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Partnership for a Healthier Fairfax

Community Health Improvement Plan 2013-2018

Annual Report – Year Five

October 2017-December 2018

April 11, 2019

Acknowledgments

This report reflects the work and contributions of many community stakeholders and governmental partners across the Fairfax community local public health system. Special gratitude is extended to the following individuals for their time, commitment, and insight in the development of this report.

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Table of Contents

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Introduction

The **Partnership for a Healthier Fairfax (PFHF)** is a coalition of community members and organizations that have been working together to strengthen the local public health system and improve community health since 2010. The members of this coalition engaged in a community-driven strategic planning process known as **Mobilizing for Action through Planning and Partnerships** to assess community health status, identify public health issues in the Fairfax community, and develop goals and strategies to address them. The resulting **Community Health Improvement Plan 2013-2018 (CHIP 1.0)** outlined the collaborative work needed to advance the Partnership's vision.

Vision

Fairfax – An engaged and empowered community working together to achieve optimal health and well-being for all those who live, work, and play here.

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Introduction

The CHIP forms the cornerstone of the **Live Healthy Fairfax** initiative. Live Healthy Fairfax encompasses the activities that governmental partners and community stakeholders engage in to make the Fairfax community a healthier place to live. The 2013-2018 CHIP 1.0 consisted of seven priority issues and their respective goals, objectives, and key actions. Annual reports have tracked the progress on key actions throughout implementation. This final annual report provides an overview of accomplishments across the entire implementation period for each objective.

Implementation

- ✓ Year 1: October 2013-September 2014
- ✓ Year 2: October 2014-September 2015
- ✓ Year 3: October 2015-September 2016
- ✓ Year 4: October 2016-September 2017
- ✓ Year 5: October 2017-December 2018

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Priority Issues

CHIP 1.0 focused on seven priority health issues for the Fairfax community.

1. **Healthy and Safe Physical Environment** – Improving the community environment to support good health for all.
2. **Active Living** – Increasing opportunities for physical activity to improve health.
3. **Healthy Eating** – Making healthy food affordable and accessible for all.
4. **Tobacco-Free Living** – Reducing tobacco use and exposure to secondhand smoke where community members live, work, and play.
5. **Health Workforce** – Expanding the workforce capacity to meet the health care needs of a diverse community.
6. **Access to Health Services** – Improving access to and quality of health care services.
7. **Data** – Integrating public health data to improve monitoring, analysis, reporting, and evaluation of community health.

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Healthy and Safe Physical Environment

Healthy and Safe Physical Environment

- **Goal 1**: Develop and implement policies that promote healthy and safe physical environments for all who live, work, and play in the Fairfax community.
  - **Objective 1.1**: Increase the number of community, street, transportation and park policies for the environment that support positive community health outcomes.

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Healthy and Safe Physical Environment *Improving the community environment to support good health for all*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
1. Develop and implement policies that promote healthy and safe physical environments for all who live, work, and play here.	1.1 Increase the number of community, street, transportation and park policies for the environment that support positive community health outcomes.	✔	**1.1.A** Educate local government staff and decision makers on the principles of the Health in All Policies (HiAP) approach.	• Co-sponsored a Healthy Community Design Summit for local government staff and community members, followed by a Leadership Briefing for decision makers. • Hired a HiAP Coordinator to foster integration of health considerations in policymaking. • Evaluated countywide policies in the comprehensive plan around the areas of land use, schools, and parks to determine whether health considerations are or could be addressed. • Proposed changes to the Fairfax County Zoning Ordinance (in collaboration with the Fairfax Food Council) for front yard gardening that have been put forth for adoption in June 2019. • Informed the One Fairfax Policy Implementation Team to recognize Health Impact Assessments as an equity tool. • Conducted a statistically valid community survey as part of the Parks Count! Needs Assessment to determine the park and recreation needs and desires of county residents. • Launched new outdoor gyms at county parks in Lincolnia, Royal Lake, and Gum Springs. • Secured support from Chairman Bulova for a nationwide campaign to ensure all residents live within a 10-minute walk of a park.
		✔	**1.1.B** Study transportation, planning, zoning, and development review processes to identify opportunities to incorporate health benefits and impact analyses into current policy frameworks.	
		✔	**1.1.C** Develop recommendations using national best practices for health considerations to be integrated into existing policies, plans, and procedures.	
		✔	**1.1.D** Conduct an assessment to identify barriers to accessing parks, fields, and recreational facilities in redeveloping, underserved, or economically challenged communities.	
		✔	**1.1.E** Develop recommendations for providing parks and non-traditional park amenities for communities that are redeveloping, underserved, or economically challenged.	
		⃠	**1.1.F** Evaluate policy alternatives identified as best practice models for community use of athletic fields.	

✔ Action Performed ↻ Action In-Progress ⃠ Action Not Started

Healthy and Safe Physical Environment

- **Population Health Indicators**
  - Physical environment ranking
  - Recreation and fitness facilities
  - Access to exercise opportunities

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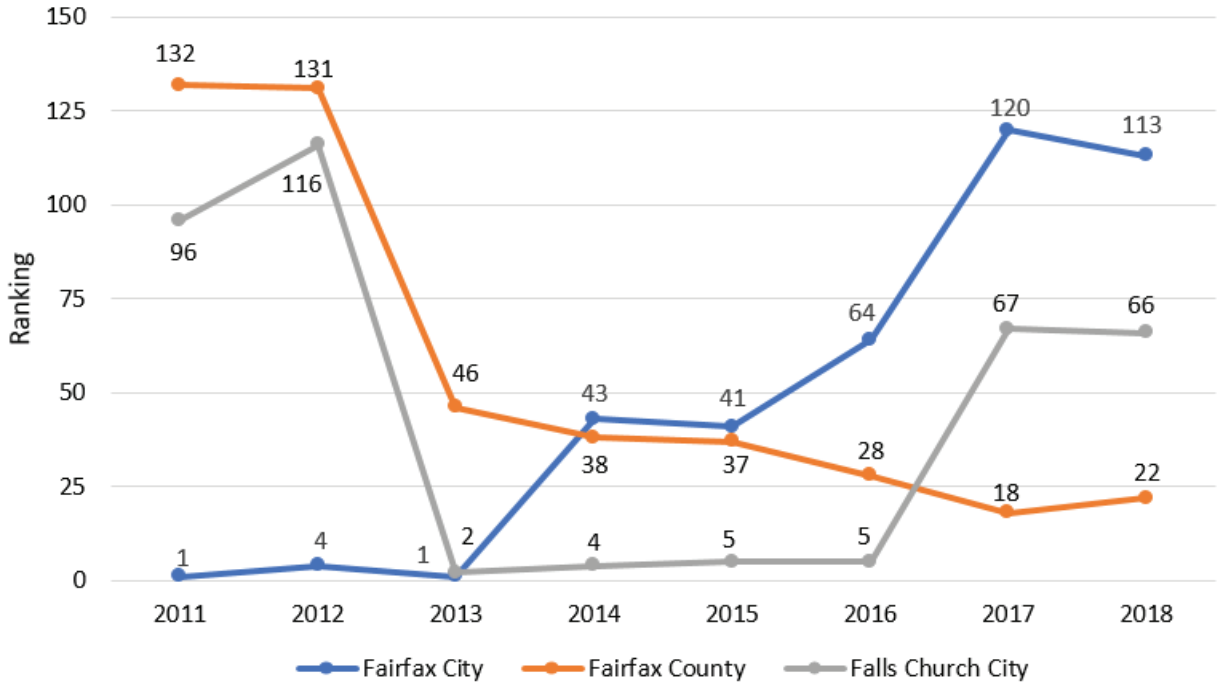
Physical Environment Ranking

