GREATER COLUMBUS

Community Health Improvement Plan 2026-2029

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR

COLUMBUS PUBLIC HEALTH

Introduction

A community health improvement plan is a critical, data-driven blueprint meant to guide communities in addressing specific health needs by ensuring that the necessary strategies, resources, and partnerships are in place to do so. Health needs are not one dimensional. Therefore, the solutions require multi-dimensional thinking and a shared vision across health departments, hospitals and community agencies.

Community health improvement plans are one step of a cyclical process of health improvement planning. To successfully develop a community health improvement plan, communities must analyze both qualitative and quantitative data as well as make a commitment to aligning their work and tracking progress. We are grateful for the resources and relationships that exist in Central Ohio that make this plan possible.

This health improvement plan is based on two foundational documents:

- *HealthMap 2025*, which is a community health assessment for Columbus and Franklin County commissioned by Columbus Public Health, Franklin County Public Health and the Central Ohio Hospital Council, in partnership with over 30 community-based organizations as well as community feedback and voices.
- *Shared Community Health Improvement Objectives 2026* (Appendix A): Columbus Public Health worked collaboratively with Franklin County Public Health and the Central Ohio Hospital Council to develop a set of shared indicators to guide the scope of work set forth in their respective community health improvement planning efforts and track the progress of their collective and individual work. This document contains a list of indicators, baseline data and goals.

Prioritized Health Needs Identified by HealthMap 2025

Social Drivers of Health, also known as Social Determinants of Health, are the non-medical circumstances or factors in a person's life that have a powerful influence on a person's health. These social and environmental factors are often described as the conditions in which we are born, live, grow, and age, but they also include our access to education, resources, money and power. Where we live can predict a lot about health outcomes and often there are unfair and preventable differences within short distances in a community.

According to the Centers for Disease and Control and Prevention, health equity is the fair and just opportunity for everyone to achieve their highest level of health, regardless of race, income, location, or background. To realize health equity, it's imperative to address social determinants of health, combat systemic and historical injustices and ensure access to high quality, unbiased healthcare.

The HealthMap steering committee recognized the importance of equity within the priority needs areas. Columbus Public Health (CPH) will strive for health equity by focusing on equitable outcomes rather than equal interventions. We will use the Targeted Universalism framework in our health planning. Targeted Universalism is an equity-focused, inclusive model that sets universal goals for everyone, but uses tailored

implementation strategies to help different groups achieve those goals. The practical application is operationalized through a 5-step process:

1. **Set universal goals:** Set a goal that everyone should achieve. Looking at baseline data for the entire population, a goal will be set for the entire community to work toward.
2. **Assess the general population's current performance:** Determine how different populations or neighborhoods experience the health issue. GIS technology can be used to create maps showing where a problem is occurring at the highest rate.
3. **Identify who is farthest from the goal:** Determine who is impacted the most by the issue and what other health issues they are experiencing. Rather than looking at just one health condition, we will be able to look at the convergence of where various health conditions are co-occurring.
4. **Determine structural barriers:** Identify what social or environmental issues are contributing the most to morbidity. CPH will use the Health Opportunity Index (HOI) in its analysis. The HOI is a multivariate tool used to identify and understand the interaction of social determinants of health at the census tract level that influences optimal health outcomes.
5. **Develop well-informed, individualized strategies:** Find out what support is needed for the intervention to be successful. CPH will access both market research data and community voice for this step, which will contribute to a deeper understanding of community conditions and strategies for building long-term resilience.

Priority Health Needs

When selecting the five prioritized health needs for Columbus and Franklin County, the steering committee for *HealthMap 2025* considered the data gathered for the report, the impact the need has on a person's quality of life and life expectancy as well as the community's resources and ability to address each need.

Social Drivers of Health with a Focus on Housing

Housing is seen as one of our most basic and foundational needs. When an individual or family struggles to afford their rent, mortgage payment and/or other housing related costs, they will most likely prioritize keeping themselves or their family housed and sacrifice other needs such as nutritious food or medical care. Further, the chronic stress of eviction, unsafe and unhealthy housing conditions and rising utility bills leads to poor mental health.

Franklin County's rate of housing cost-burdened households is higher than the state of Ohio, but just 1% higher than the national average. Central Ohio is not alone facing a housing crisis, as the rate of cost-burdened households at the state and national level both increased from 2023 to 2024, and the number at the national level reached an all-time high in 2024. The situation does not have one leading cause, and the solution requires a multi-sector, multi-faceted approach. The concept of safe and healthy housing as a public health issue is not new, and public health has a long standing and important seat at a long table of experts working together to improve housing and its impact on the residents of our community.

Factors contributing to housing instability:

- Income restraints
- Rising cost of home repairs
- Zoning
- Low housing stock
- Historic disinvestment
- Inability to navigate resources
- Lack of housing diversity
- Landlord/tenant tension
- Violence
- Cultural/language barriers
- High property taxes
- Inflation outpacing wage growth

In a 2024 report commissioned by Columbus Public Health, housing was identified as one of nine consistent barriers that impacted one's access to healthcare. The report also noted that low-income and communities of color were more likely to be impacted by housing instability and that the disparity was even more prevalent in those with behavioral health needs. These findings are supported by ADAMH's 2024 Community Needs Assessment for Franklin County, which noted that the daily life challenges faced by lower-income individuals, including housing, exacerbate issues of mental health and substance use.

Mental Health

Mental health is a broad term that encompasses emotional, psychological and social well-being. There are many factors that contribute to the fluctuating status of a person's mental health. Genetics, social circumstances, exposure to trauma and abuse, substance use, lifestyle choices as well as social relationships and support systems can all impact mental health.

The *HealthMap* steering committee members expressed concern with the rates of reported loneliness (26.4%) and depression (23.7%) in Franklin County. Both conditions were more prevalent in Franklin County's western and northern zip codes. These zip codes also score high on the social vulnerability index, indicating that residents in these zip codes may also be experiencing other barriers and conditions that are known to impact mental health, such as poverty, disability, cultural and linguistic barriers, access to healthcare and housing instability.

Youth have been identified as a particular group of concern for mental health conditions. Nationally, data from the 2023 Youth Behavior Risk Factor Surveillance Survey show that 33% of high school students and 20% of middle school students report that their mental health is not good most or all of the time. Healthy, resilient children have a better chance of becoming healthy, high-functioning adults who can reach their full potential.

