screenings indicate concern

Sexually transmitted infections screening

- Screening sexually active adolescents, especially females under 25, annually for STIs at the Pediatric and Adolescent Gynecology clinic

Behavioral Health

ACCESS TO MENTAL HEALTH CARE RESOURCES AND SCREENING FOR MENTAL HEALTH CARE ISSUES

2022 Implementation Strategy Initiatives:

To improve access to mental health care resources and screening for mental health care issues, Nationwide Children's committed to:

- Extend MRSS crisis services to Franklin County residents through OhioRISE.
- Develop the clinical pathway for safer suicide care at Nationwide Children's for patients presenting to Nationwide Children's locations with a primary behavioral health concern or who are otherwise identified as being at risk for suicide. This includes:
  - Continuing adoption and expansion of safer suicide care practices throughout Nationwide Children's non-behavioral health departments, including standardized screening, assessment and safety planning, with the ultimate goal of universal screening.
  - Renewing focus on best-practice suicide care in Nationwide Children's crisis services utilizing evidence-based, suicide-specific treatments within behavioral health (Examples: Collaborative Assessment and Management of Suicidality, Safety Planning Intervention and Safe Alternatives for Teens & Youths).
  - Defining and building an extended "wrap around" treatment pathway for youth with chronic suicidality.
  - Supporting a workforce that is educated (competent) and confidently trained in relation to suicide assessment and management.
  - Creating effective handoff communication tools internal and external to Nationwide Children's.
  - Implementing a postvention process that utilizes existing programs to support staff and communities affected by suicide.
- Increase ECHO practice sessions by 10% each year.
- Increase Behavioral Health - Treatment Insights and Provider Support (BH-TIPS) calls by 20%.
- Engage 50 practices in Behavioral Health Integration.
- Continue community efforts to disseminate safer suicide care among youth in Ohio. This includes:
  - Train nine Ohio community providers (including regional hospitals, behavioral health practices, and primary care practices) on standardized tools for screening, assessment and intervention.
  - Disseminate school-based prevention programming throughout Ohio and increase PAX programming to one more school per year with saturation in Franklin County.
  - Continue participation with suicide collaboratives in the community, including OCHA, Cardinal Health and Ohio Zero Suicide.
  - Create a Teen Advisory Board.

Screening and treatment for mental health care is complicated by the stigma associated with mental illness. Children's mental health has been called a national crisis by a former United States surgeon general. Provider access also presents a challenge, as mental health providers have higher ratios of residents to a single practitioner compared to other types of health practitioners. Expanding access by training non-behavioral health providers, implementing school-based preventions and extending crisis services all remained high-priority action items from 2022 to 2024.

Extend MRSS crisis services to Franklin County residents through OhioRISE

Launched in August 2022 as part of OhioRISE, the Mobile Response and Stabilization Services (MRSS) program has significantly enhanced access to crisis intervention, assessment, support and linkage for families in Franklin County. Since its inception through December 2024, MRSS has served 1,436 families. Currently, the program operates from 8 a.m. to 8 p.m., Monday through Friday, with plans for continued expansion aligning with state policy and Nationwide Children's strategic plan to increase access to mental health services.

From August 2022 through December 2024,

Nationwide Children's MRSS successfully met with 100% of families face-to-face in the community. During the same period, the team was able to respond to crisis visits within 60 minutes 79.5% of the time. This is crucial for effectively managing crises and providing timely assistance. If the team is unable to respond within 60 minutes or it is outside of MRSS hours, the Franklin County Youth Psychiatric Crisis Line (Telecrisis Team) provides crisis intervention via telephone.

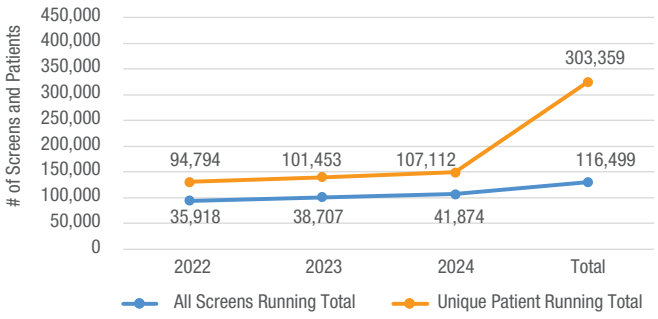
Over 80% of families were referred to or successfully linked with services during their time with MRSS. During the same period, MRSS required police support for just 5.7% of visits, highlighting the program's effectiveness in de-escalating crises and providing safe, community-based interventions with limited need for law enforcement involvement.

Develop the clinical pathway for safe suicide care at Nationwide Children's for patients presenting to Nationwide Children's locations with a primary behavioral health concern or who are otherwise identified as being at risk for suicide. This includes:

Continuing adoption and expansion of safer suicide care practices throughout Nationwide Children's non-behavioral health departments, including standardized screening, assessment and safety planning, with the ultimate goal of universal screening

Suicide screening remains a priority throughout clinical departments that do not focus solely on behavioral health. Seven departments fully implemented a safer suicide care practice between 2022 and 2024. Four additional departments were exploring and planning to adopt or expand a practice at the end of 2024.

ASQ Monthly Screening Behavioral Health Patients Ages 12-19



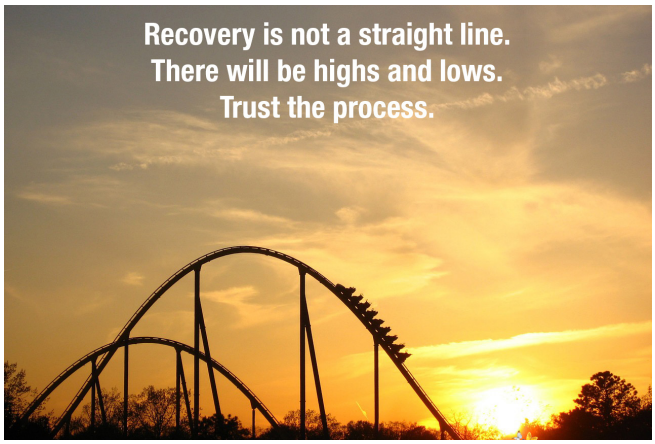
Renewing focus on best-practice suicide care in Nationwide Children's crisis services utilizing evidence-based, suicide-specific treatments within behavioral health (Examples: Collaborative Assessment and Management of Suicidality (CAMS,) Safety Planning Intervention (SPI+) Safe Alternatives for Teens & Youths (SAFETY)

Nationwide Children's provided training on and implemented evidence-based, suicide-specific treatments in Acute Services-Critical Assessment and Treatment Clinic providing Collaborative Assessment and Management of Suicidality, Safety Planning Intervention and Safe Alternatives for Teens & Youths (acute and brief.) The team continued to monitor monthly compliance with suicide screening during new and follow-up visits, assessment following a positive screen and safety planning when indicated.

Defining and building an extended "wrap around" treatment pathway for youth with chronic suicidality

The team convened a workgroup to explore pathway development including identifying the patient population, evidenced-based practices, monitoring and evaluation, and training and support. The team shifted focus to improving transitions in care through initiatives like Caring Contacts and Primary Care Discharge Letters.

The Center for Suicide Prevention and Research created a program that sends a series of 19 caring messages over the course of a year to youth who have been treated for suicidal thoughts or behaviors in several of our acute Behavioral Health services. The Caring Contacts program helps to bridge the gap in care after a patient receives treatment for concerns of suicidality and has been discharged from a Behavioral Health unit. The Caring Contacts program will intervene via text messages to teens by providing support and encouragement and providing appropriate and accessible crisis resources. Another initiative are Psychiatric Crisis Department discharge letters to primary care providers. The primary care physician of record receives a communication that includes recommended timeframe for follow-up, information about suicide risk level, follow-up recommendations including any medication additions/changes, and resources for provider-to-provider consultation.



Caring Contacts text message sample

Supporting a workforce that is educated (competent) and confidently trained in relation to suicide assessment and management

Nationwide Children's staff suicide prevention training was developed and embedded in the annual curriculum for clinical staff. The team completed collaborative training prior to the roll-out of an updated suicide prevention policy. This included newly created Behavioral Health Learning Library modules that cover a range of suicide prevention topics including screening, intervention and assessment, recovery and relapse prevention, care transitions, measuring outcomes by applying quality improvement (QI) methodology, documentation and record keeping, and medication management. Grand Rounds presentations and hospital consultations are offered ongoing, time-limited and as needed.

Creating effective handoff communication tools internal and external to Nationwide Children's

The team developed and implemented the process for Psychiatric Crisis Department discharge letters to primary care providers. This QI project focused on transitions in care to improve the completion of primary care discharge letters for youth discharged from the Psychiatric Crisis Department by a psychiatry provider or behavioral health clinician. Particularly for suicidal youth, the time (weeks to months) after discharge from the emergency department setting or an inpatient hospitalization is one of elevated risk (200-300 times more likely to die as a result of suicide.) The primary care physician of record receives a communication that includes recommended timeframe for follow-up, information about suicide risk level, follow-up recommendations including any medication additions/changes, and resources for provider-to-provider consultation like Behavioral Health Treatment Insights and Provider Support (BH-TIPS) and Nationwide Children's Physician Direct Connect. This raised compliance from 32% to 57%.