The physical environment ranking is a composite indicator calculated from the following measures: daily fine particulate matter, drinking water violations, severe housing problems, driving alone to work, and long commute while driving alone. This indicator measures how well the physical environment supports physical health and healthy lifestyle behaviors. Fairfax County has been steadily improving since 2011, ranking 22 out of 133 jurisdictions in Virginia in 2018 for this indicator (with 1 being the highest rank). The City of Falls Church and the City of Fairfax have declined in rank in recent years.



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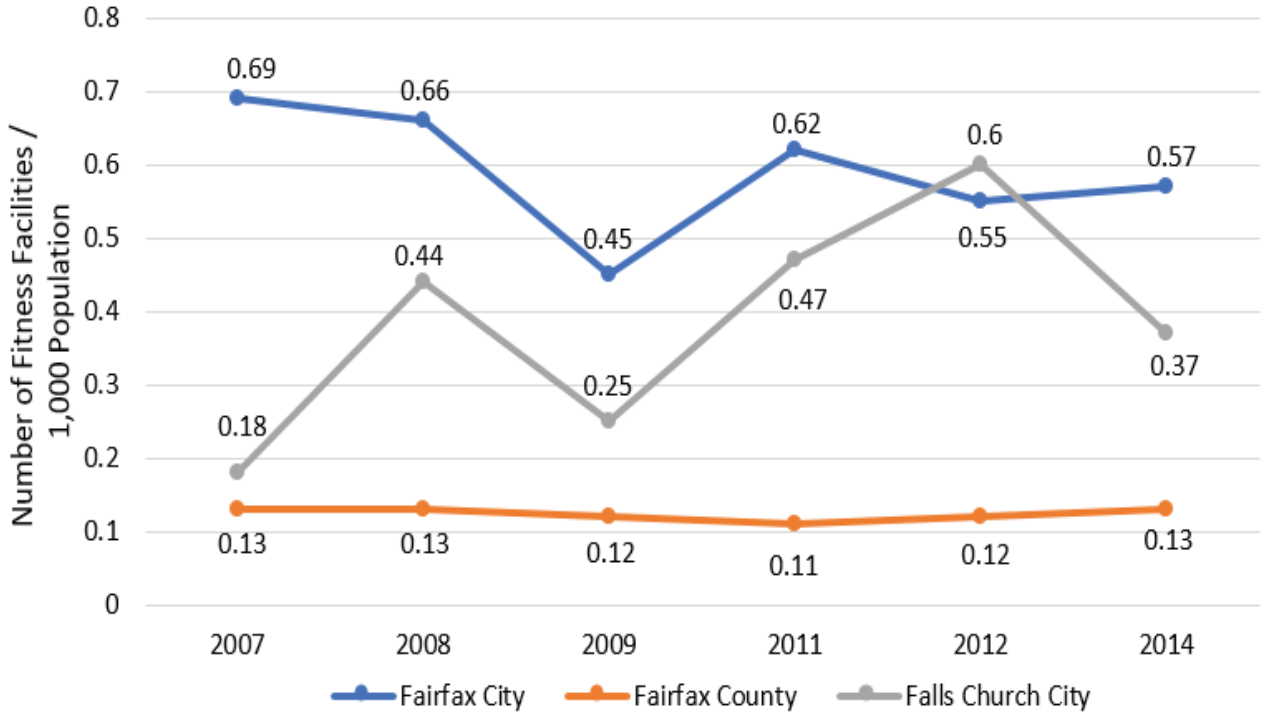
Recreation and Fitness Facilities

This indicator shows the number of fitness and recreation centers per 1,000 population. Fairfax County residents have had greater access to recreation and fitness facilities at 0.13 facilities per 1,000 population than U.S. residents on average (0.06 facilities per 1,000 population). While more variable, the Cities of Falls Church and Fairfax had substantially higher rates of recreation and facility access than the County.