While loneliness and depression are experienced at higher rates in certain geographic areas and groups of people, they occur across all age groups, socioeconomic groups, and races. Solutions for these conditions are challenging. Due to a shortage of mental health providers in Central Ohio, many report long wait times. Additionally, there is a general lack of knowledge about mental health and existing services. Loneliness often indicates issues with social infrastructure. Loneliness occurs when there is a lack of community connectedness, sense of belonging, loss of hope or fear of being one's authentic self. As a community we must commit to building community resiliency, fostering inclusive communities and improving access to mental health education and services.

Adverse Childhood Experiences

Adverse Childhood Experiences (ACES) are potentially traumatic experiences that happen to a child before the age of eighteen. ACES can include, but are not limited to experiencing or witnessing trauma, abuse or violence, having a family member die by suicide, having a family member with substance use disorder, living in poverty, and experiencing parental separation due to divorce, deployment or incarceration. ACEs are prevalent in Franklin County with 16.9% of adults reporting four or more ACES. Those identifying as Black had a prevalence of 21.8%. According to the CDC, nationally certain groups are at a greater risk of experiencing one or more ACES, such as females and youth identifying as part of the LGBTQIA+ community.

ACES can have lasting consequences on a person's physical and mental health and negatively affect a person's life opportunities. ACES have been associated with lower high school graduation rates, increased maternal and child health problems, and higher rates of chronic disease. Additionally, those experiencing ACES related to growing up in poverty or under-resourced, unstable homes are more likely to have job instability, struggle with finances and experience depression in adulthood. Further, ACES have generational impacts if they remain unresolved and can affect the ways families face stress. As a result, some may develop maladaptive coping mechanisms.

There are protective factors for ACES and preventing ACES is possible. Strong families help build strong communities. It may not be possible to avoid all ACES, however we can work to reduce the impact of difficult events and improve a child's ability to move positively through life afterward. Having access to nurturing relationships with both peers and adults is very important. That includes strong caretakers both at home, in school and in the wider community.

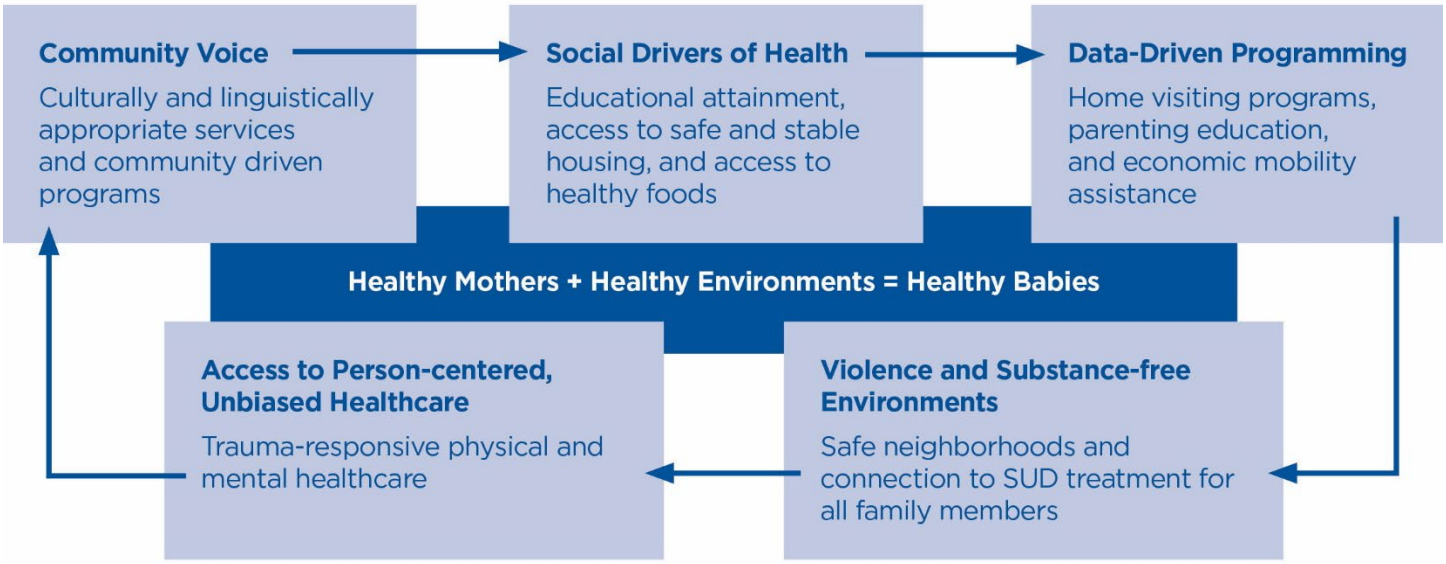
Building a community where families have access to resources, including healthcare, housing, and economic help in addition to strong relationships is critical. Residents must feel connected not only to resources but to each other. Studies have shown that communities with strong partnerships between healthcare systems, community-based organizations, government and business offer a protective factor against ACES. Central Ohio has a strong foundation for collaboration and partnership and remains committed to utilizing existing partnerships and building new ones to become a truly ACES-Resilient community.

Maternal and Infant Health

Maternal and infant health is an important indicator of a community's health. It shows us the importance of addressing mental and physical health throughout the lifespan. Prenatal care is critical, but chronic disease management, access to nutritious food and managing stress must begin long before a pregnancy occurs. Focusing only on the perinatal period would prevent progress in working toward improving upstream health factors that have a heavy impact on maternal morbidity and infant health.

ZIP codes with the highest infant mortality rates also experience concentrated poverty, limited prenatal care access, and systemic barriers to good health. Mothers in these ZIP codes are less likely to receive timely prenatal care: 57.7% of births in these neighborhoods initiated prenatal care in the first trimester of pregnancy, compared with 70.0% of births in the rest of Franklin County. Racial disparities are also concerning: in 2025, 30% of births in Franklin County were to non-Hispanic Black mothers, yet this population experienced 53% of infant deaths. These disparities are the result of avoidable and unjust differences in our community. It is imperative that multi-disciplinary teams further explore the causes of disparities in birth outcomes, maternal health, and infant deaths. We must consider how both clinical and community-based strategies can work together to reduce disparities and health inequities.

All the priority health needs in this plan influence maternal and infant health. The solutions for improving outcomes lie at the intersection of public health research, practice and policy.



Violence and Injury-related Deaths

Violence and injury-related deaths are a significant public health problem. Injuries and violence, such as car crashes, suicide, overdoses, and homicides, are the leading cause of death for Americans aged 1-44, according to the Centers for Disease Control. By and large, these deaths are preventable. Much work remains to reduce the prevalence of these deaths and eliminate disparities among the groups disproportionately experiencing suicide, unintentional overdose deaths, and community violence.