Implementing a postvention process that utilizes existing programs to support staff and communities affected by suicide

A dedicated email was created to facilitate communication of suspected or confirmed youth suicide deaths. The email alerts a team including the Nationwide Children's Center for Suicide Prevention and Research medical director and suicide prevention coordinator who are responsible for both internal and community facing postvention response activities. Nationwide Children's Behavioral Health staff were trained to use this email to communicate this sensitive and timely information, as previously there had been no standard, operationalized way to communicate this matter.

Additionally, the Franklin County Coroner's office uses that email to alert Nationwide Children's of a youth suicide death in Franklin County. This email is also being shared with areas/departments across Nationwide Children's who are participating in the Suicide Safer Care Collaborative to further improve communication. The primary goals of the postvention response process include:

1. Alerting Nationwide Children's providers who may encounter/care for youth impacted by a suicide death.
2. Supporting those bereaved in the community in partnership with other community organizations like LOSS Community Services and OhioHealth Hospice.
3. Communicating with and caring for impacted caregivers/providers in the Nationwide Children's system.

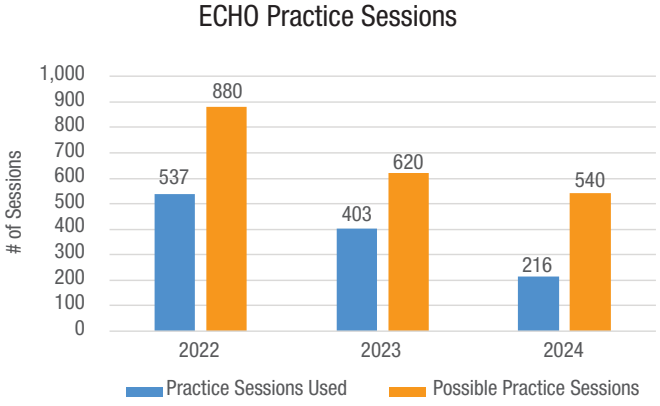
From a contagion notification standpoint, once a suicide death in Franklin County or the contiguous counties

has been confirmed, an email is sent to areas where an impacted youth is most likely to present (for example, psychiatry providers, the Psychiatric Crisis Department and Telecrisis, which operates the Franklin County Psychiatric Crisis Line for Youth). This email defines suicide contagion, contains some high-level information about the decedent (school system, grade), provides education about reporting using the dedicated email and shares staff support resources.

Increase ECHO practice sessions by 10% each year

Behavioral Health launched Project ECHO (Extension for Community Health Care Outcomes) in 2019. This initiative is dedicated to increasing comfort and capacity of primary care providers to care for patients with behavioral health needs and developing a system of care connecting communities to specialty resources. Project ECHO utilizes an expert interdisciplinary behavior health team to work collaboratively with pediatricians throughout each series so that they are more confident in their ability to respond to their primary care patients who present with behavioral health concerns. Primary care providers can ask questions and present cases to interdisciplinary teams at Nationwide Children's as well as other primary care sites.

The team pivoted from a 10% increase in the number of sessions to focus on different series subject matter. A new Continuity series has been created that builds upon the knowledge gained from the Foundations series and offers deeper dives into relevant subjects to participants. Participants can now choose from 28 sessions throughout the year — two eight-session Foundations series and 12 Continuity sessions — offered monthly. This model has been gaining better participant interactions during the sessions.



Increase Behavioral Health – Treatment Insights and Provider Support (BH-TIPS) calls by 20%

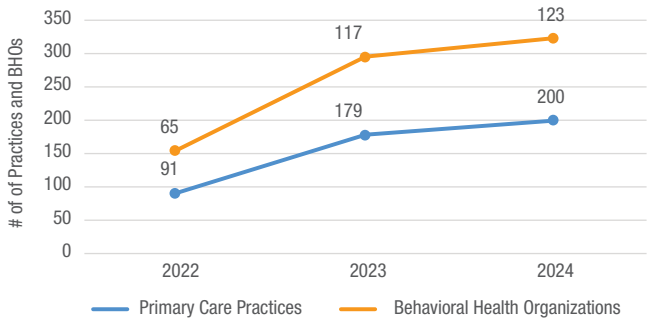
BH-TIPS was created to help address the long wait times for a psychiatry appointment. The program offers primary care providers a way to schedule a 15-minute video consultation with a Nationwide Children's psychiatrist and social worker to discuss any cases on their caseload with behavioral health concerns. Primary care providers can sign up for a time that fits into their clinic schedule, allowing them to continue to offer care to patients with minimal interruption. Since 2021, BH-TIPS has worked to increase utilization through various marketing efforts, including individual practice pitches, organization-wide pitches to large primary care practice organizations, and trainee, residency and educational programs through various local universities. The 20% increase in consultation calls was achieved in 2022 and 2023. In 2024, there was a shift in approach to targeted marketing efforts. With increased responsibilities, the team's ability to personally reach out to individual practices was limited. However, the team remained committed to supporting practices through increased marketing efforts. Physical materials like flyers and magnets were sent to interested practices, and the program was highlighted in relevant newsletters. The team continues to evaluate the more effective marketing and recruitment strategies to reach program goals in the future.

Engage 50 practices in Behavioral Health Integration

The integration of behavioral health providers within primary care improves access, clinical outcomes and equity. The Nationwide Children's and Partners For Kids Behavioral Health Integration (BHI) program supports the integration of community primary care practices by providing a curriculum, technical assistance, resources and a learning collaborative to support the operational, clinical and financial aspects of integration. Between 2022 and the end of 2024, the BHI team engaged 41 community primary care practices and 27 behavioral health organizations, and BHI was implemented within 21 primary care practices. In total, the program has engaged 83 primary care and behavioral health organizations since launching in 2019. Once established, BHI practices continue to work with the team to

improve quality and outcomes for families. Primary care clinicians also receive ongoing education and consultation through initiatives such as Project ECHO and BH-TIPS.

Behavioral Health and Primary Care Reach



Continue community efforts to disseminate safe suicide care among youth in Ohio. This includes:

Train nine Ohio community providers (including regional hospitals, behavioral health practices and primary care practices) on standardized tools for screening, assessment and intervention

Behavioral health continued to expand suicide prevention services. Behavioral health engaged with nine entities, including three pediatric practices, four community behavioral health organizations and two regional/community hospital systems through the ZerOH Suicide Collaborative. By building each participant's comfort, confidence and competence in suicide screening, assessment and safety planning within their organizations, the teams implemented, tested, improved and embedded suicide safer care best practices in their own health and behavioral health care settings.

Disseminate school-based prevention programming throughout Ohio and increase PAX programming to one more school per year with saturation in Franklin County

The PAX Good Behavior Game is a universal prevention model that is implemented in schools. The model has a strong evidence base with regards to short- and long-term youth outcomes in the areas of social, academic and behavioral functioning. Nationwide Children's support for the PAX Good Behavior Game encompasses consultation to schools and community partners for planning, implementation and sustainability of PAX at school and regional levels, as well as support with integration into requirements, such as Positive Behavioral Intervention and Supports (PBIS).

PAX School-Based Programming

Year	# of schools	County
2022	2	Muskingum
		Franklin
2023	2	Perry
		Fairfield
2024	2	Franklin
		Fairfield

Continue participation with suicide collaboratives in the community, including Ohio Children's Hospital Association (OCHA), Cardinal Health and Ohio Zero Suicide

Nationwide Children's is both a participating and leading organization in the Ohio Children's Hospital Association Ohio Youth Suicide Prevention Collaborative with a vision of zero suicides for Ohio youth aged 12 to 18. Teams representing Ohio's six children's hospitals met monthly as part of the Ohio Youth Suicide Prevention Collaborative to reduce youth suicide statewide. Together they developed a data monitoring and reporting infrastructure focused on pediatric emergency departments, aimed at estimating the magnitude of suicidality among Ohio youth, understanding factors associated with suicidal ideation and behavior, and informing the implementation of best practices.

Extended suicide prevention teams from each Ohio children's hospital met in June 2024 for an educational retreat. Members of the collaborative attended and delivered the closing address at a two-day national workshop that brought together pediatric health care leaders engaged in suicide prevention work. Sustainability constructs essential for maintaining Zero Suicide initiatives in pediatric health care were explored. Common barriers to sustainability were addressed as well as strategic approaches to overcome them. Robust data and evaluation methods

were emphasized to ensure continuous improvement and lasting impact in preventing pediatric suicides.

Create a Teen Advisory Board

The team benchmarked against organizations around the country with existing teen advisory boards. Through learnings identified, it was decided to partner with existing groups including Youth Advisory Councils (YAC) at Columbus City Schools.