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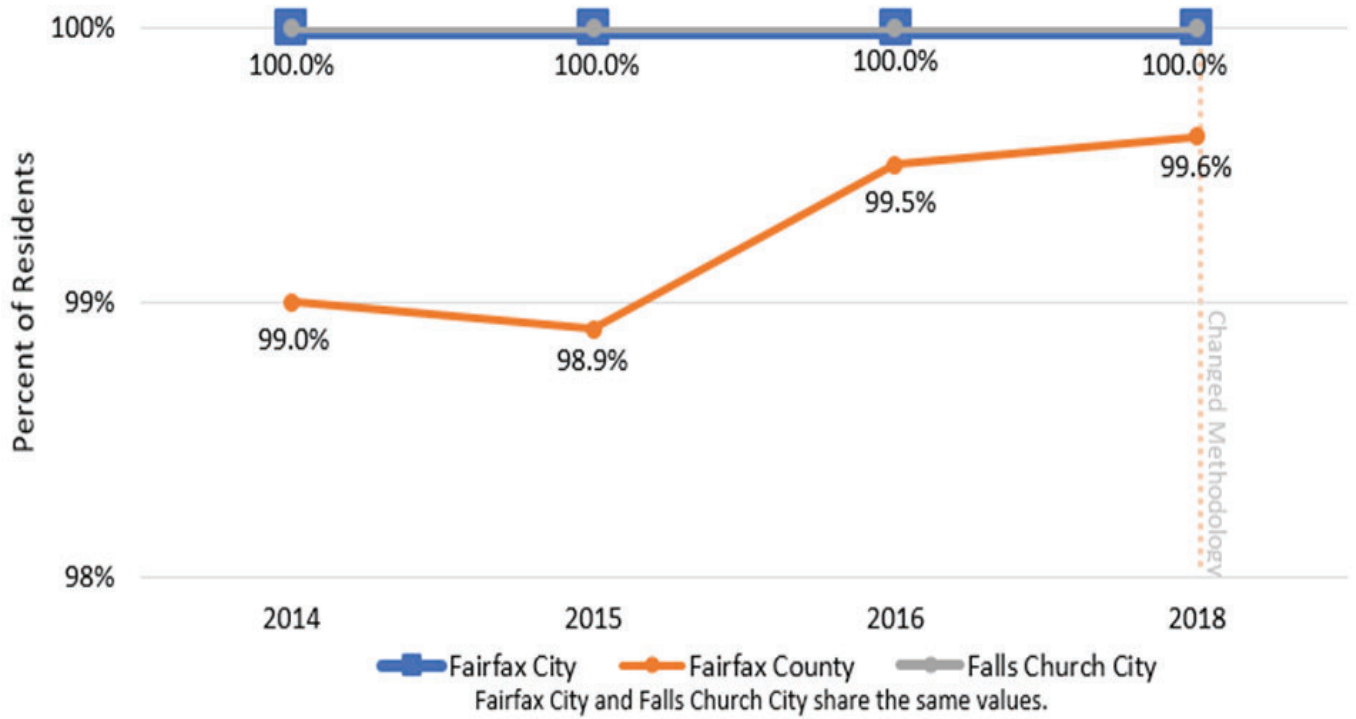
Access to Exercise Opportunities

This indicator measures the percentage of individuals who live reasonably close to a park or recreational facility. In Fairfax County, 99.6% of residents resided within a reasonable distance from a park or recreation facility which was higher than the national average of 83.1%. In the Cities of Fairfax and Falls Church, 100% of residents lived close to exercise opportunities.



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Active Living

Active Living

- **Goal 1**: Increase the number of children and adolescents who engage in daily physical activity.
- **Goal 2**: Increase the number of adults who engage in daily physical activity.
- **Goal 3**: Promote sustainability of programs and facilities that promote physical activity.

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Active Living

- **Goal 1**: Increase the number of children and adolescents who engage in daily physical activity.
  - **Objective 1.1**: Increase the number of opportunities for children ages birth to 5 years and those in child care settings to engage in daily physical activity.
  - **Objective 1.2**: Increase the number of elementary schools that participate in the Safe Routes to School program.
  - **Objective 1.3**: Increase the number of children and adolescents from families of low socioeconomic status participating in organized recreational activities.

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Active Living *Increasing opportunities for physical activity to improve health*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
1. Increase the number of children and adolescents who engage in daily physical activity.	1.1 Increase the number of opportunities for children ages birth to 5 years and those in child care settings to engage in daily physical activity.	✔	**1.1.A** Educate new parents with targeted materials and resources that promote active play for infants and young children at home.	• Created an *Eat and Run* educational handbook in multiple languages for families to learn about healthy food and physical activity options. • Conducted *Eat and Run* workshops.
		✔	**1.1.B** Develop a campaign to increase the number of structured play opportunities and outlets for children ages birth to 5 years.	
		✔	**1.1.C** Promote physical activity guidelines with family child care providers and child care centers.	
	1.2 Increase the number of elementary schools that participate in the Safe Routes to School program.	✔	**1.2.A** Identify community groups that can partner and provide logistical support in coordinating the Safe Routes to School (SRTS) program.	• Purchased 2,000 reflective stickers for student backpacks at three schools and 40 reflective vests for parents who walk students to school. • Engaged schools to participate in Bike to School Day. • Assisted the SRTS program to secure bike helmet donations for school children and purchased and posted "Children Walking" signs to promote awareness and safety.
		✔	**1.2.B** Mobilize resources to educate school communities on safe walking and cycling.	
		✔	**1.2.C** Provide guidance for establishing an infrastructure for the Safe Routes to School program in participating schools.	
		✔	**1.2.D** Promote the Safe Routes to School program through local public education outlets.	
	1.3 Increase the number of children and adolescents from families of low socioeconomic status participating in organized recreational activities.	✔	**1.3.A** Examine the current availability of scholarship funds and identify potential funding gaps.	• Partnered to provide the Leveling the Playing Field Program. • Streamlined the Youth Sports Scholarship Program application process. • Addressed transportation barriers through the creation of the free Student Bus Pass SmarTrip card allowing middle and high school students to ride the Fairfax Connector and City of Fairfax CUE buses to assist with practices, games, and other leisure activities.
		✔	**1.3.B** Leverage resources to fill gaps and identify additional funding sources.	
		✔	**1.3.C** Identify opportunities to promote the availability of scholarships.	
		✔	**1.3.D** Revise transportation guidelines to promote the use of public transportation for commuting to organized sports.	

✔ Action Performed ↻ Action In-Progress ⊘ Action Not Started

Active Living

- **Goal 2**: Increase the number of adults who engage in daily physical activity.
  - **Objective 2.1**: Increase the number of adults who engage in walking and biking.
  - **Objective 2.2**: Increase the number of opportunities to promote active lifestyles for adults.
  - **Objective 2.3**: Promote opportunities for physical activity for older adults.

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Active Living (continued) *Increasing opportunities for physical activity to improve health*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
2. Increase the number of adults who engage in daily physical activity.	2.1 Increase the number of adults who engage in walking and biking.	✔	**2.1.A** Develop and implement public education efforts to highlight opportunities to incorporate physical activity into daily activities.	• Supported the Park Authority's "Take 12 Steps to Health" and the "City of Fairfax Health Challenge." • Supported the Greater Reston Chamber of Commerce's Healthy Workplaces Initiative. • Provided a letter of support for the Fairfax County Department of Transportation (FCDOT) Multi-Modal Transportation Improvement Plan for the Springfield District section of Rolling Road to add 10-feet-wide shared-use paths for pedestrians and bicyclists. • Submitted a letter of support for the I-66 Corridor Improvements Project addressing the placement of bike lanes. • Secured funding for the Fairfax County Park Authority (FCPA) to install "Bike to Parks" bike racks to promote biking as a safe and reliable transportation method to recreational destinations. This will add 60 bike racks in 15 parks and recreation centers near Countywide trails in two high-density revitalization areas, Annandale and Richmond Highway.
		↻	**2.1.B** Develop opportunities for businesses to support non-motorized commuting.	
		✔	**2.1.C** Explore opportunities to expand bicycling in the community by installing bike racks and creating bike-share programs.	
	2.2 Increase the number of opportunities to promote active lifestyles for adults.	✔	**2.2.A** Promote the use of social media to share group physical activity opportunities.	• Collaborated with the National Park Service to provide a data file of FCPA sites for the Park Rx America website. • Leveraged the Partnership to expand and enhance the Park Authority's Healthy Strides Initiative. • Advertised and hosted a 2.0-hour Continuing Medical Education (CME) educational event in May 2018 to educate Fairfax community health care providers on the Park Rx for Life program and encourage their participation.
		✔	**2.2.B** Develop campaigns and provide materials and resources that emphasize the benefits of families being active together.	
		✔	**2.2.C** Partner with commercial entities to provide more active programs targeting families.	