Suicide

Despite significant efforts to prevent suicide, the suicide rate in Franklin County has continued to increase over the last five years. Certain groups in Franklin County, such as veterans, older adults aged 75-84, young adults aged 15-24, and those who identify as LGBTQIA+ are at a higher risk of dying by suicide. There are many underlying societal factors and conditions that may lead to suicide. Strategies aimed at improving the social determinants of health, mental health and ACES indicators in this plan can also have significant impact toward reducing suicide. Increased access to mental health support, crisis care, community support and data are necessary for addressing the growing number of suicides. There is a significant lack of data for at least two of the high-risk groups noted above: LGBTQIA + and youth. Partners across the community remain committed to understanding and addressing the causes contributing to suicide and improving interventions and supportive care that can prevent suicide.

Unintentional Overdoses

Unintentional overdose deaths and nonfatal overdoses remain significant public health challenges in Franklin County, although recent years have shown encouraging signs of progress. After reaching historic highs during the COVID-19 pandemic, both overdose deaths and nonfatal overdoses have declined due to expanded community collaboration, increased naloxone distribution, improved access to treatment and recovery supports, risk reduction efforts, and stronger overdose surveillance systems. In 2025, there were fewer than 400 overdose deaths for the first time in nearly a decade. Despite these improvements, overdoses continue to place a significant strain on emergency response and healthcare systems and disproportionately impact certain communities and populations. Communities of color, people experiencing homelessness, and people who are justice-involved, continue to bear a disproportionate share of overdose deaths and nonfatal overdoses. In 2025, the overdose death rate was 1.7 times higher for Black individuals than for White individuals. Additionally, the drug supply has become increasingly complex, with fentanyl frequently being combined with stimulants and other substances. Addressing the overdose crisis requires continued coordination across public health, healthcare, behavioral health, public safety, outreach organizations, and community partners. Expanding access to prevention, risk reduction, treatment, recovery support, linkage to care, and timely data will remain critical to sustaining overall progress and reducing disparities in Franklin County.

Violence-related Deaths

Columbus, like many other large cities in the United States, faced an increase in violence during the COVID-19 Pandemic. This was especially true for gun violence. In 2021, violence spiked in Columbus with 209 homicides, over 85% of which were the result of a gun. Gun violence comes at a great cost to residents, taking the lives of their loved ones every year. Not only does it lead to poor mental and physical health, but it costs taxpayers a significant amount of money. The neighborhoods experiencing high rates of violence, also known as hotspots, are also experiencing significant social and health needs.

In February,2022, the City of Columbus declared gun violence as a public health crisis. In response, in 2023, the City established an Office of Violence Prevention and greatly expanded its violence reduction programming. This key step has allowed for stronger collaboration, more effective prevention efforts, and an increase in community resiliency, thus leading to a large reduction in homicides, nonfatal shootings, and other violent crimes. In 2025, Columbus recorded 84 homicides, a 60% reduction from 209 homicides in 2021. There were 209 non-fatal shootings with a gunshot wound injury, a 31.25% reduction from 2024.

Using data to understand where crime is happening and who it is happening to, as well as working together through a blended approach of law enforcement, education, social services, community empowerment, and innovation, offers hope for a safer and healthier Central Ohio.

Goals and Strategies

Background: Subject matter experts across seven divisions at Columbus Public Health and numerous community-based organizations helped develop this plan. Their guidance and commitment ensured that this plan meets the needs of the community and will improve lives for not only our most vulnerable populations, but all residents of our greater Columbus community. CPH and its partners agreed upon the following high-level strategies as the best way to move toward improving health outcomes and achieving equity in Social Determinants of Health, Mental Health, Adverse Childhood Experiences, Maternal and Infant health and Violence and Injury-Related Deaths.

The next step will be the development of an implementation plan based on the goals below. CPH will work with its partners to determine the actions necessary to implement these strategies and track their progress. The implementation plan will be an annual plan that can be reviewed and revised as necessary to ensure that work is moving forward. Progress reports will be available via dashboards and annual reports.

GOAL A: Utilize Intentional Inter-Agency Collaboration: Streamline planning efforts and break down silos among community partners and city agencies.

STRATEGY 1: Improve access to care through a coordinated effort among healthcare partners by launching the Columbus Access to Care Collaborative

Lead Agency: Columbus Public Health

Partners: Healthcare service providers, including, but not limited to, hospitals, Federally Qualified Health Centers (FQHCs), and Free & Charitable Clinics that provide healthcare services in Columbus.

The Columbus Access to Care Collaborative is a citywide partnership initiative led by Columbus Public Health to address barriers that prevent residents from accessing timely, affordable, and quality preventative healthcare services. The Collaborative will serve as a formal structure for healthcare providers and public health leaders to coordinate efforts, identify service gaps, and implement strategies that improve access to care and prioritize improving routine and preventative healthcare access for underserved populations throughout Columbus. The initiative will focus on strengthening partnerships among healthcare systems, reducing duplication of services, improving referral coordination, and identifying innovative solutions that increase healthcare accessibility and equity across the community.

Columbus Public Health aims to convene the collaborative and to set formal goals and priorities to work closely with healthcare providers to improve healthcare access for uninsured and underinsured residents, strengthen coordination across healthcare systems, enhance efficiency in service delivery, and support healthier outcomes for all Columbus residents.

STRATEGY 2: Identify and fill data gaps necessary for community health planning

Lead Agencies: Columbus Public Health, Franklin County Public Health, Central Ohio Hospital Council, other partners as identified

Central Ohio is home to two local health departments, three adult hospital systems and one children's hospital system. To streamline resources, improve the health planning process, and meet PHAB accreditation requirements, Columbus Public Health (CPH), Franklin County Public Health (FCPH) and the Central Ohio Hospital Council (COHC) have worked together successfully over the last five health planning cycles (2013, 2016, 2019, 2022, 2025) to develop Franklin County *HealthMap*, the county's community health assessment. *HealthMap* is an important guidebook for directing health departments, hospitals and community partners toward strategies to improve the community's health. While it aims to be a comprehensive picture of the community's health, gaps in data remain. Data gaps can prevent agencies from truly understanding where problems are occurring, who is impacted, and what forces are driving morbidity.

CPH, FCPH and COHC aim to maximize their partnership to improve access to needed data for their partners by assessing and filling data gaps. As the executive steering committee for *HealthMap*, they will collaborate on an on-going basis to collect data, share data with the public and identify additional processes and collaborations needed for future health needs assessments and community plans. Streamlining and improving data collection and distribution will help identify root causes of community health issues and strengthen interventions to improve health outcomes.