This program began in 2022 and is led by Nationwide Children's School Health Services in four local high schools. These student-led, adult-guided groups empower youth to serve as health ambassadors, advocate for peer wellness and support connections between students and health resources in their schools. Approximately 40 students participate in the YAC each year, focusing on topics such as mental health and grief, healthy relationships, substance misuse prevention and local resource navigation. During the summers of 2023 and 2024, six students traveled to Washington, D.C., to participate in the National School-Based Health Alliance Be the Change Youth Conference. Students reported gaining confidence, leadership skills, emotional intelligence, adaptability and more. This collaborative approach has been monumental in meeting students where they are — amplifying their voices, improving behavioral health outcomes and boosting mental well-being across communities.

DECREASE UNINTENTIONAL DRUG AND ALCOHOL DEATHS

2022 Implementation Strategy Initiatives:

To decrease unintentional drug and alcohol deaths throughout 2022-2024, Nationwide Children's committed to:

- Increase screening from 0% to 50% for substance use disorders outside of adolescent medicine with implementation of QI techniques in Nationwide Children's Primary Care clinics.
- Increase referral to Medication Assisted Treatment for Addiction (MATA) clinic from 0% to 50% for adolescents with positive substance use disorder screens for full assessment and treatment recommendations.
- Increase prescriptions for intranasal naloxone for opioid overdose reversal to all patients with substance use disorder as they are at risk of unintentional overdose and death.

Addiction is preventable but difficult to cure. Nationwide Children's offers outpatient treatment for substance use disorders including opioids, benzodiazepines, cannabis, alcohol and nicotine. In addition, they provide patient and family support and education as well as training and community outreach to address the growing problems of adolescent substance use and overdose deaths. For youth in Franklin County with both substance abuse and mental health concerns, the hospital also offers in-home treatment.

Increase screening from 0% to 50% for substance use disorders outside of Adolescent Medicine with implementation of QI techniques in Nationwide Children's Primary Care clinics

Standardized screening with the Screening to Brief Intervention (S2BI) and CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) interventions have been implemented at Primary Care Centers. The S2BI is a screening tool that consists of frequency of use questions to categorize substance use by adolescent patients into different risk categories. The accompanying resources assist clinicians in providing patient feedback and resources for follow-up. The CRAFFT is a health screening tool designed to identify substance use, substance-related riding/driving risk, and substance use disorder among youth ages 12-21. Using these two standardized protocol has been occurring in Adolescent Medicine as well as with patients older than 12 admitted to the trauma service. Adolescent Medicine has a 92% screening rate for substance use disorders at well visits.

Increase referral to MATA clinic from 0% to 50% for adolescents with positive substance use disorder screens for full assessment and treatment recommendations

MATA clinic changed its name to Substance Use Treatment and Recovery (STAR) Program. This name change reflects updated best practices in the field and allows the program to treat a wide range of substance use disorders.

The CRAFFT is a health screening tool designed to identify substance use, substance-related riding/driving risk, and substance use disorder among youth ages 12-21. Patients with a score of two or greater are flagged in Adolescent Medicine, and a variety of interventions are offered for providers to discuss with the patient at that time. Not all patients who score CRAFFT >2 are currently using substances, as the screener asks within the past year. At times, no action is needed, as patients may have stopped using substances after their original use earlier in the year. Positive feedback is usually given at that time. Other interventions include notifying Social Work at that visit and Social Work discussing a referral to the Substance Use Treatment and Recovery Program at Nationwide Children's or providing brief counseling at that time.

Historically, referrals to the STAR Program were made through informal handoffs, with patients being given a phone number to call. This process made it difficult to track referral data accurately within EPIC, limiting the ability for the Screening to Brief Intervention (S2BI) CRAFFT Quality Improvement team to measure progress toward the referral goal. In 2024, a standardized referral order to the STAR Program was implemented in electronic medical record. While the infrastructure to track referrals is now in place, Nationwide Children's is still in the early stages of data collection. With the implementation of the new electronic medical record referral order, the clinic anticipates being able to evaluate referral trends more accurately moving forward.

Increase prescriptions for intranasal naloxone for opioid overdose reversal to all patients with substance use disorder as they are at risk of unintentional overdose and death

Intranasal naloxone prescriptions were steady at an average of 55% of patients within the STAR program from 2022 through early 2024, then decreased later in 2024. Reasons for not increasing during this time include patients who had obtained a naloxone prescription from another source outside the clinic, and it was not on their medication list as well as patients who refused naloxone prescription at that time.

In summer of 2024, the STAR team applied to become an opioid overdose education and naloxone distribution site through the Ohio Department of Health's Project DAWN (Deaths Avoided With Naloxone) Initiative and was then able to deliver education and naloxone on site to patients and families. The naloxone given to patients at that time was not from a prescription and was not added to their medication list, so a decrease has been seen in the rest of 2024 for naloxone prescriptions.

YOUTH MENTAL HEALTH SUPPORT

2022 Implementation Strategy Initiatives:

To improve youth mental support throughout 2022-2024, Nationwide Children's committed to:

- Ensure that suicide prevention efforts (especially SOS) in Franklin County schools have reached a level of saturation (e.g., >80%). As of May 2022, SOS has been implemented in 212 schools and 3,001 classrooms.
- Increase community and youth suicide prevention efforts that address gaps in traditional school-based work (e.g., Be Present Ohio: The Online Experience (BPO:XP), Boys and Girls Clubs, primary care screening, population specific community trainings, suicide reporting partnerships with media, adaptation of SOS in schools that serve primarily youth of color).
- Provide quarterly risk assessment and safety planning trainings through CSPR to school staff and youth-serving agencies to increase number of responsive adults to nearly 600 over three years.
- Complete the development and piloting of the Be Present Ohio: The Online Experience (BPO:XP) suicide prevention app that is meant to engage youth in a highly interactive manner to support learning and engagement with suicide prevention materials outside of the classroom in ways that young people currently consume information.
- Develop infrastructure within the EMR to centrally

house detection tools, safety plan documentation, and risk categorization worked to support initial workforce training and serves as a framework for continuing expansion. As a result, since 2019, screening has increased from 48% to 98% and the number of patients who have received appropriate care following screening has increased from 78% to 94%.

- Continue to train Ohio community providers on standardized tools for screening, assessment and intervention through ZerOH Suicide work.
- Renew focus on best-practice suicide care in Nationwide Children's crisis services through monthly monitoring of suicide screening, assessment, and safety planning.

Ensure that suicide prevention efforts (especially Signs of Suicide, SOS) in Franklin County schools have reached a level of saturation. As of May 2022, SOS has been implemented in 212 schools and 3,001 classrooms

In both middle and high schools, Signs of Suicide (SOS), developed by MindWise Innovations, is a nationally recognized suicide prevention program offered by the Center for Suicide Prevention and Research (CSPR). The SOS program teaches students, school staff and parents that suicide is preventable by promoting the ACT® message. When anyone notices warning signs of depression or suicide, they should acknowledge there is a serious concern, care and show the person you care, and tell a trusted adult. SOS programming was implemented in 42 schools in 2022, 49 schools in 2023 and 49 schools in 2024.

Signs of Suicide Programming in Local Schools

	2022	2023	2024
# of elementary schools	12	16	19
# of middle schools	10	8	6
# of high schools	20	25	24
# of classrooms	214	277	277
# of students	**5,350**	**6,124**	**5,827**

Increase community and youth suicide prevention efforts that address gaps in traditional school-based work (e.g., Be Present Ohio, Boys and Girls Clubs, primary care screening, population specific community trainings, suicide reporting partnerships with media, adaptation of SOS in schools that serve primarily youth of color)

Expanding partnerships in Franklin County help identify and support vulnerable populations (e.g., Black youth, LGBTQ+ youth, immigrant/refugee youth, youth in foster care, youth in the juvenile justice system, youth in low income/resource families and rural youth). Boys and Girls Clubs in Franklin County received standardized suicide prevention training with curriculum developed by the Center for Suicide Prevention and Research (CSPR) at Nationwide Children's. Youth received the 10-session curriculum focused on awareness, coping and reduction of suicidal behavior with demonstration of increased knowledge and staff preparedness to support youth in crisis.

From 2022 to 2024, CSPR provided over 126 trainings to more than 3,500 adults in the community. Examples of nuanced trainings include general trusted adults, foster and adoptive care providers, postvention, trauma informed, faith-based communities, LGBTQ+ youth, Latino youth, youth with physical disabilities, first responders working with youth, and transition age youth. Community organizations could request custom trainings with a suicide prevention focus as well.

CSPR developed a curriculum for Boys and Girls Club of America staff to use with youth in their programming along with training for adults. The implementer training had been provided to two Boys and Girls Club of America national staff in 2022, 25 in 2023, and four in 2024. Trusted adults training was provided to more than 25 staff in 2022 and over 50 staff in 2023. In addition, a digitized version of the trusted adult training was developed and is now included in Spillett University, the staff training platform for over 60,000 club staff and leaders nationally. CSPR also collaborated with Boys and Girls Club of America leadership to update the club's national suicide prevention and response policy.

Little Acts: SOS for Elementary Schools was collaboratively developed with MindWise Innovations and FableVision through an iterative process of focus groups with researchers, families, teachers, administrators and counselors; content development and scripting, animation and activity creation and small group piloting. While student impact data for Little Acts is not yet available, considerable progress in program development was made through the end of 2024. This included finalizing a three-module prototype, student activities, lesson plan, staff and caregiver training. The team ran a national focus group in five cities to elicit feedback from researchers, counselors, parents, youth and individuals with lived experience.