✔ Action Performed ↻ Action In-Progress ⃠ Action Not Started

Active Living (continued) *Increasing opportunities for physical activity to improve health*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
2. Increase the number of adults who engage in daily physical activity.	2.3 Promote opportunities for physical activity for older adults	✔	**2.3.A** Promote the use of social media to share group physical activity opportunities for older adults.	• Implemented a 50+ Portal to improve access to recreation and wellness opportunities for the 50+ adult population. • Provided staff support for the Northern Virginia Senior Olympics.
		✔	**2.3.B** Collaborate with community partners to provide physical activities that promote aging in place for older adults, including those with physical limitations.	
		✔	**2.3.C** Support the development of organized active recreation opportunities such as individual fitness competitions, adult-based sports organizations and local competitions.	

✔ Action Performed ↻ Action In-Progress ⃠ Action Not Started

Active Living

- **Goal 3**: Promote sustainability of programs and facilities that promote physical activity.
  - **Objective 3.1**: Implement policies and procedures that support physical activity in the community.
  - **Objective 3.2**: Identify consistent funding streams to maintain current and future facilities, trails, and equipment so that community members have access to safe physical activity.
  - **Objective 3.3**: Encourage public and private partnerships to identify facilities that could be made available to the public for free or at a reduced rate.

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Active Living (continued) *Increasing opportunities for physical activity to improve health*			
Goals	**Objectives**	**Key Actions**	**Progress-to-Date**
3. Promote sustainability of programs and facilities that promote physical activity.	3.1 Implement policies and procedures that support physical activity in the community.	✔ **3.1.A** Convene community stakeholders to review policies and procedures related to community use of fields and facilities for physical activity.	• Reviewed and revised the county's Gym and Field Allocation policies. • Identified barriers to physical activity including inequitable access to turf fields, transportation, language access, and participation costs. • Developed a Results-Based Accountability performance management plan to track numbers served, scholarships provided, and equitable allocation.
		✔ **3.1.B** Identify polices that may be inconsistently implemented.	
		✔ **3.1.C** Identify barriers that discourage physical activity.	
		✔ **3.1.D** Create an action plan to minimize barriers.	
		✔ **3.1.E** Develop accountability mechanisms.	
	3.2 Identify consistent funding streams to maintain current and future facilities, trails, and equipment so that community members have access to safe physical activity.	✔ **3.2.A** Review existing legislation and policies that affect funding.	• Evaluated park facilities and trails to determine the current backlog of maintenance and life cycle replacements and projected resource needs for the next five years, some of which were included in the 2016 $94 million park bond.
		✔ **3.2.B** Determine desired funding levels for maintenance of existing and future facilities, trails, and equipment.	
		↻ **3.2.C** Seek funding partners in the community.	
		✔ **3.2.D** Identify legislation and policies that may need revision or identify gaps in policies that may need to be addressed with new legislation and policies.	
		✔ **3.2.E** Promote needed changes with appropriate stakeholders.	
	3.3 Encourage public and private partnerships to identify facilities that could be made available to the public for free or at a reduced rate.	⊘ **3.3.A** Explore opportunities for facility use with local institutions of higher learning, faith-based communities, and businesses.	• This objective was not implemented due to changing priorities and limitations in capacity and resources.
		⊘ **3.3.B** Establish memorandums of understanding for facility use by the community for physical activity.	
		⊘ **3.3.C** Publicize partnerships.	

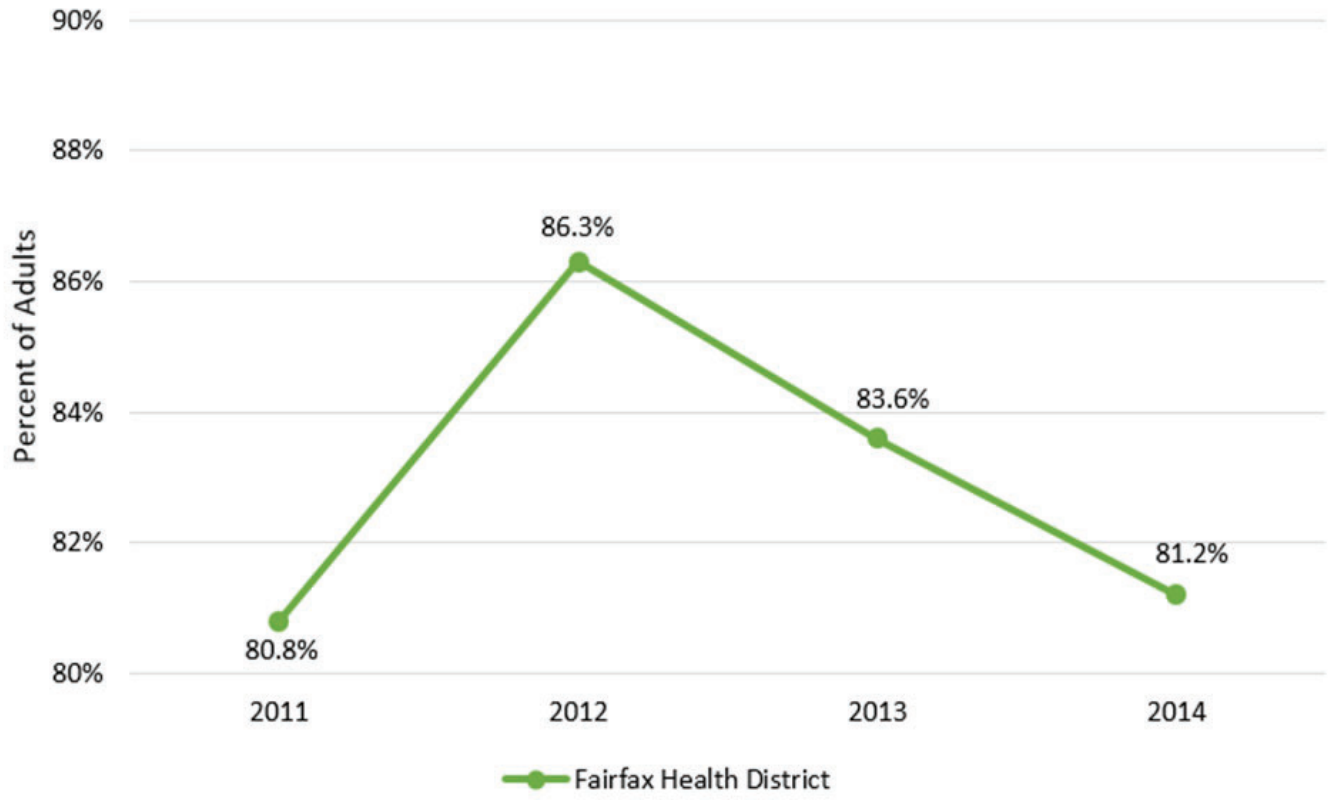
✔ Action Performed ↻ Action In-Progress ⊘ Action Not Started

