Healthy Eating

- **Goal 1**: Increase resources to identify and address food insecurity.
    - **Objective 1.2**: Encourage and evaluate food insecurity screenings and food program referrals.

LiveHealthy FAIRFAX
Transforming our communities together
Partnership for a Healthier Fairfax

Priority Issue: Healthy Eating					
Goal 1	Increase resources to identify and address food insecurity. *				
Objective 1.2	Encourage and evaluate food insecurity screenings and food program referrals.				
Key Actions		**Timeline**	**Responsible Partners**	**Dedicated Resources**	**Accomplishments**
1.2. A ✔	Promote screenings by medical practitioners and health and human service providers.	01/2019 - 12/2023	Fairfax County Health Department (FCHD), Fairfax Food Council (FFC) Arcadia Center for Sustainable Food and Agriculture (Arcadia), FFO, Inova Health System, NCS & Fairfax County Department of Family Services (DFS)	Northern Virginia Health Foundation Grant (Arcadia) $75,000 01/2019 – 12/2019	• Implemented food insecurity screenings at the FCHD Annandale District Office immunization clinic, FCHD Maternal and Child Health Home Visiting Program, and Neighborhood Health. • Analyzed data from food insecurity screenings to assess barriers to food access and inform efforts to improve accessibility and utilization of food resources in the future.
1.2.B ↻	Explore opportunities for a pilot food insecurity screening program for older adults.	01/2020 - 12/2023	NCS, AAA, COA, FFC and FCHD	None identified	• AAA began exploration of a pilot food insecurity screening effort in tandem with county senior center sites. • Fairfax Agency on Aging and County Business Analysts identified congregate nutrition participants who screened positive for food insecurity. • Fairfax AAA plotted next steps that include working with this pool of participants to ask additional questions regarding food security, encourage maximum attendance at congregate nutrition sites, provide assistance for SNAP enrollment and link participants to resources. Follow-up with participants will happen in 6 months.
1.2.C ✔	Promote referral of individuals identified as food insecure to supplemental food programs.	01/2019 – 12/2023	FCHD, FFS, DFS, Fairfax County Public Schools (FCPS), Emergency Food Strategy Team (EFST), Neighborhood and Community Services Community Impact Unit	None identified	• Provided referrals to any persons screened who were identified as food insecure. • Created geographically tailored resource packets for the Annandale and South County areas that have local food resources and maps. • Collaborated with NCS to hold weekly/bi-weekly meetings with nonprofit, faith, FCPS and community organizations who were meeting the food needs in Fairfax County. The effort included the County development of a GIS map that documents all locations offering food assistance. • Participated in the EFST, comprised of county, nonprofit, faith, FCPS and community organizations meeting food needs in Fairfax County. Included development of GIS map of all food assistance locations. (**more next page**)

Status Legend: ✔ Action Performed ↻ Action In-Progress ⊘ Action Not Started

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1.2.C ✔	Promote referral of individuals identified as food insecure to supplemental food programs.	01/2019 – 12/2023	Neighborhood & Community Services Impact Unit	$7.5 million for FY22 – FY24	(**continued from previous page**) • Food Access Program (FAP) provided $7.5 million to nonprofit organizations and houses of worship to provide food assistance, support innovative models of direct food service delivery and infrastructure investments (FY22-24)
1.2.D ✔	Collect data on the use of food insecurity screenings, and food program referrals.	01/2019 – 12/2023	FCHD, FFC, NCS, NCS, AAA, COA, FFO & CAFB	None identified	• Implemented a social needs screening at the FCHD Annandale District Office (Oct – Dec 2022) that included two food insecurity questions where 55.8% of those screened were identified as food insecure. • Analyzed data of those identified as food insecure who were referred to food resources. At their 30-day follow-up, 62.2% had received food related services. Community Health Workers met with all the clients at the time of their screenings.