Provide quarterly risk assessment and safety planning trainings through CSPR to school staff and youth-serving agencies to increase the number of responsive adults to nearly 600 over three years

As part of both hospital-based zero suicide and behavioral health settings outside of the hospital, the Center for Suicide Prevention and Research has engaged in best practices for risk assessment and safety planning training. Outreach has expanded over time and quarterly trainings were added in 2020. From 2022 to 2024, CSPR trained more than 570 school and community agency staff to conduct risk assessments in schools.

Complete the development and piloting of the Be Present Ohio suicide prevention app that is meant to engage youth in a highly interactive manner to support learning and engagement with suicide prevention materials outside of the classroom in ways that young people currently consume information

Be Present Ohio: The Online Experience (BPO:XP) is a web-based suicide prevention program for 7th through 12th graders that combines individual learning and group application activities supervised by a trained local facilitator. It was developed in 2022 in partnership with Ohio Suicide Prevention Foundation (OSPF) and Ohio Department of Mental Health and Addiction Services (OMHAS). The program was finalized in 2023 and piloted across multiple sites to create a manual and implementation guide to allow facilitation by program partners. In total, BPO:XP has been delivered to 15 organizations and 990 youth.

Develop infrastructure within the electronic medical record (EMR) to centrally house detection tools, safety plan documentation and risk categorization worked to support initial workforce training and serves as a framework for continuing expansion. As a result, since 2019, screening has increased from 48% to 98% and the number of patients who have received appropriate care following screening has increased from 78% to 94%

The team built and leveraged the Suicide Risk Toolkit within the hospital's EMR. The toolkit and resources have been used by multiple departments including Medical Social Work, Psychology, Psychiatry, Nursing, Primary Care and more. Between 2022 and 2024, the toolkit was utilized within EMR 320,600 times across the organization.

Continue to train Ohio community providers on standardized tools for screening, assessment and intervention through ZerOH Suicide work

Nationwide Children's Behavioral Health team engaged with nine entities, including three pediatric practices, four community behavioral health organizations and two regional/community hospital systems through the ZerOH Suicide Collaborative. Through this training, the team helped participants feel more comfortable, confident and competent in suicide screening, assessment and safety planning. They also introduced, tested, refined and integrated best practices for suicide-safer care into health and behavioral health settings.

Renew focus on best-practice suicide care in Nationwide Children's crisis services through monthly monitoring of suicide screening, assessment and safety planning

Nationwide Children's Behavioral Health provided training and implemented evidence-based, suicide-specific treatments in Acute Services-Critical Assessment and Treatment Clinic. These included the Collaborative Assessment and Management of Suicidality, Safety Planning Intervention, and Safe Alternatives for Teens & Youths (acute and brief). The team also tracked monthly compliance with suicide screening for both new and follow-up visits, conducted assessments after positive screens, and completed safety plans when needed.

Maternal and Infant Health

INFANT MORTALITY AND MATERNAL PRE-PREGNANCY HEALTH

2022 Implementation Strategy Initiatives:

To reduce the rates of premature birth and infant mortality and increase prenatal care, Nationwide Children's committed to the following priorities in collaboration with OBBO and CelebrateOne:

- Increase referrals made from prenatal clinics at hospital systems and federally qualified health centers (FQHCs) to evidence-based home visiting programs to 30%.
- Increase women served in Franklin County to evidence-based home visiting from prenatal clinic referrals to 5,000.
- Maintain LARC for immediate postpartum during maternal stay for women (6%) and increase postpartum LARC to represent pre-COVID levels of 9%. (Mount Carmel Health System excluded)
- Develop new initiative to expand LARC use in teens (as a proportion of all teens seen in the hospital systems). (Mount Carmel Health System excluded)
- Increase number of women served by OBBO Medical Legal Partnership from 2021 number of 457 women.
- Increase number of women served by Baby & Me Tobacco Free with negative tobacco test in first trimester from 2021 number of 60 women.
- Achieve a 90% participation rate of women's health staff who have completed the addressing racism continuing education.

Nationwide Children's aims to decrease infant mortality and preterm births and improve prenatal care in Franklin County through several programs and services. Since 2015, CelebrateOne, Ohio Better Birth Outcomes (OBBO), Nationwide Children's and other partners have implemented action steps in safe sleep education, prematurity prevention and early access to prenatal care. This work has resulted in a reduction of the Franklin County infant mortality rate by 20%.

Despite this progress, the unacceptable racial disparity still exists. The new phase of the CelebrateOne 2021-2026 strategic plan is aimed at accelerating the decrease in Black infant mortality.

Increase referrals made from prenatal clinics at hospital systems and federally qualified health centers (FQHCs) to evidence-based home visiting programs to 30%

When teens are pregnant, Nationwide Children's Teen and Pregnant (TaP) program offers assistance to young women up to age 22 so they can have a healthy pregnancy and postpartum experience. A total of 35% of babies born to women in the TaP clinic who enrolled in Care Navigation have been referred for additional services. The Care Navigation Program makes it easier for families to access care by working with insurance companies, community groups and health care teams to help the child get the care they need.

Ohio Better Birth Outcomes (OBBO) is the lead partner of Franklin County's public-private partnership to reduce infant mortality, CelebrateOne. OBBO is a quality improvement collaborative that is accountable for health care system-based interventions across the prenatal and perinatal periods.

OBBO's implementation efforts focus on improving prenatal care and strengthening connections with upstream providers. This includes expanding access to evidence-based home visiting programs and reproductive health planning — particularly by increasing access to long-acting reversible contraceptives (LARCs). The team also continues clinical quality improvement initiatives aimed at increasing the use of progesterone in certain high-risk pregnancies. An average of 34.2% of patients in OBBO prenatal care clinics were referred to a home visiting program.

Increase women served in Franklin County to evidence-based home visiting from prenatal clinic referrals to 5,000

Home visiting continues to be a priority within the county with persistent efforts to increase capacity to serve more families. Healthy Families America (HFA) and Nurse Family Partnership (NFP) serve as the two evidence-based home visiting programs in Franklin County. Nationwide Children's is one of the largest providers of both models, which operate as part of The Center for Family Safety and Healing. The programs improve pregnancy outcomes and reduce child abuse by promoting preventive health practices and screening for intimate partner violence. The programs enhance self-efficacy through home visits by nurses, social workers and early childhood professionals.

IN 2024, THERE WERE:

16,399 home visits

1,491 families served

IN 2024:

89% of infants were born full-term

86% of infants breastfed by 1 year of age

85% of mothers received depression screening

Maintain LARC for immediate postpartum during maternal stay for women (6%) and increase postpartum LARC to represent pre-COVID levels of 9% (Mount Carmel Health System excluded)

Long-acting reversible contraceptives (LARCs) are the most effective methods of birth control, lasting between two months and 10 years, depending on the option selected. Although access to LARC continues to be an initiative that the hospital systems implement, data collection discontinued after 2022. With the increased focus on the impacts of structural drivers of health on infant mortality and the consistent work done by the hospital systems on contraception access, LARC initiatives were considered integrated into usual care after 2022. In 2022, immediate postpartum LARC was at 6% and postpartum LARC was at 5.3% and teen LARC was at 11.9%. Nationwide Children's operates the BC4Teens clinic, providing patient-centered, non-coercive contraception care to teens and adolescents.

Develop new initiative to expand LARC use in teens (as a proportion of all teens seen in the hospital systems) (Mount Carmel Health System excluded)

Teen access to LARC continues to be an initiative that the hospital systems implement, however, data collection discontinued after 2022. As of 2022, the proportion of teens receiving LARC reached 11.9%. With increased focus to social determinants of health and their impact on outcomes such as infant mortality, LARC access has been integrated into routine care practices rather than treated as a standalone initiative. This highlights the commitment of hospital systems to provide equitable, patient-centered reproductive health services as part of comprehensive adolescent care.

Nationwide Children's continues to lead in this area through the BC4Teens clinic, offering confidential, non-coercive contraception counseling and services tailored to the needs of adolescents. The focus of this initiative remains on improving access, reducing disparities and addressing broader social determinants that influence teen reproductive health.

Increase number of women served by OBBO Medical Legal Partnership (MLP) from 2021 number of 457 women

Formerly known as the Medical Legal Partnership (MLP), the program was renamed Lawyers for Kids™ to more clearly reflect the program's mission and services. Lawyers for Kids helps vulnerable families overcome barriers that directly impact their health outcomes, such as housing instability, access to benefits and family safety.

Between 2022 and 2024, the program served an average of 232 families referred by OBBO. Changes to Lawyers for Kids' recruitment strategy in 2023 prioritized identifying and supporting women with more complex legal and social needs. While this resulted in fewer overall referrals, the cases that were referred required more time, coordination and resources to address. Although the total number of women served decreased, the depth and intensity of services provided increased, aligning with the program's commitment to delivering high-impact, equity-focused care to those with the greatest need. This has had a ripple effect in laying the groundwork for healthier pregnancies, stronger parent-child bonds and improved early childhood outcomes. Stable housing, access to health care and protection from domestic violence are just a few of the ways legal support can help ensure every baby has the best possible start in life.