Active Living

- **Population Health Indicators**
  - Adults engaging in physical activity
  - Adults who are overweight or obese
  - Workers who walk to work
  - Adults 20+ who are sedentary

Adults Engaging in Physical Activity

This indicator shows the percentage of adults who participated in any physical activities or exercises in the past month, other than their regular job. While somewhat variable, a greater percentage of adults in the Fairfax Health District (81.2%) engaged in physical activity compared to adults nationwide (77.4%).



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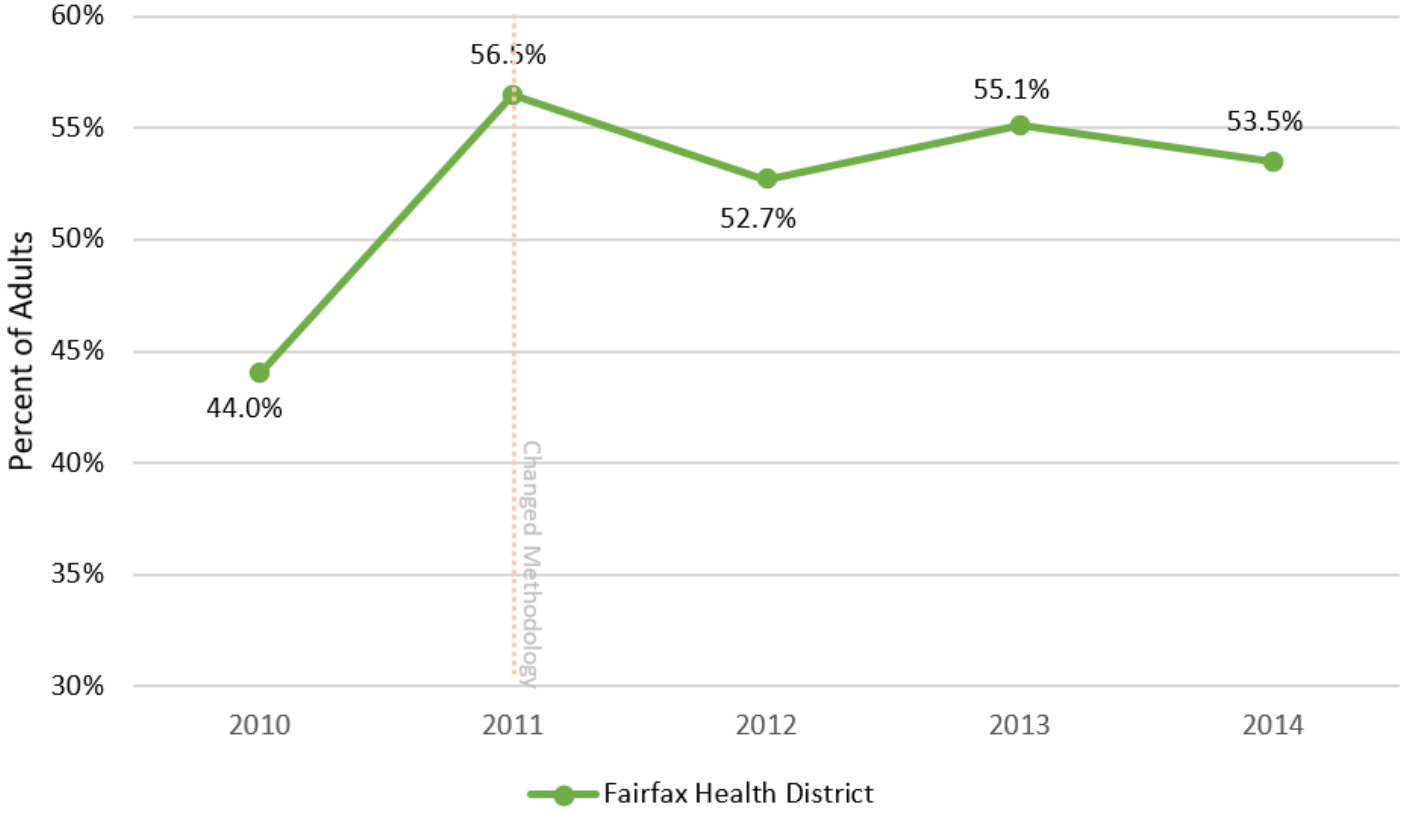
Adults Who Are Overweight or Obese

This indicator shows the percentage of adults who are overweight or obese according to the Body Mass Index (BMI). A BMI between 25 and 29.9 is considered overweight and a BMI of 30 or greater is considered obese. Of Fairfax Health District adults, 53.5% had a BMI in the overweight or obese range, lower than the national average of 65% of adults.