STRATEGY 3: Improve real-time data sharing across agencies to identify emerging trends, high-risk populations, and guide interventions and resource allocation to reduce overdose deaths.

Lead Agency: Columbus & Franklin County Addiction Plan (CFCAP) at Columbus Public Health

Partners: CFCAP Coalition partners

The Columbus & Franklin County Addiction Plan (CFCAP) is a multi-sector coalition housed at Columbus Public Health, bringing together partners from public health, healthcare, behavioral health, recovery support, harm reduction, public safety, faith-based communities, and other community organizations. While Franklin County has seen recent declines in overdose deaths, the drug supply and patterns of use continue to shift, and disparities persist across populations and neighborhoods.

CFCAP serves as a central hub for overdose surveillance, integrating data from EMS response records (ODMAP), emergency department syndromic surveillance (Epicenter), mortality data, and frontline partner observations. CFCAP shares information with coalition partners and frontline organizations through biweekly overdose surveillance bulletins, surge notifications, coalition meetings, and other communications to support coordinated action aimed at reducing fatal and non-fatal overdoses and associated disparities.

This strategy will strengthen Columbus and Franklin County's cross-sector data infrastructure to enable earlier identification of emerging trends, geographic hotspots, and populations experiencing disproportionate burden. Ultimately, this work will enhance the community's ability to deliver timely, targeted, and equitable overdose prevention and response across Columbus and Franklin County.

GOAL B: Prepare the workforce to meet community needs: Build a competent, compassionate and equity-minded workforce.

STRATEGY 1: Enhance workforce development by strengthening and expanding Academic Health Department and similar relationships

Lead Agency: Columbus Public Health

Partners: The Ohio State University College of Public Health, Ohio University Alliance for Population Health

Academic Health Department is a recognized national community-based program, managed by the Council on Linkages Between Academia and Public Health Practice, that supports the development, maintenance, and expansion of partnerships between health departments and academic health professions institutions to share related knowledge and experiences, as well as to work collaboratively to create resources and tools. Academic Health Department relationships provide an essential opportunity for the future public health workforce to gain first-hand experience in public health via internships, projects and conferences. Academic Health Department relationships offer an opportunity to ensure that students can translate academic competencies into professional job competencies. In turn, the current public health workforce benefits through enhanced access to research, access to data, mentorship experiences, professional development, and opportunities to influence best practices. When health departments work together with academic institutions, their ability to deliver essential public health services improves.

Columbus Public Health (CPH) aims to expand both the number of academic partnerships and the impact of the program via the students it serves. The field of public health is constantly evolving, and the workforce must adapt and grow with the changes. CPH will work with their existing partners to broaden and strengthen program objectives, expand opportunities for public health professionals to bring real-world perspectives to academic practice and increase leadership skills for both the current and future workforce. CPH will seek out additional academic institutions for partnership and explore innovative ways to utilize all Academic Health Department relationships to improve workforce development and enhance our ability to meet community needs.

STRATEGY 2: Build the future public health workforce and improve public health programming through youth engagement.

Lead Agency: Columbus Public Health

Partners: Columbus City Schools

Columbus Public Health's Youth Advisory Council (YAC) is a school-based service-learning program designed to expose high school students to public health careers while empowering them to see themselves as leaders and changemakers in their communities. This initiative is rooted in the Positive Youth Development framework and supports the development of a future workforce that is passionate about public health by creating meaningful opportunities for youth to learn about health equity, social determinants of health, prevention, community engagement, and public service directly from public health professionals at Columbus Public Health. Through partnership with Columbus City Schools, students participate in interactive sessions, mentorship, career exposure, and youth-led projects that connect classroom learning to real-world public health challenges.

Youth are greatly impacted by public health issues but may not know that public health is a career pathway where they can use their lived experience, creativity, and leadership to improve community health outcomes. Through the YAC, Columbus Public Health will continue to build intentional pathways for high school students to explore public health, strengthen leadership skills, and contribute their voices to community health improvement efforts. By centering youth voice and connecting students with public health professionals, CPH is working to cultivate a Columbus-centric professional pipeline that honors hyper-local knowledge by sustaining a workforce that is deeply embedded in the social and cultural fabric of the areas we serve.

STRATEGY 3: Train and utilize health equity champions to integrate health equity planning in all services.

Lead Agency: Columbus Public Health

Columbus Public Health's Center for Public Health Innovation (CPHI) is the division responsible for advancing health equity. CPHI will be training and supporting Health Equity Champions. Health Equity Champions will be identified Columbus Public Health staff from all divisions who will be trained in advanced health equity concepts and charged with driving forward a health equity vision and planning process within their division.

Health Equity Champions will be able to conduct place-based analysis, which is a localized evaluation method that examines social, economic, and environmental outcomes within a specific geographic area. It allows for targeted community planning to reduce disparities and inequities by identifying where adverse health conditions coexist at their highest levels all the way down to the census tract. Additionally, it allows for the ability to determine the unique cultural, environmental, and social conditions that influence how a specific community functions.

CPH Health Equity Champions will move the vision of health equity forward on a broader scale by recruiting and training Health Equity Champions across all departments of the City of Columbus. This will create opportunities for all departments to have access to technical support within their respective departments to enhance city planning with a health equity vision. Employees will be able to integrate health equity into their daily work with the public as well as their work with community and regionally-based organizations.

STRATEGY 4: Expand the reach of trauma-responsive care by training public health professionals, school personnel and community members in addition to healthcare workers.

Lead Agency: Columbus Public Health

Partners: Columbus CARE Coalition trauma training volunteers, Finding Hope Consulting, LLC, The Center for Family Safety & Healing, Franklin County ACES Coalition

Trauma-responsive care is a framework that helps a caregiver understand the complete picture of a person's past experiences and how those experiences may be impacting their current symptoms and behaviors. Many people have experienced trauma, but they may not realize how it affects their current struggles or may avoid discussing it. At the same time, care providers may fail to ask about trauma or feel unequipped to respond to the person's needs or situation. Trauma-responsive approaches focus on creating safe, collaborative, and compassionate environments. When equipped with the right skills, care givers and peers can avoid practices that may retraumatize their clients, students or neighbors. Meanwhile, they can support their strengths and resilience. Safe adults serve as a primary protective factor for children and youth, fostering resilience by providing consistent emotional support, guidance, and safety, which mitigates the impact of Adverse Childhood Experiences (ACEs). These caring, trustworthy individuals encourage healthy development, improve mental health, and boost academic success.