Increase number of women served by Baby & Me Tobacco Free with negative tobacco test in first trimester from 2021 number of 60 women

The Baby & Me – Tobacco Free Program™ is a free smoking and vaping cessation program that provides critical support for expecting women, empowering them to overcome nicotine addiction during a vital stage of their pregnancy. By offering personalized counseling, education and incentives, the program helped women and families quit tobacco while also promoting healthier pregnancies and improving birth outcomes. Between 2022 and 2024, 113 women were supported by this program. Although the program will no longer be available after July 2025, the impact of reaching 113 families is significant. Each mother who successfully quit tobacco reduced the risk of complications such as low birth weight, premature birth and respiratory issues

in newborns. The program also extended its influence to families, encouraging smoke-free environments that benefit both mothers and babies.

Achieve a 90% participation rate of women's health staff who have completed the addressing racism continuing education

Since the conception of this annual education in 2023, there has been a steady increase in participation numbers from partners. This is primarily due to systems making the education mandatory or a part of merit increases. In 2023, participation was 15%. The initial rollout provided valuable insights into the barriers to engagement and helped inform more effective strategies for the following years. Continued efforts to embed this training into organizational culture, along with leadership support, are expected to drive further progress.

Disease Management

ASTHMA

2022 Implementation Strategy Initiatives:

To keep children out of the hospital and minimize the impact of asthma on children's well-being, Nationwide Children's committed to:

- Increase six-month asthma follow-up visit rates in the Primary Care Network from 52% to 65%.
- Standardize acute asthma care in the emergency department with the use of new ED asthma pathway.
- Standardize acute asthma care in the urgent care department with the use of new asthma pathway.
- Work with Partners For Kids to create outpatient asthma management guidelines recommendations to be utilized by community pediatricians based on most recent asthma guidelines to provide asthma education to community practices.
- Recover and exceed enrollment levels prior to the pandemic. This will be achieved via targeted student recruitment, including encouragement of referral for children seen in urgent/acute care settings, rebuilding of staffing lost during the health crisis, and ongoing efforts to improve program efficiency while maintaining its efficacy.

Asthma is the most common chronic childhood illness and can significantly impact quality of life with missed school days, difficulty with physical activity and exacerbations resulting in emergency department visits and/or hospitalization. Nationwide Children's has initiatives in Primary Care Centers, schools, community pediatricians' offices and home visitation programs to help children and their families improve control of their asthma and reduce the impacts.

Increase six-month asthma follow-up visit rates in the Primary Care Network from 52% to 65%

In 2024, asthma care follow-up visit rates increased to 59% within Primary Care Centers, driven by enhanced outreach strategies and implementing user-friendly online scheduling tools. Pulmonology clinics also made meaningful progress in improving follow-up rates.

Efforts remain ongoing as Pulmonology continues to collaborate closely with Primary Care and Partners For Kids to align strategies and further improve continuity of asthma care.

Standardize acute asthma care in the Emergency Department with use of new ED asthma pathway

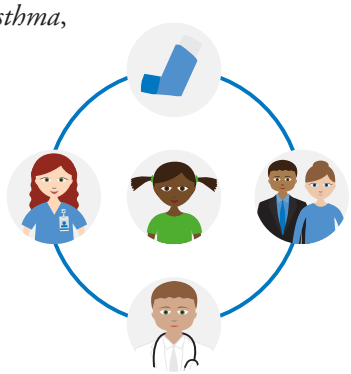
A new asthma clinical pathway was created for use in the Emergency Department. The 17-page document is accessible to clinicians and includes flowcharts, patient inclusion and exclusion criteria, asthma exacerbation criteria, acute and chronic diagnoses, clinical scores, bronchodilator options, recommended treatments, not recommended treatments, discharge instructions, clinical support tools, and continuous albuterol floor protocol for level 3 care.

Standardize acute asthma care in the urgent care department with use of new asthma pathway

A new asthma clinical pathway was created for use in Urgent Care Centers. The 17-page document is accessible to clinicians and includes flowcharts, patient inclusion and exclusion criteria, asthma exacerbation criteria, acute and chronic diagnoses, clinical scores, bronchodilator options, recommended treatments, not recommended treatments, discharge instructions, clinical support tools, and continuous albuterol floor protocol for level 3 care.

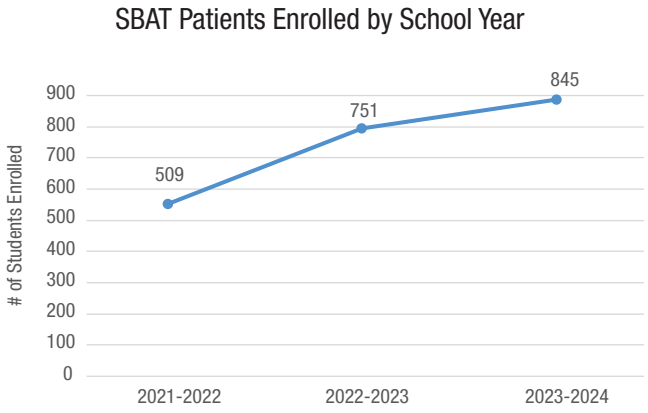
Work with Partners For Kids to create outpatient asthma management guidelines recommendations to be utilized by community pediatricians based on most recent asthma guidelines to be provided with asthma education to community practices

Outpatient asthma management guidelines are now available for download by community pediatricians and practices. Titled Initial *Outpatient Evaluation and Ongoing Management of Asthma*, the pathway includes diagnosis tools including classifying asthma severity, classifying asthma control, differential diagnosis for asthma, modifiable risk factors and classifying exacerbation severity. The tool also includes different medication charts including acute exacerbation dosing, short-course medications, inhaled corticosteroids, long-acting beta agonist (ICS) and SMART dosing.



Recover and exceed enrollment levels prior to the pandemic. This will be achieved via targeted student recruitment, including encouragement of referral for children seen in urgent/acute care settings, rebuilding of staffing lost during the health crisis and ongoing efforts to improve program efficiency while maintaining its efficacy

School-Based Asthma Therapy (SBAT) helps children with poorly controlled asthma, marked by frequent or severe symptoms at school, or frequent exacerbations requiring urgent therapy. The program promotes communication among the school, caregiver and health care providers. It focuses on ensuring children are taking their routine controller therapy (medications that help prevent asthma symptoms). Participating schools assist by administering a portion of the students' controller doses at school. Enrollment levels have been exceeded prior to the pandemic, and SBAT has more than 920 kids now enrolled.



DIABETES

2022 Implementation Strategy Initiatives:

To improve the quality of life for patients with chronic pediatric diabetes, allowing children to live as normal a life as possible, Nationwide Children's committed to:

- Improve health equity among T1D patients' use of glucose technology.
- Decrease rate of acute care ED visits by T1D clinic patients from average 2.29 to 1.75 per 1,000 encounters.
- Increase the number of patients compliant with their retinopathy screen.
- Create a multidisciplinary type 2 diabetes clinic to better meet the unique needs of patients with type 2 diabetes.
- Elect physician champions to serve as type 2 diabetes medical leaders and develop type 2 team of support staff specialized in treating type 2 diabetes.

Nationwide Children's Diabetes Program continually strives to improve and expand the comprehensive outpatient care it offers to children with the disease. The program's overall goal is to provide patients and their families with needed care and the tools to self-manage diabetes, resulting in independent, healthy and active lives.

Improve health equity among T1D patients' use of glucose technology

Nationwide Children's created the Diabetes and School Health, or DASH, program in 2021. A specially trained team meets with students enrolled in the program monthly at their schools and coordinates ongoing care with school nurses.

The program is now available at 65 schools across 12 districts in central Ohio, plus another 12 charter schools. Among the program's biggest successes is an increase in the use of continuous glucose monitors from 16% of eligible students to 81%. The goal is to reach a 1.0 ratio for both CGM (continuous glucose monitor) and insulin pump, meaning there is no disparity in utilization between White type 1 diabetes patients and Black type 1 diabetes patients.

Increase in the use of continuous glucose monitors from 16% of eligible students to 81%.

Decrease rate of acute care ED visits by T1D clinic patients from an average of 2.29 to 1.75 per 1,000 encounters

Emergency Department Visits per 1,000

Type 1 Diabetes Patients

2022	2.5 per 1,000
2023	1.8 per 1,000
2024	2.7 per 1,000

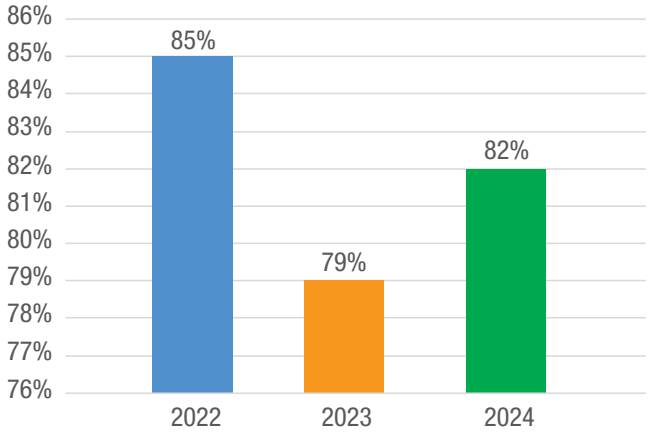
To address high rates of emergency department utilization among patients with type 1 diabetes, the Endocrinology Division meets biweekly to review Emergency Department cases. These reviews focus on identifying preventable factors, improving care coordination and ensuring that each patient has a clear, actionable follow-up plan for managing their condition.