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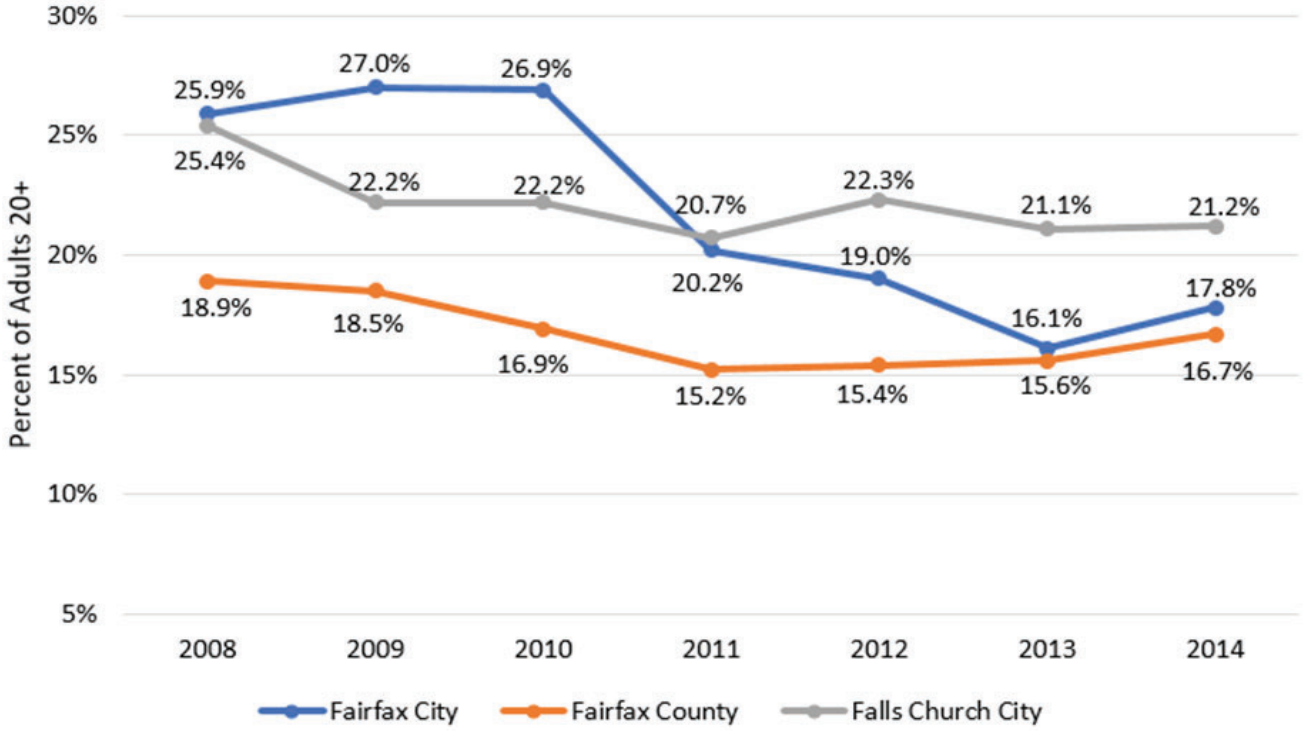
Adults 20+ Who Are Sedentary

This indicator shows the percentage of adults (ages 20 and up) who did not participate in any leisure-time activities (physical activities other than their regular job) during the past month. Nearly 17% of County adults were sedentary compared to 22.3% of Virginian adults and 23% of U.S. adults. The Cities of Fairfax and Falls Church were slightly higher but still lower than the national average. All three jurisdictions had rates that were significantly lower than the Healthy People 2020 target of 32.6%.



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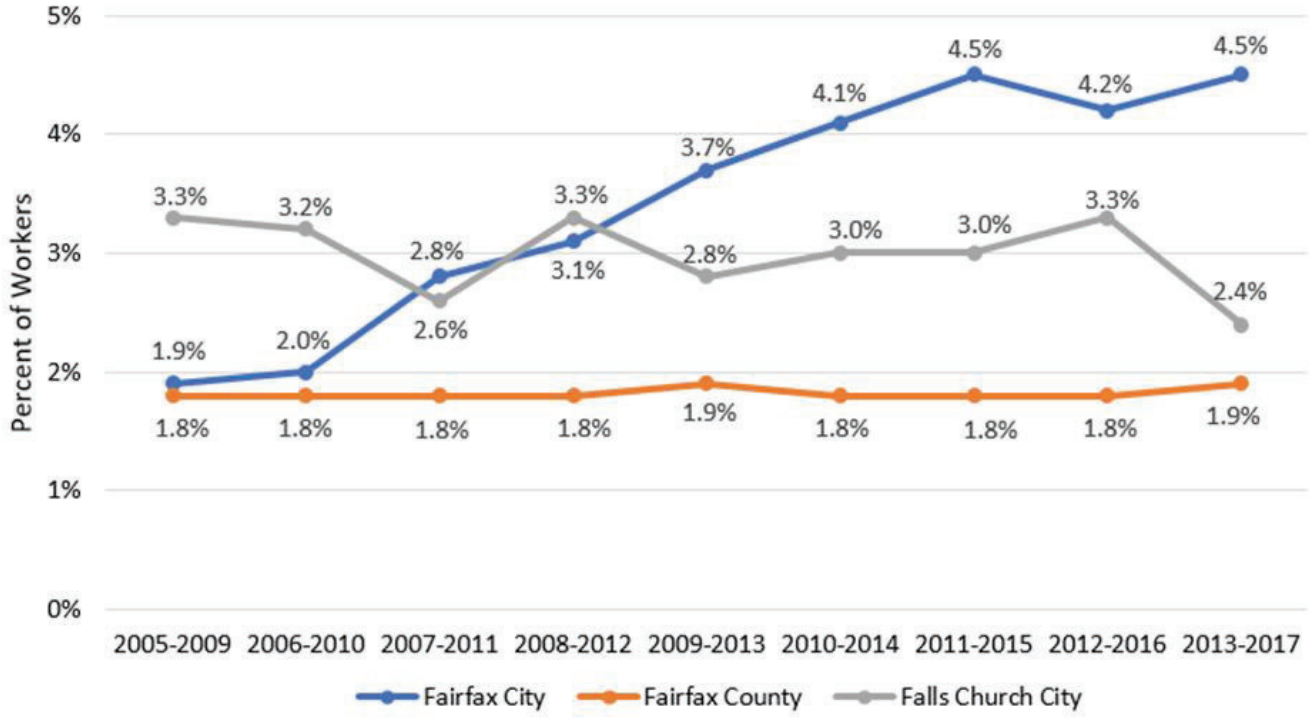
Workers Who Walk to Work

This indicator shows the percentage of workers aged 16 years and over who get to work by walking. 1.9% of Fairfax County adults walked to work compared to workers in the City of Fairfax who had been walking to work increasingly over the past 12 years (4.5% at the time of measurement). City of Falls Church workers who walked to work trended around 3% but decreased in the most recent period of data collection.



Healthy Eating

Healthy Eating

- **Goal 1**: Increase the accessibility and affordability of healthy food.
- **Goal 2:** Increase the number of environments that promote healthy food choices and educational resources.