Columbus Public Health (CPH) actively integrates trauma-responsive knowledge into its policies, practices and programs. Additionally, the CARE Coalition team has been a leader in training the community in trauma-informed care. CARE Coalition provides free trainings to community members and social service providers on the impact of individual and community trauma, the paradigm shift to trauma-responsive care, and ways to emphasize and expand resilience factors. CARE Coalition facilitates "train the trainer" sessions so that staff and volunteers can provide these trainings on behalf of the Coalition. These trainings vary from introductory one-hour sessions to multi-day deep dives into the neuroscience behind trauma and resilience.

CPH aims to build a trauma-responsive workforce and community mindset, not just among healthcare professionals, but also among all people who act in the care and support space- including peers, teachers, mentors, parents and coaches. CPH, together with partners from healthcare agencies, schools, community-based organizations and faith communities will explore ways to increase access to evidence-based curriculums that are tailored to the intended audience. Additionally, CPH aims to train additional staff to facilitate expansion of community training efforts.

GOAL C: Enhance linkages to care: Ensure that residents and partners have timely access to community resources.

STRATEGY 1: Through a coordinated, countywide approach, Franklin County will increase access to crisis care, ensuring that residents can receive the support they need quickly, easily, and at the appropriate level of care.

Lead Agency: ADAMH Franklin County

Partners: ADAMH Network Providers

Franklin County is experiencing a sustained increase in behavioral health needs that is outpacing current crisis-care capacity. The ADAMH Community Needs Assessment noted that 8% of residents reported needing crisis care but were unable to access it. In response to this need, ADAMH and its partners are working to ensure that crisis care is strengthened and easier to access than ever before.

988 was nationally launched in 2022 and provides immediate telephonic assistance to those having a mental health crisis. Calls are free and confidential and aim to offer support for people experiencing suicidal ideation, mental health challenges, depression, anxiety, loneliness, and general emotional distress. In Franklin County, ADAMH collaborates with Network providers and Community Partners to increase awareness of and access to 988. Community mobile crisis teams are also available to those in need and can transport to the Franklin County Crisis Care Center when necessary. Together, these resources will increase the community's access to timely and appropriate services.

ADAMH opened the Franklin County Crisis Care Center (FCCCC) in 2025. The center is a collaboration between ADAMH and ADAMH Network Providers and offers the community a no-wrong door approach for accessing crisis care, including 24/7 walk in service, 23-hour observation, and a discharge pharmacy. Guests are provided with needed connection to further community-based care upon discharge. The Crisis Center will phase in additional services in 2026 and 2027. Through 988 services and FCCCC services, ADAMH and their partners aim to reduce the unmet need for crisis care.

STRATEGY 2: Prevent literal homelessness and reduce the burden on shelters through expanded housing services programs and partnerships.

Lead: City of Columbus Department of Development

Partners: Columbus Public Health, City of Columbus Building and Zoning Services, Department of Development Resilient Housing Initiatives partners

As the Emergency Rental Assistance (ERA) program ended in the fall of 2025, the Columbus Department of Development launched a new homelessness prevention initiative for residents at risk of unsheltered homelessness. Insights from the ERA program and the Central Ohio Street Housing Network (COSHN) highlighted a critical need for both direct financial aid and supportive services.

To address this, the Resilient Housing Initiative collaborates with local non-profits to deliver housing-focused case management, problem-solving services, prevention and diversion tactics, relocation services, and financial assistance. To meet growing demand, the city is expanding the service provider network from 10.75 to 16 Full-Time Equivalents in 2026, while allocating additional financial aid funds. Under program guidelines, housing is considered stable when a household can remain in their home long-term, typically achieved when housing costs consume 30% or less of their income.

Unsafe living conditions also severely threaten local housing stability. When property owners fail to maintain rental units, tenants face displacement. Following large-scale emergency closures at complexes like Latitude 525 and Colonial Village, the City of Columbus established the Vacated Tenant Services program to provide temporary hotel stays and relocation support.

This safety net was legally formalized under Columbus's Tenant Relocation Ordinance. Under this law, if Code Enforcement orders a tenant to vacate due to unsafe conditions that are not the tenant's fault, the property owner can be legally required to provide up to three months of relocation payments and assistance. When a vacate order is issued, Code Enforcement immediately notifies the Department of Development and Columbus Public Health (CPH). CPH social workers then coordinate with the displaced tenants to secure city-funded temporary housing and connect them with comprehensive relocation services. These programs will prevent literal homelessness, reduce the burden on the shelter system, and provide tenants with stability, dignity, and support as they search for new housing.

STRATEGY 3: Maximize cross-sector partnerships to strengthen healthcare provider outreach and parent education to increase lead screening for children 0-6 and pregnant women and connect families to mitigation and prevention resources.

Lead Agency: Columbus Public Health

Partners: Ohio Chapter of the American Academy of Pediatrics, City of Columbus Department of Development

Lead exposure affects the health, safety and wellbeing of children by damaging their brain and nervous system, causing speech and hearing problems, and increasing anti-social behavior that leads to violence and incarceration. Every year in Columbus, an average of 140 children have elevated lead levels. From August 2024 to July 2025, Columbus Public Health (CPH) screened over 230 kids for elevated blood lead levels, with 6% of children testing high. Many of these children are poisoned in their own homes.

In 2023, CPH held a Call to Action to address the inequities in exposure to lead in our community. Children living in redlined and disinvested neighborhoods where homes were built prior to lead paint being banned in 1978 are exposed to lead at much higher rates. A disproportionate number of those children are black. Since the kickoff of the Healthy Children and Safe Home by 2040 initiative, CPH has successfully worked with other City of Columbus Departments, community partners and community members themselves to increase access to lead screening, educate parents and healthcare providers of importance of screening and increase access to lead remediation resources offered by the City of Columbus Department of Development.

CPH aims to build on their successes in the healthcare and community spaces by making their education and screening services more accessible. CPH is committed to continuing their outreach to pediatric healthcare providers and will expand to OBGYN providers to deliver guidance on testing pregnant and lactating

women. Previous education has been provided in person but will now be available virtually on-demand with free continuing education credits for both nurses and physicians. The CPH Strategic Nursing team will utilize their new mobile unit to increase their ability to screen children in high-risk neighborhoods via community events, daycares and WIC Clinics. Additionally, lead screening will be expanded to the CPH Immunization clinic. Any child screening high will be connected to lead remediation services and resources for home repairs in Columbus.