The division provides access to an urgent phone line, staffed by an advanced practitioner team, to provide real-time support for patients and families. This service is designed to divert non-emergency cases away from the emergency department and urgent care clinics by offering immediate clinical guidance and scheduling in-clinic appointments when appropriate.

Increase the number of patients compliant with their retinopathy screen

A retinal exam is part of the standard of care for patients with diabetes. Diabetic retinopathy can start with no symptoms to mild symptoms and can lead to blindness. Endocrinology recently purchased its own retinopathy scanner, no longer relying on patients to be referred to Ophthalmology or seen offsite for their scan. In partnership with Nationwide Children's Ophthalmology, the Ophthalmology team interprets the scans performed in-house and follows up with Endocrinology with results.

Percent of Type 1 Diabetes Patients Receiving Retinopathy Scan

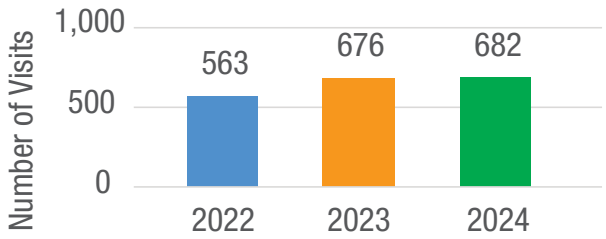


Create a multidisciplinary type 2 diabetes clinic to better meet the unique needs of patients with type 2 diabetes

In 2022, a dedicated type 2 diabetes clinic was launched to provide comprehensive, family-centered care. The clinic's care team serves as both educators and coaches to empower families to manage diabetes effectively 24 hours a day, seven days a week, year-round. The team is comprised of physicians and advanced practitioners, diabetes educators, dieticians, social workers, diabetes nurses and a psychologist, ensuring that each patient receives holistic support in addressing medical, nutritional, psychological and social aspects of diabetes care.

Since its inception, the clinic has seen steady growth in patient visits, reflecting both increased demand and the value brought to families.

Type 2 Diabetes Clinic Patient Visits



Elect physician champions to serve as type 2 diabetes medical leaders and develop type 2 team of support staff specialized in treating type 2 diabetes

The Endocrinology Division appointed two faculty members as physician champions. These leaders serve as the clinical and strategic leads for the type 2 diabetes clinic, guiding care protocols, team coordination and quality improvement initiatives. Since its launch, the type 2 diabetes clinic has expanded from a twice-monthly schedule to three sessions per month in response to its growing demand. Several disciplines rotate through the clinic including Nephrology, Nutrition and Social Work. The diabetes team works together to care for patients and families affected by diabetes. The goal is to empower families to successfully manage diabetes at home to provide as normal a life as possible for patients with diabetes. The teams offer a variety of approaches to diabetes therapy, customized to family needs, such as insulin pump or basal/bolus therapy. The approach is proactive — medically, educationally and psychosocially — to identify needs early to prevent problems from developing.

OBESITY

2022 Implementation Strategy Initiatives:

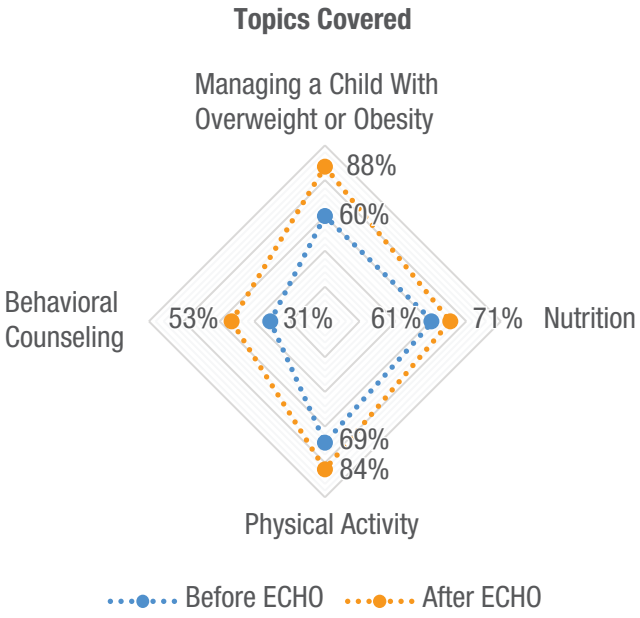
To reduce or prevent pediatric obesity and to help children already facing this chronic condition, Nationwide Children's committed to:

- Establish and maintain ECHO Obesity Framework by 1) increasing physician knowledge and comfort with weight management, 2) practice defined BMI screening and 3) nutrition and physical activity counseling and appropriate billing documentation.
- Improve patient engagement in the center by increasing the percent of children with an average number of treatment contacts to three or more visits in six months and increasing the percentage with decreased body mass index to 60%.
- Establish partnerships with six community organizations to address: 1) food access, 2) nutrition education, 3) reducing sugar sweetened beverage consumption and 4) physical activity in schools through programming and policy.
- Maintain Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program for adolescent bariatric surgery as demonstrated by 45 bariatric surgery cases in the next three years.

Establish and maintain ECHO Obesity Framework by 1) increasing physician knowledge and comfort with weight management, 2) practice defined BMI screening and 3) nutrition and physical activity counseling and appropriate billing documentation

The Center for Healthy Weight and Nutrition (CHWN) developed and implemented an obesity-focused training program for pediatric clinicians using the Extension for Community Health care Outcomes (ECHO) platform, a national practice model that uses case-based learning to train health care clinicians. The ECHO obesity core curriculum is an eight-session series on assessment and management of childhood obesity. Topics include implementing lifestyle interventions; motivational interviewing and counseling techniques for parenting, nutrition, and physical activity; coding and billing for obesity-related visits, pharmacotherapy, and bariatric surgery. Since 2021, the ECHO program has trained more than 100 health care clinicians. After the eight-week series, ECHO participants reported an increase in knowledge for managing a child with overweight or obesity (60% vs 88%), nutrition (61% vs 71%), physical activity (69% vs 84%), and behavioral counseling (31% vs 53%).

Knowledge Increase Due to ECHO Series



Improve patient engagement in the center by increasing the percent of children with an average number of treatment contacts to three or more visits in six months and increasing the percentage with decreased body mass index by 60%

Children with obesity often have risk factors for other health complications, such as heart disease and diabetes. These can persist or worsen if they remain overweight or obese in adulthood. As a way of enhancing patient engagement and improving outcomes, the Center for Healthy Weight and Nutrition (CHWN) worked to improve patient contact to three more visits within six months. More than 73% of the center's established patients have successfully achieved three or more visits within six months. Since 2021, this has resulted in an 8% increase in the number of patients who achieved three or more visits in a six-month period.

Establish partnerships with six community organizations to address: 1) food access, 2) nutrition education, 3) reducing sugar sweetened beverage consumption and 4) physical activity in schools through programming and policy

The center partners with community organizations to increase healthy food access, promote nutrition and physical activity education and expand resources on healthy lifestyles habits to improve the health of the community.

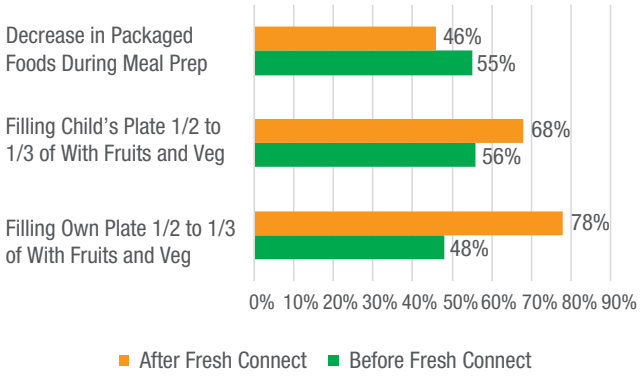
Since its inception in 2022, the center has partnered with Columbus City Schools, Nationwide Children's School-Based Health Centers and Local Matters to deliver lunch and learn sessions at five Columbus City Schools locations, impacting more than 300 students. The primary aim of the lunch and learn series is to collaboratively deliver health interventions, with a focus on nutrition and physical activity, to at-risk high school students in low-income, resource-limited communities. These interventions involved introducing students to healthy food choices, promoting mindful decision-making and emphasizing the value of physical activity. To encourage behavior change and offer additional resource support, meal kits were provided after each lunch and learn session. These kits included all the ingredients for families to recreate the same meal at home.