Healthy Eating

- **Goal 1**: Increase the accessibility and affordability of healthy food.
  - **Objective 1.1**: Establish a food policy council to examine the local food system and make recommendations for how to increase access to healthy and affordable food in underserved areas.
  - **Objective 1.2**: Increase the amount of healthy food that is donated to pantries.
  - **Objective 1.3**: Establish new community and school gardens in additional locations.
  - **Objective 1.4**: Review gaps and opportunities for improving healthy and affordable food options at farmers markets and all other food retail outlets in low income neighborhoods.

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Healthy Eating *Making healthy food affordable and accessible for all*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
1. Increase the accessibility and affordability of healthy food.	1.1 Establish a food policy council to examine the local food system and make recommendations for how to increase access to healthy and affordable food in underserved areas.	✔	**1.1.A** Establish membership and charter a food policy council.	• Established the Fairfax Food Council (FFC) and its governance structure. The FFC includes a contact list of approximately 300 individuals and operates through a 30-member Steering Committee and three working groups focused on Urban Agriculture, Food Access, and Food Literacy. • Finalized the 2015 Community Food Assessment report. • Provided support, resources, and training to communities where health disparities are evident.
		✔	**1.1.B** Set priorities for areas of the local food system to examine.	
		✔	**1.1.C** Promote food system and policy changes to increase the consumption of healthier foods.	
	1.2 Increase the amount of healthy food that is donated to pantries.	✔	**1.2.A** Develop guidelines and recommendations for healthy food donations.	• Developed and printed the "Guidelines for Food Pantry Donations" brochure. • Piloted family nutrition activities at local food pantries. • Revised Food Pantry Nutrition Toolkit materials for distribution to pantries and community programs and posted it on the FFC website. • Maintained a current list of food pantries accepting fresh produce.
		✔	**1.2.B** Promote guidelines and recommendations to local food providers.	
		✔	**1.2.C** Create and disseminate a listing of food pantries accepting fresh produce.	
	1.3 Establish new community and school gardens in additional locations.	✔	**1.3.A** Examine best practices for community gardening.	• Distributed small assistance awards to community organizations for the establishment or expansion of community gardens at Westlawn Elementary, Riverside Elementary, and the Herndon Environmental Network to increase the availability of healthy and affordable food. • Developed and implemented a community gardens workshop series consisting of 14 workshops during 2017 and 2018 with Virginia Cooperative Extension (VCE).

✔ Action Performed ↻ Action In-Progress ⃠ Action Not Started

Healthy Eating (Continued) *Making healthy food affordable and accessible for all*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
1. Increase the accessibility and affordability of healthy food.	1.3 Establish new community and school gardens in additional locations.	✔	**1.3.B** Identify potential sites for gardens at schools and in the community.	• Developed a survey for data collection using the Geographic Information System mapping program in cooperation with Fairfax County Park Authority to identify areas of need of additional gardening opportunities and serve as a networking resource for community gardeners. • Gave garden awards to Mt. Vernon High School, Lake Anna and Herndon Elementary Schools, Stony Brook Apartments, and Pine Springs Head Start. • Created and maintained a planning, planting, and maintaining edible gardens resource guide. • Streamlined the Tool Lending Shed Program and added to existing inventory. • Hosted a FFC Summit in 5/18 which focused on and highlighted Urban Agriculture in Fairfax County.
		✔	**1.3.C** Establish partnerships to support additional gardening efforts.	
		✔	**1.3.D** Establish or expand community gardens, targeting areas with the greatest needs.	
		✔	**1.3.E** Develop tools and resources to support local gardening efforts.	

Healthy Eating (Continued) *Making healthy food affordable and accessible for all*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
1. Increase the accessibility and affordability of healthy food.	1.4 Review gaps and opportunities for improving healthy and affordable food options at farmer's markets and all other food retail outlets in low income neighborhoods.	✔	**1.4.A** Identify geographic locations where access to fresh food is limited.	• Collaborated with the Capital Area Food Bank (CAFB) and other local entities to provide access to fresh food at the Southgate Community Center in Reston and other areas through the Mobile Marketplace. • Piloted a mobile market and Community Supported Agriculture farm share in the Bailey's Crossroads area and held a Family Day to promote Supplemental Nutrition Assistance Program (SNAP) acceptance and provide nutrition education. • Developed a survey to assess barriers to SNAP redemption at farmers' markets in the Mt. Vernon area. • Developed and promoted the Virginia Fresh Match Program (SNAP matching) at farmers' markets through the Departments of Family Services (DFS) and Neighborhood and Community Services (NCS), Fairfax County Public Schools, and other partner organizations. • Worked with the Community Food Works and the Fairfax County Park Authority to apply for and receive three years of Food Insecurity Nutrition Incentive (FINI) grant funds for SNAP matching at farmers' markets in Fairfax County. • Expanded SNAP matching to 10 Farmers' Markets across Fairfax County and to additional Community Food Works Markets. • Developed a FFC Zoning Committee to provide input on zoning changes.
		✔	**1.4.B** Increase access to affordable farmer's markets for low socioeconomic status communities.	
		✔	**1.4.C** Study programs in other jurisdictions that have successfully introduced fresh food products to underserved areas.	
		⃠	**1.4.D** Work with local chambers of commerce to encourage corner markets, ethnic markets, and convenience stores to sell fresh produce and other healthy food items.	
		⃠	**1.4.E** Work with ethnic and international grocery stores to accept SNAP benefits.	

✔ Action Performed ↻ Action In-Progress ⃠ Action Not Started

Healthy Eating

- **Goal 2:** Increase the number of environments that promote healthy food choices and educational resources.
  - **Objective 2.1**: Increase the number of schools that adopt healthy eating guidelines outside of the Fairfax County Public School's Food and Nutrition Services setting.
  - **Objective: 2.2**: Increase the number of faith communities that adopt healthy eating guidelines.
  - **Objective 2.3**: Increase the number of family child care providers and child care centers participating in the Child and Adult Care Food Program.
  - **Objective 2.4**: Promote healthy eating resources in the business community.
  - **Objective 2.5**: Promote nutrition as a part of standard health care.