STRATEGY 4: Establish an internal Hepatitis C Workgroup to improve testing, care coordination, treatment access, and community-based intervention strategies that strengthen infectious disease response systems and improve access to equitable care coordination and treatment services.

Lead Agency: Columbus Public Health

Partners: Community healthcare providers, hospital systems, Federally Qualified Health Centers (FQHCs), behavioral health providers, and community-based organizations.

The Hepatitis C Workgroup is an internal multidisciplinary initiative led by Columbus Public Health (CPH) focused on improving Hepatitis C (HCV) testing, linkage to care, treatment coordination, and long-term disease management throughout the Columbus community. The Workgroup will coordinate efforts across programs and external healthcare partners to reduce barriers to treatment access and improve referrals and care coordination to improve health outcomes for individuals disproportionately impacted by Hepatitis C.

Hepatitis C remains a significant public health concern, particularly among vulnerable populations facing barriers related to healthcare access, substance use, housing instability, transportation, insurance coverage, and stigma. While highly effective curative treatments are available, many individuals remain undiagnosed, disconnected from care, or unable to successfully complete treatment due to fragmented systems.

To address these challenges, Columbus Public Health will establish a formal internal workgroup focused on building coordinated systems for Hepatitis C testing, follow-up, referrals, and treatment navigation. The Workgroup will support the integration of new EPIC capabilities within Columbus Public Health to improve data sharing, referral management, patient navigation, and continuity of care across internal programs and external healthcare providers.

GOAL D: Build Community Resiliency: Foster safe environments for all residents to grow and thrive.

STRATEGY 1: Engage schools across Franklin County to strengthen connections to behavioral health resources and foster learning environments that support the mental health of all students.

Lead: ADAMH Franklin County

Partners: Franklin County school districts

Franklin County is facing a significant and growing behavioral health crisis, and young people are at the center of it. While mental health has worsened across the broader population over the past decade, data make clear that young people are on the leading edge of this trend. Depression rates among Franklin County residents ages 12–25 rose meaningfully from 2012 to 2018, while rates among adults 26 and older remained flat, pointing to adolescence and early adulthood as a particularly critical window for intervention.

In Ohio, 35% of high school students reported symptoms consistent with clinical depression in 2023, up from 26% a decade earlier. Income-related disparities compound these concerns: Franklin County youth ages 11–18 in lower-income households experience mental health impairment at rates more than 50% higher than the overall youth population. Schools increasingly serve as primary point of contact for students experiencing mental health challenges and many are seeking stronger connections to community-based resources, trained partners, and coordinated systems that extend beyond what any single institution can provide alone. ADAMH will engage Franklin County schools to determine their needs. Working together, and in partnership with ADAMH-funded school-based prevention providers, they will develop a coordinated, community-driven approach that meets schools where they are and builds on existing strengths within Franklin County school districts.

STRATEGY 2: Enhance the effectiveness of the Community Violence Intervention Ecosystem through formalized partnerships, processes and plans.

Lead Agency: City of Columbus Office of Violence Prevention

Partners: Columbus Public Health (ReRoute, VOICE, Linden Anti-Violence, CARE Coalition, Living After Loss, One Block at a Time, Family Engagement and the Violent Crime Review Group), Columbus Recreation and Parks (ReRoute and VOICE), Columbus Violence Reduction, Columbus Urban League and Community for New Direction.

A Community Violence Intervention (CVI) Ecosystem is a coordinated network of city programs and community-based organizations working together to reduce violence. The Office of Violence Prevention has worked to establish an ecosystem that is currently composed of Columbus Violence Reduction, Columbus Urban League, Community for New Direction, and multiple programs from Columbus Public Health and Columbus Recreation and Parks. The City of Columbus Office of Violence Prevention (OVP) serves as a convening and coordinating agent of Columbus' CVI ecosystem.

CVI ecosystems address the root causes of violence, intervene in imminent acts of violence, and provide comprehensive support to those affected by violence. Each program in the ecosystem specializes in at least one of the CVI components, such as hospital-based violence intervention, crisis management, or preventive youth development.

Cross-program collaboration bolsters the ecosystem's collective impact. Programs work together to provide integral support after violence occurs or to prevent the next violent incident.

OVP hosts monthly meetings for ecosystem leaders, providing dedicated time and space for collaboration. The ecosystem works together to reduce violence through formalized collaboration, working towards the establishment of an ecosystem referral process and the co-creation of an explicit, written emergency preparedness plan.

STRATEGY 3: Engage those at the highest risk of being impacted by gun violence

Lead: City of Columbus Office of Violence Prevention (Columbus Violence Reduction)

Partners: Columbus Division of Police, Community Violence Intervention Ecosystem, Department of Youth Services, Department of Rehabilitation and Correction, Franklin County Adult Probation, Franklin County Prosecutor, Franklin County Juvenile Court, United States Attorney's Office for the Southern District of Ohio

Data shows that most of a city's violent crimes are committed by a very small number of people. To create a culture of anti-violence and community caring, different levels of intervention are necessary for different groups of people. Those who are already involved in violent crime require a higher level of support and services to make a transition to leading a life without violence than those who may be at-risk but have not yet engaged in violent or criminal acts.

Columbus Violence Reduction (CVR) is a specific, relationship-based gun violence reduction strategy. Grounded in evidence-informed practices and the principles of focused deterrence, CVR works with individuals who are at the very highest risk of involvement in gun violence. Through coordinated collaboration with public safety, criminal justice professionals, and community stakeholders, the program delivers intensive outreach, life coaching, cognitive behavioral interventions, and individualized support to reduce violence, improve outcomes, and enhance public safety.

STRATEGY 4: Increase access to violence prevention resources and engagement opportunities

Lead: City of Columbus Office of Violence Prevention

Partners: Columbus City Schools, Franklin County Juvenile Intervention Center, and Community Based Organizations

Prevention is an essential component of the strategy to reduce violence. Prevention efforts include gaining an understanding of the root causes driving community violence, raising awareness about available resources, and providing skill-building opportunities for community members to learn about conflict resolution, bystander intervention, and healthy relationships.

The Safer Together 614 campaign is based on 2024 violent crime statistics and causative factors that persisted into 2025. In 2025, 27.5% of homicides in Columbus were caused by arguments and disputes and an additional 36.9% were connected to domestic violence.

In response to these recurring causative factors, the Office of Violence Prevention launched the Safer Together 614 Campaign, an educational campaign designed to offer alternative solutions to conflict and promote peaceful de-escalation by way of a toolkit geared towards a youth and young adult audience.

The toolkit features educational materials on bystander intervention, understanding, and identifying healthy relationships through red and green flags, and setting healthy boundaries.