The center partners with Local Matters, a nonprofit organization, to educate children and their families about nutritious food: how to cook it, how to grow it and how to access it affordably. In partnership with a local community center, free, community cooking classes are offered monthly, reaching nearly 700 individuals between 2022 to 2024.

In 2023, the center partnered with Local Matters on a pilot program called Fresh Connect. The pilot established an electronic system to allow low-income families living within the Linden area zip codes of 43211 and 43224 to purchase fresh fruits and vegetables from the Mobile Farmers Market or a local grocery store. In addition to grocery tours, nutrition education and counseling, the six-month pilot program provided $150 per month for each family to make purchases of fresh produce. After the six-month pilot, caregivers self-reported an increase in filling a third to half of their plate with fruits and vegetables other than potatoes (48% vs 78%), and an increase in filling one-third to one-half of their child's plate with fruits and vegetables other and potatoes (56% to 68%). Additionally, caregivers reported a decrease in packaged foods in their meals prepared at home (55% vs 46%).

The center is the convener for The Healthy Kids Coalition of Central Ohio (HKC), which works to implement multi-level strategies targeting policies, systems and environmental changes to improve the lifestyles and health of all children in central Ohio.

Fresh Connect Lifestyle Changes



Families reported better eating habits after their time participating in the Fresh Connect pilot program. Comments included:

"We eat less greasy food and more vegetables and fruit."

"My A1C went down, I lost weight, my daughter did too."

"We eat a ton of salads and fresh veggies and fruit, making us feel better, eating a lot healthier."

Maintain Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program for adolescent bariatric surgery as demonstrated by 45 bariatric surgery cases in the next three years

For adolescent patients who have not achieved their desired weight loss through lifestyle changes, weight loss surgery is an option. CHWN offers three types of bariatric surgeries: gastric sleeve, gastric bypass and laparoscopic adjustable band surgeries. The metabolic and bariatric surgery program at Nationwide Children's was the first adolescent-only center in the U.S. to earn accreditation by the American College of Surgeons (ACS) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) in 2015. This nationally accredited certification acknowledges Nationwide Children's ongoing commitment to provide and support quality improvement initiatives, including patient safety efforts, in children with severe obesity undergoing surgical intervention. The Center for Healthy Weight and Nutrition received their reaccreditation in 2018 and 2022. The center performed 56 bariatric surgeries between 2022 and 2024.

Preventive Care

WELL CHILD VISITS AND IMMUNIZATIONS

2022 Implementation Strategy Initiatives:

To improve access to well child visits and immunizations through Primary Care Centers, Nationwide Children's committed to:

- Increase patient access from 203,000 to 240,000 visits per year.
- Increase population well visit completion rates (3 to 21 years old) from 67% to 70%.
- Expand community health worker/parent coach program from one to four offices.
- Optimize mental health management by expanding Integrated Psychology services to two additional sites.
- Expand the Olentangy Primary Care Center to allow space to incorporate Integrated Psychology services.

In response to the need for more appropriate, accessible care, Nationwide Children's has committed to providing additional primary and subspecialty health care to Franklin County residents and assisting with coordinating care for vulnerable patients. Part of this initiative was reducing emergency department utilization for non-emergency care. Among youth (age 0 to 18), a breathing-related issue – specifically, a respiratory infection – was the most frequent specific cause of a visit to an emergency department. Fevers, viral infections, vomiting, influenza, strep throat and cough were also frequently diagnosed as the specific cause of a visit to an emergency department. The Primary Care team worked to expand access across Franklin Country through expanded clinic times, messaging reminders, new scheduling system and opening a new clinic.

Increase patient access from 203,000 to 240,000 visits per year

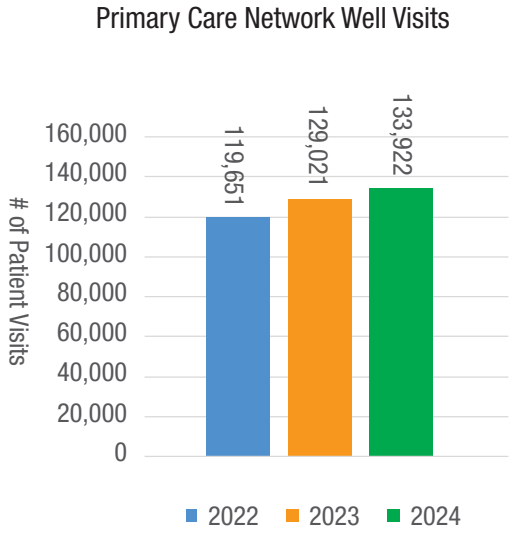
Between 2022 and 2024, Nationwide Children's made great strides in expanding access to primary care, surpassing the goal of increasing annual patient visits. By the end of 2024, the Primary Care Network recorded 242,023 visits, reflecting the strong commitment to meeting the growing health care needs of children

and families in Franklin County. This was driven by expanding capacity and convenience for families, including the expansion of Olentangy Primary Care and Eastland Primary Care Center, as well as opening a new Primary Care Center in the Northern Lights area.

Patient scheduling configurations were also optimized to offer more flexibility. This included adjustments to appointment templates to accommodate both well-child and sick visits, allowing clinics to respond dynamically to changes in demand. During periods of high illness volume, surge clinics were implemented to provide additional same-day access for children needing care urgently.

Increase population well visit completion rates (3 to 21 years old) from 67% to 70%

Well visit completion rates for the Primary Care Network population are closely followed. A full patient journey from early childhood through young adulthood spans nearly two decades, creating limitations in tracking comprehensive completion rates over a three-year timeframe. However, year-over-year trends have shown a steady increase in well visits, experiencing a 11.97% increase between 2022 and 2024.



Several successful strategies were implemented to increase well visit access, using patient-friendly technology including the patient portal and texting initiatives. The Primary Care Network implemented Epic campaigns that automate text message reminders to parents and caregivers of children past due for well care. The outreach team was also expanded to proactively connect to families in need of follow-up care for chronic conditions such as asthma and ADHD. A new ticket and online scheduling system was rolled out to make scheduling easier and more family friendly to encourage compliance and well visit completion rates.

Expand community health worker/parent coach program from one to four offices

To better support families facing social and economic challenges, Primary Care expanded its community health worker (CHW) and parent coach programs from one office to seven primary care locations. In addition, the program now operates in five partner prenatal care clinics, including OhioHealth, The Ohio State University Wexner Medical Center, Lower Lights Christian Health Center and PrimaryOne Health.

Primary Care implemented universal screening for social determinants of health (SDoH) at all visit types, using a standardized, hospital-wide tool. This ensures consistent identification of needs such as food insecurity, housing instability, transportation barriers and more. CHWs and parent coaches provide tailored support through education, advocacy and warm handoffs to community-based services. Their presence within the clinics allows for real-time engagement with families and timely intervention. Ongoing efforts will continue to expand these programs' reach, focusing on embedding CHWs and parent coaches in additional pediatric and prenatal care sites.

Optimize mental health management by expanding Integrated Psychology services to two additional sites.

Patients whose medical home has an integrated psychologist are 134% more likely to receive behavioral health services than those who do not have an integrated psychologist. A pediatric primary care psychologist can help families and their primary care provider make a plan and set goals. The psychologist can be present during primary care visits, answering questions from parents and helping the provider understand the parent's concerns, along with providing therapy for concerns if needed. In

2022, Integrated Psychology was offered at eight Primary Care Centers. The Primary Care Network now has Integrated Psychology at 10 out of 14 offices.

Expand the Olentangy Primary Care Center to allow space to incorporate Integrated Psychology services

In response to the growing need for accessible mental and behavioral health care, the Olentangy Primary Care Center completed a strategic expansion to create a dedicated space for psychology services. This provides behavioral health support directly into patients' pediatrician offices, allowing for more holistic, coordinated care.

Primary Care Center psychology visit volume rose from 10,470 visits to 13,072 visits annually. Families now benefit from improved access to behavioral health services without the need for separate referrals or appointments at various locations, timely intervention for mental health concerns and more comprehensive and personalized treatment plans.

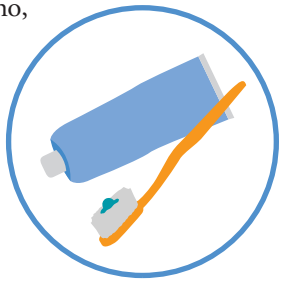
DENTAL CARE ACCESS

2022 Implementation Strategy Initiatives:

To improve access to pediatric preventative and restorative dental care, Nationwide Children's committed to:

- Improve patient access to services and timely scheduling of restorative/surgical care, support this model for dental emergencies and enhance the model for collaborative scheduling for clinical and surgical services to coordinate timely scheduling. This will reduce wait time from referral to first scheduling call attempt by 10% for medically compromised patients and by 5% for general anesthesia patients. These are high risk subsets of the dental patient population and the focus on reducing wait time.
- Improve services for patients with special health care needs including adapted environments and expansions of services for adolescents by hiring a general dentist with expertise in special health care populations and creating adapted environments for children with sensory disability.
- Continue to work with School Health Services and other community partners to continue to provide comprehensive dental care in community sites. In addition to the roving clinic, the department will explore permanent sites to support large populations of underserved students.
- Expand access to oral surgery services in collaboration with The Ohio State College of Dentistry Department of Oral Surgery by increasing the number of sessions available at Nationwide Children's from two to eight per month. This will ensure timely management of urgent dental conditions such as pain, pathology and trauma.

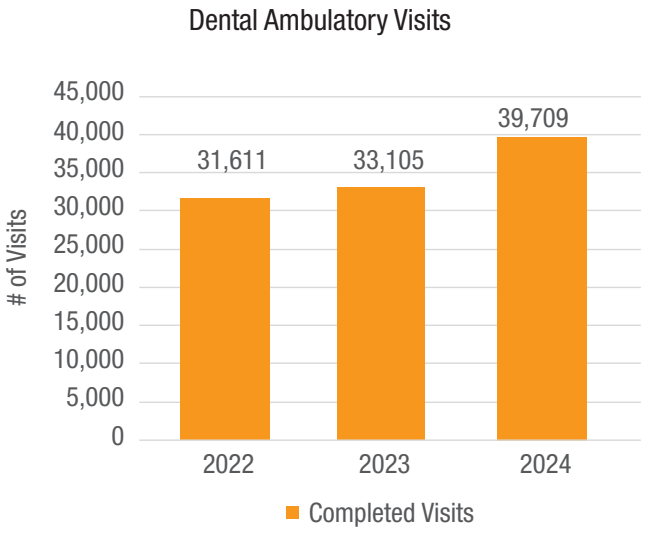
Nationwide Children's is committed to meeting the community need for oral health care by offering a safety net dental clinic. The safety net clinic provides dental services to members of the community who, due to low income, special needs or other barriers, lack access to dental care. More than 80% of the patients seen annually at the dental clinic are covered by Medicaid, with the majority from Franklin County. Most of the clinical care is provided by pediatric dental residents selected through a highly competitive match program. A team of more than 40 community pediatric dentists and other specialty dentists serve as attending dentists, faculty and care providers.



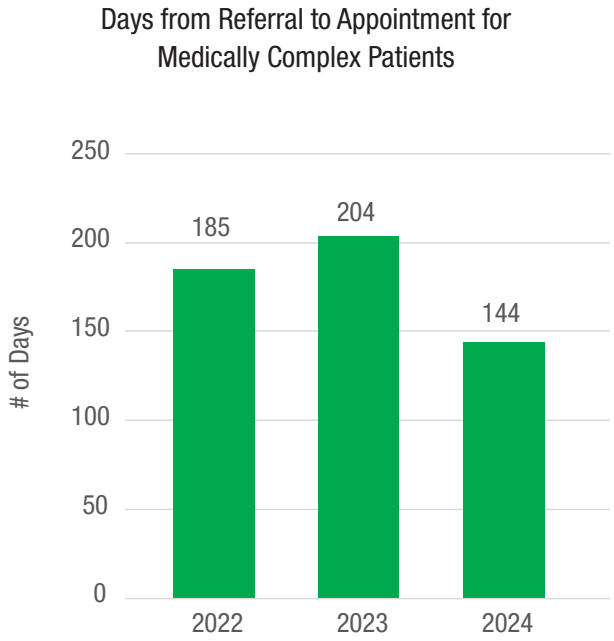
Improve patient access to services and timely scheduling of restorative/surgical care, support this model for dental emergencies and enhance the model for collaborative scheduling for clinical and surgical services to coordinate timely scheduling. This will reduce wait time from referral to first scheduling call attempt by 10% for medically compromised patients and by 5% for general anesthesia patients. These are high risk subsets of the dental patient population and the focus on reducing wait time

To improve care and access to dental services, the Dental Clinic at Nationwide Children's enhanced the model for collaborative scheduling for clinic and surgical services to coordinate timely scheduling for clinical and

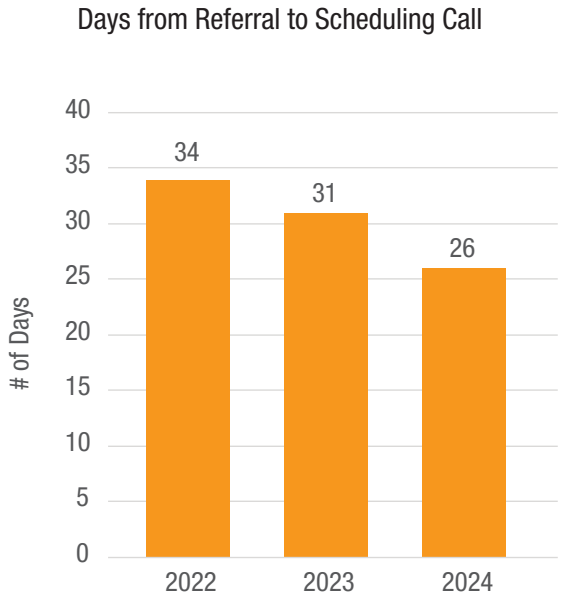
surgical patients. Additional staffing was brought on to reduce wait times. Two dental surgical schedulers and two clinical scheduling administrators were added to the team. These team members are available to schedule patients for follow-up services prior to leaving the clinic, which improves scheduling, shortens wait times and enhances patient follow-up. More dental residents were scheduled each day (from two to three) to increase the number of dental walk-in patients the clinic could accommodate.



Increased resident providers scheduled daily for dental walk ins from 2 to 3 in order to increase capacity



Average 41 day reduction in Referral to Appointment Date and 22% reduction in wait time



Average 8 days reduction in wait time and 23% reduction in wait time

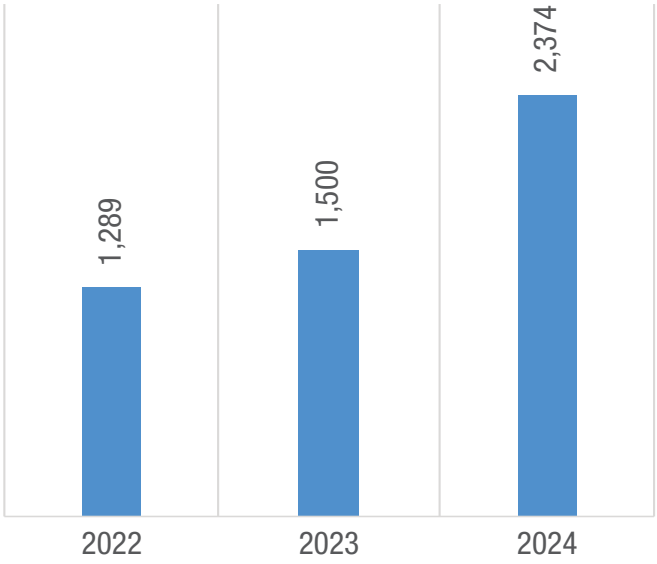
Improve services for patients with special health care needs including adapted environments and expansions of services for adolescents by hiring a general dentist with expertise in special health care populations and creating adapted environments for children with sensory disability

A new dentist with a focus on adolescents and patients with special health care needs was hired in August 2022. This dentist completed a fellowship at NYU's Oral Health Care Center for People with Disabilities. The Dental Clinic implemented a patient survey for patients with special health care needs, sent via MyChart when the appointment is scheduled. Questions are specific to opportunities for dental team support to improve visit quality, patient preferences for lights, sound, fidget toys, etc.

Continue to work with School Health Services and other community partners to continue to provide comprehensive dental care in community sites. In addition to the roving clinic, the department will explore permanent sites to support large populations of underserved students

A number of studies over last decade have shown that untreated dental issues cause children to miss millions of hours of school per year, sometimes with significant impact on their educational achievement. Children who come from families with low incomes experience this far more often than their peers. To help address these concerns, Nationwide Children's created a "roving" community dental clinic in 2021, which can set up quickly in empty school classrooms, conference rooms, staff lounges and other unused spaces to treat dental concerns. In 2023 to 2024, the clinic has seen more than 1,000 children and performed more than 7,000 procedures. The initial funding for the clinic came through a five-year grant from the U.S. Health Resources and Services Administration. Nearly 40% of the patients seen so far have been diagnosed with a mental, behavioral and/or neurodevelopmental condition.

Community Dental Completed Visits



Expand access to oral surgery services in collaboration with The Ohio State University College of Dentistry Department of Oral Surgery by increasing the number of sessions available at Nationwide Children's from two to eight per month. This will ensure timely management of urgent dental conditions such as pain, pathology and trauma

Oral surgery services with The Ohio State University College of Dentistry Department of Oral Surgery remain at two sessions per month. Despite strong collaboration and shared commitment to improving access, The OSU Department of Oral Surgery was unable to provide additional sessions due to ongoing staffing constraints within their department. The existing sessions continue to provide critical care for patients with urgent dental needs, and efforts are ongoing to explore alternative strategies for increasing capacity.

Conclusion

In conclusion, Nationwide Children's has made significant improvements in health in Franklin County. Advancement in health outcomes will continue to be a priority to improve the health of our community.

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