OVP's community engagement team is dedicated to bringing this facilitated conversation and content into the community in locations such as Columbus City Schools or the Franklin County Juvenile Intervention Center. These engagements range in scale from school-wide community conversations spanning across grade levels to smaller, intimate group settings. The team also provides scenario-based learning opportunities, allowing youth to practice skills in real time.

STRATEGY 5: Build housing resiliency through a unified community education plan that helps residents address housing issues before they reach a crisis level.

Lead Agency: City of Columbus Department of Development

Partners: Columbus Public Health, Columbus Water and Power, and other social services and community-based organizations

Columbus residents facing housing insecurity are often unaware of the resources available to them and the protections they have under federal, state, and local laws. The Department of Development Division of Housing Stability will employ a Community Outreach Specialist to engage with tenants, property owners, and residents facing homelessness. The Division will create and execute a community education plan, including the creation and distribution of materials on housing rights. Potential topics of initial public education materials include Columbus's tenant protection ordinances, fair housing rights, eviction prevention, housing resilience resources available in Columbus, and how to address unsafe rental housing conditions and practices. When Columbus residents better understand their rights and obligations around housing, they are better prepared to enforce their rights and are less susceptible to predatory practices.

GOAL E: Advance policy and system-level strategies that improve health outcomes and reduce inequities.

STRATEGY 1: Support cross-sector policy approaches that improve housing quality, accountability, and housing stability for residents.

Partners: City of Columbus Department of Development, Building and Zoning Services (BZS), City of Columbus Women's Commission, Columbus Public Health, Columbus Water and Power, Community Mediation Services of Central Ohio, Legal Aid Society of Southeast and Central Ohio, Community Shelter Board, CelebrateOne

Stable housing and healthy home environments are closely connected to health outcomes, neighborhood stability, and quality of life. In April of 2026, the City of Columbus passed a rental registry ordinance requiring that all residential rental properties in the City register, provide basic information to the City, and allow preventative education inspections of critical systems such as heat, water, and fire safety on a tri-annual basis. Properties with significant, recurring housing safety issues can be designated as conditional registrants and are subject to additional inspections and interventions from Building and Zoning Services. This new rental registry system is an opportunity for the City of Columbus to be more proactive in identifying unsafe living conditions before they reach a crisis stage, preventing displacement of residents due to critical systems failures.

When tenants do reach a point where they are facing eviction, they often lack the ability to successfully navigate the legal process. The City of Columbus supports housing stability for vulnerable Columbus families through the funding of the Access to Counsel program. Through this program, Legal Aid of Southeast and Central Ohio (LASCO) provides free legal representation in eviction court for Columbus households living at or below 100% of the Federal Poverty level that have at least one child in the home. Through LASCO's Tenant Advocacy Project, eligible families can access no-cost legal representation to prevent disruptive displacement through eviction. For residents not utilizing the Access to Counsel Program, the City funds Community Mediation Services to provide mediation services to households facing eviction on-site at the courthouse.

To ensure that fair and effective policies are enacted, programs remain funded, and the appropriate people have access to services, the Division of Housing Stability and its partners will reconvene the Eviction Prevention Working Group. This group will consist of representatives from various City agencies, other local government actors, the Municipal Court, and social service agencies. The Eviction Prevention Working Group will create policy and program recommendations to reduce disruptive displacement of residents, focusing its efforts on both up-stream and acute eviction prevention through two internal working groups utilizing data to target and finetune eviction prevention efforts supported by the City.

STRATEGY 2: Advance policy approaches that improve economic stability and reduce barriers impacting health.

Strategy Leaders: Columbus Public Health, City of Columbus Department of Development, RISE Together Innovation Institute

Economic stability is closely connected to housing stability, behavioral health, maternal and infant health, and long-term community well-being. Rental housing costs continue to increase, as do many other indicators of affordability. According to the 2026 National Low Income Housing Coalition Report, a full-time worker in the Columbus area must earn $27.79 per hour to afford the average fair market rent for a two-bedroom apartment. This highlights the need for the Department of Development, CPH, and their partners to work collaboratively to support system-level approaches that improve economic stability and address upstream barriers impacting health outcomes. This includes support for cross-sector partnerships connected to the Economic Mobility Accelerator (EMA) initiative and continued collaboration through the TRUST Community of Practice focused on economic support and direct cash assistance strategies. A progress report from July 2025 for the EMA showed that 91% of participants were housing cost burdened, with nearly three-quarters being severely burdened. In addition to direct cash assistance, the program provides participants with a guided pathway to strengthen their ability to seek higher education and career

advancement. This two-year pilot program is currently in progress and partners will work to continue building momentum and bringing partners together to scale cash-based interventions.

STRATEGY 3: Increase access to healthy food and nutrition support through policy, systems, and cross-sector collaboration.

Strategy Leads: Columbus Public Health, Franklin County Public Health, Franklin County Economic Development & Planning

Partners: Franklin County Women, Infants and Children, Mid-Ohio Food Collective, healthcare systems, Local Food Board, and other community-based organizations

Food access and nutritional support programs such as Supplemental Nutrition Assistance Program (SNAP) and Women, Infants and Children (WIC) are evidence-based and closely connected to chronic disease prevention, maternal and child health outcomes, and overall community wellness. The leaders of this strategy aim to support policy and systems approaches that improve access to healthy and affordable food throughout Columbus and Franklin County. This includes alignment and implementation support related to the Columbus and Franklin County Local Food Action Plan, Produce Prescription programming opportunities, nutrition incentive efforts, and urban agriculture initiatives as well as the formation of a work group to explore the feasibility of universal WIC screening strategies.

The work group aims to understand and evaluate the current screening and referral pathways for the WIC Program. Screening and referral efforts can help identify eligible individuals who may not be participating in the program despite qualifying for services. Exploring a universal WIC screening process will determine what resources and partnerships would be needed to support implementation and sustainability as well as determine any unintentional consequences such as increased demand exceeding current service capacity.

Strategy Alignment & Priority Health Needs

KEY:
- Social Drivers of Health with a Focus on Housing
- Adverse Childhood Experience
- Violence and Injury-related Deaths
- Mental Health
- Maternal and Infant Health

Strategies ▼	Priority Health Needs ▼				
GOAL A: Utilize Intentional Inter-Agency Collaboration: Streamline planning efforts and break down silos among community partners and city agencies.					
Improve access to care through a coordinated effort among healthcare partners by launching the Columbus Access to Care Collaborative *Strategic Roadmap Priorities**: Prosperity 4.1, 4.2*	✓	✓		✓	✓
Identify and fill data gaps necessary for community health planning *Strategic Roadmap Priorities**: Prosperity 4.1, 4.2; Operations 5.2*	✓	✓	✓	✓	✓
Improve real-time data sharing across agencies to identify emerging trends, high-risk populations, and guide interventions and resource allocation to reduce overdose deaths. *Strategic Roadmap Priorities**: Safety 2.1, Prosperity 4.1, Operations 5.2, 5.3*	✓	✓		✓	✓
GOAL B: Prepare the workforce to meet community needs: Build a competent, compassionate and equity-minded workforce.					
Enhance workforce development by strengthening and expanding Academic Health Department and similar relationships *Strategic Roadmap Priorities**: Prosperity 4.3, Culture 6.3*	✓	✓	✓	✓	✓
Build the future public health workforce and improve public health programming through youth engagement *Strategic Roadmap Priorities**: Prosperity 4.1, 4.2, 4.3; Operations 5.3, Culture 6.3*	✓	✓	✓	✓	✓
Train and utilize health equity champions to integrate health equity planning in all policies and services. *Strategic Roadmap Priorities**: Safety 2.2, Prosperity 4.1, 4.2, 4.3, Operations 5.2, 5.3, Culture 6.2*	✓	✓	✓	✓	✓
Expand the reach of trauma-responsive care by training public health professionals, school personnel and community members in addition to healthcare workers. *Strategic Roadmap Priorities**: Prosperity 4.1, Operations 5.3*	✓	✓	✓	✓	✓
GOAL C: Enhance linkages to care: Ensure that residents and partners have timely access to community resources.					
Through a coordinated, countywide approach, Franklin County will increase access to crisis care, ensuring that residents can receive the support they need quickly, easily, and at the appropriate level of care. *Strategic Roadmap Priorities**: Prosperity 4.1*	✓	✓	✓	✓	✓
Prevent literal homelessness and reduce the burden on shelters through expanded housing services programs and partnerships. *Strategic Roadmap Priorities**: Housing 1.2, 1.3, Prosperity 4.3*	✓			✓	
Maximize cross-sector partnerships to strengthen healthcare provider outreach and parent education to increase lead screening for children 0-6 and pregnant women and connect families to mitigation and prevention resources. *Strategic Roadmap Priorities**: Housing 1.3, Prosperity 4.1, 4.2*	✓	✓	✓	✓	

Strategy Alignment & Priority Health Needs, continued

Strategies ▼	Priority Health Needs ▼				
Establish an internal Hepatitis C Workgroup to improve testing, care coordination, treatment access, and community-based intervention strategies that strengthen infectious disease response systems and improve access to equitable care coordination and treatment services. *Strategic Roadmap Priorities**: Prosperity 4.2, Operations 5.3*					
GOAL D: Build Community Resiliency: Foster safe environments for all residents to grow and thrive.					
Engage schools across Franklin County to strengthen connections to behavioral health resources and foster learning environments that support the mental health of all students. *Strategic Roadmap Priorities**: Prosperity 4.1, Operations 5.3*					
Enhance the effectiveness of the Community Violence Intervention Ecosystem through formalized partnerships, processes and plans. *Strategic Roadmap Priorities**: Safety 2.1, 2.2; Prosperity 4.2; Operations 5.3*					
Engage those at the highest risk of being impacted by gun violence *Strategic Roadmap Priorities**: Safety 2.1, 2.2; Prosperity 4.2; Operations 5.3*					
Increase access to violence prevention resources and engagement opportunities *Strategic Roadmap Priorities**: Safety 2.2; Prosperity 4.1, 4.2; Operations 5.3*					
Build housing resiliency through a unified community education plan that helps residents address housing issues before they reach a crisis level. *Strategic Roadmap Priorities**: Housing 1.2, 1.3, Prosperity 4.3*					
GOAL E: Advance policy and system-level strategies that improve health outcomes and reduce inequities.					
Support cross-sector policy approaches that improve housing quality, accountability, and housing stability for residents. *Strategic Roadmap Priorities**: Housing 1.1, 1.2, 1.3*					
Advance policy approaches that improve economic stability and reduce barriers impacting health. *Strategic Roadmap Priorities**: Prosperity 4.1, 4.2, 4.3*					
Increase access to healthy food and nutrition support through policy, systems, and cross-sector collaboration. *Strategic Roadmap Priorities**: Prosperity 4.2, Operations 5.3*					

*Aligns with Ohio's 2020-2022 State Health Improvement Plan. At the time of publication, the state had not released their 2025-2029 plan.

**The City of Columbus' strategic roadmap provides priority focus areas for moving the city's vision forward, which is *A Columbus where equitable opportunities foster prosperity for all who call Columbus Home.*

Closing

Thank you to the following organizations for your thoughtful input and contributions to this plan:

- ADAMH Franklin County
- Celebrate ONE
- Central Ohio Hospital Council
- City of Columbus Department of Development
- City of Columbus Department of Neighborhoods
- City of Columbus Office of Violence Prevention
- Columbus City Schools
- Columbus & Franklin County Addiction Plan
- Community Shelter Board
- Franklin County Public Health
- Franklin County Suicide Prevention Coalition
- Franklin County Veterans Service Commission
- Franklin County Women, Infants and Children
- The OHIO Alliance for Population Health
- Ohio Better Birth Outcomes
- Ohio Center of Excellence for Behavioral Health Prevention and Promotion, funded by Ohio Department of Behavioral Health and administered by Ohio University's Voinovich School for Leadership and Public Service in partnership with the Pacific Institute for Research and Evaluation
- The Ohio State University College of Public Health
- Worthington Schools

If you would like more information about the Community Health Improvement Plan, or would like to be involved, please contact:

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Looking for more information about data presented in this plan? Please visit the following links:

- ADAMH 2024 Community Needs Assessment
- ADAMH Data Dashboard
- Centers for Disease Control and Prevention 2023 Youth Risk Behavior Survey Results
- Centers for Disease Control and Prevention- ACES
- Centers for Disease Control and Prevention -Health Equity
- City of Columbus Office of Violence Prevention Data Reports
- Columbus and Franklin County Addiction Plan
- Columbus Division of Police Annual Reports
- Columbus Public Health Data and Reports
- Franklin County Suicide Prevention Coalition Data Reports
- Harvard University Joint Center for Housing Studies
- HealthMap 2025
- National Survey on Drug Use and Health- State Estimates of Mental Health and Substance Use
- Ohio Medicaid Assessment Survey 2023