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Healthy Eating (Continued) *Making healthy food affordable and accessible for all*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
2. Increase the number of environments that promote healthy food choices and educational resources.	2.1 Increase the number of schools that adopt healthy eating guidelines outside of the Fairfax County Public School's Food and Nutrition Services setting.	↻	**2.1.A** Review and revise school wellness policies and procedures for activities during the instructional day.	• Served on the Real Food for Kids' Lunch Room Collaborative, an alliance of school, industry, agriculture, nonprofit, and policymaking partners focused on raising the profile of and conversations around school meals as a catalyst for change in communities and across the public health field. • Developed a taskforce to examine school nonprofit food assistance programs for areas lacking coverage and opportunities for collaboration. Identified additional resources, and continue to maintain a list of all schools being served and monitor the program. • Expanded the weekend food program to additional schools.
		✔	**2.1.B** Establish a community taskforce to examine nutrition in schools outside of school meals provided by Food and Nutrition Services.	
		✔	**2.1.C** Establish, communicate, and implement guidelines and recommendations.	
	2.2 Increase the number of faith communities that adopt healthy eating guidelines.	✔	**2.2.A** Develop guidelines and identify best practices for healthy eating at faith community events and programs.	• Created a "*Healthy Eating & Faith Communities*" webpage to provide guidance on healthy eating and active living programs, practices, and policies that have been established by faith communities in the U.S. The website also highlights healthy food recipes for large groups.
		✔	**2.2.B** Develop culturally and linguistically appropriate educational materials.	
		✔	**2.2.C** Provide and promote the use of healthy eating resources to faith communities.	
	2.3 Increase the number of family child care providers and child care centers participating in the Child and Adult Care Food Program (CACFP).	✔	**2.3.A** Develop culturally and linguistically appropriate materials to promote joining the Child and Adult Care Food Program.	• Developed culturally-appropriate educational materials to help child care providers understand the process and requirements for obtaining a Child and Adult Care Food Program permit. • Developed the *Eat and Run* handbook which was used as an incentive for permitted or licensed childcare providers who enrolled in the CACFP.
		✔	**2.3.B** Educate providers and families about the benefits of the Child and Adult Care Food Program.	

✔ Action Performed ↻ Action In-Progress ⊘ Action Not Started

Healthy Eating (Continued) *Making healthy food affordable and accessible for all*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
2. Increase the number of environments that promote healthy food choices and educational resources.	2.4 Promote healthy eating resources in the business community.	⃠	**2.4.A** Examine best practices around healthy eating in the local business community.	• This objective was not implemented due to changing priorities and limitations in capacity and resources.
		⃠	**2.4.B** Develop guidelines that identify opportunities for businesses to improve nutrition in the work environment.	
		⃠	**2.4.C** Promote and disseminate guidelines to local businesses.	
	2.5 Promote nutrition as a part of standard health care.	✔	**2.5.A** Examine best practices for nutrition screening and counseling for primary care doctors and compile recommendations.	• Used *Addressing Food Insecurity: A Toolkit for Pediatricians*, developed by the American Academy of Pediatricians and the Food Research and Action Center, to develop and deliver a Continuing Medical Education (CME) education program to local health providers. • Hosted a panel discussion on food insecurity screening in medical settings targeted to pediatricians and family practitioners. • Promoted the use of the Hunger Vital Signs for physicians to use to screen for food insecurity and connect families to food resources in the county. • Provided CME pilot data to the Department of Health's Division of Epidemiology and Population Health for analysis. • Created a Food Resource Guide.
		✔	**2.5.B** Identify community resources and tools that medical practices can use for referral sources.	
		✔	**2.5.C** Promote awareness of recommendations, tools, and resources.	

✔ Action Performed ↻ Action In-Progress ⃠ Action Not Started

Healthy Eating

- **Population Health Indicators**
  - Farmers market density
  - SNAP certified stores
  - Food insecurity rate
  - Children with low access to a grocery store
  - Food environment index

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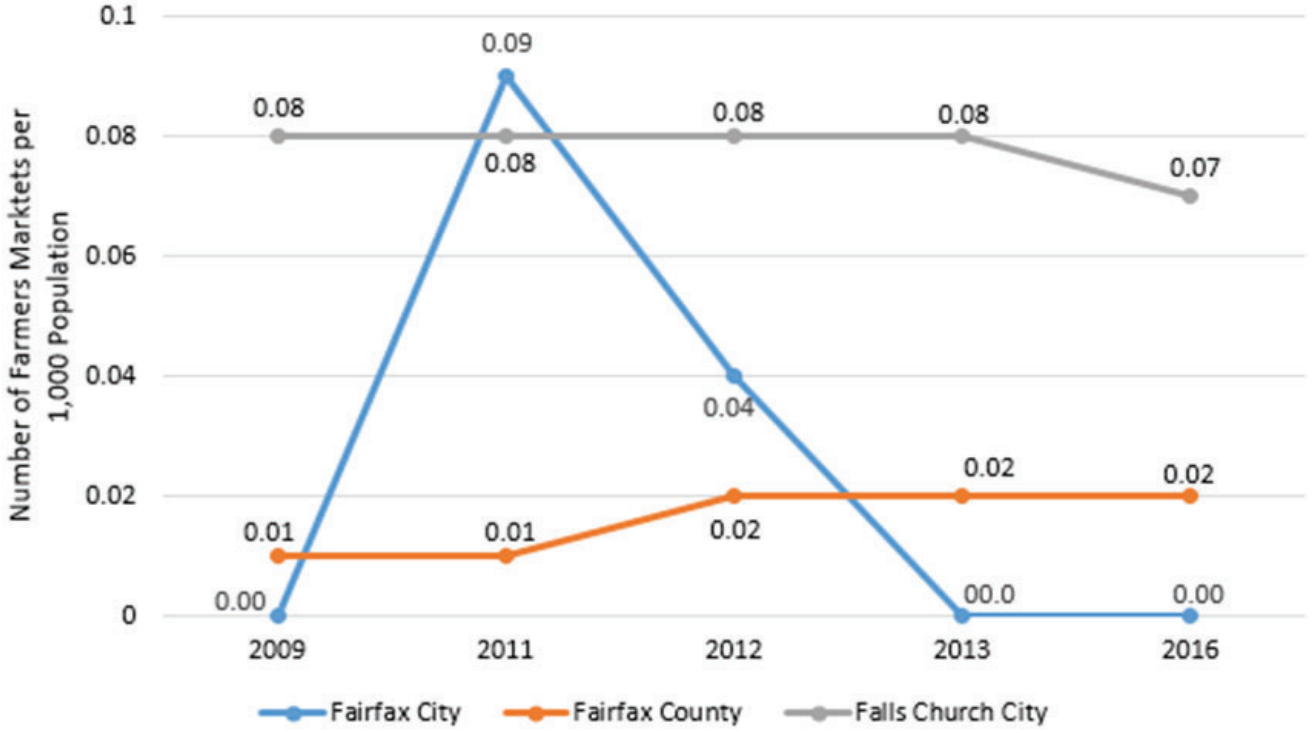
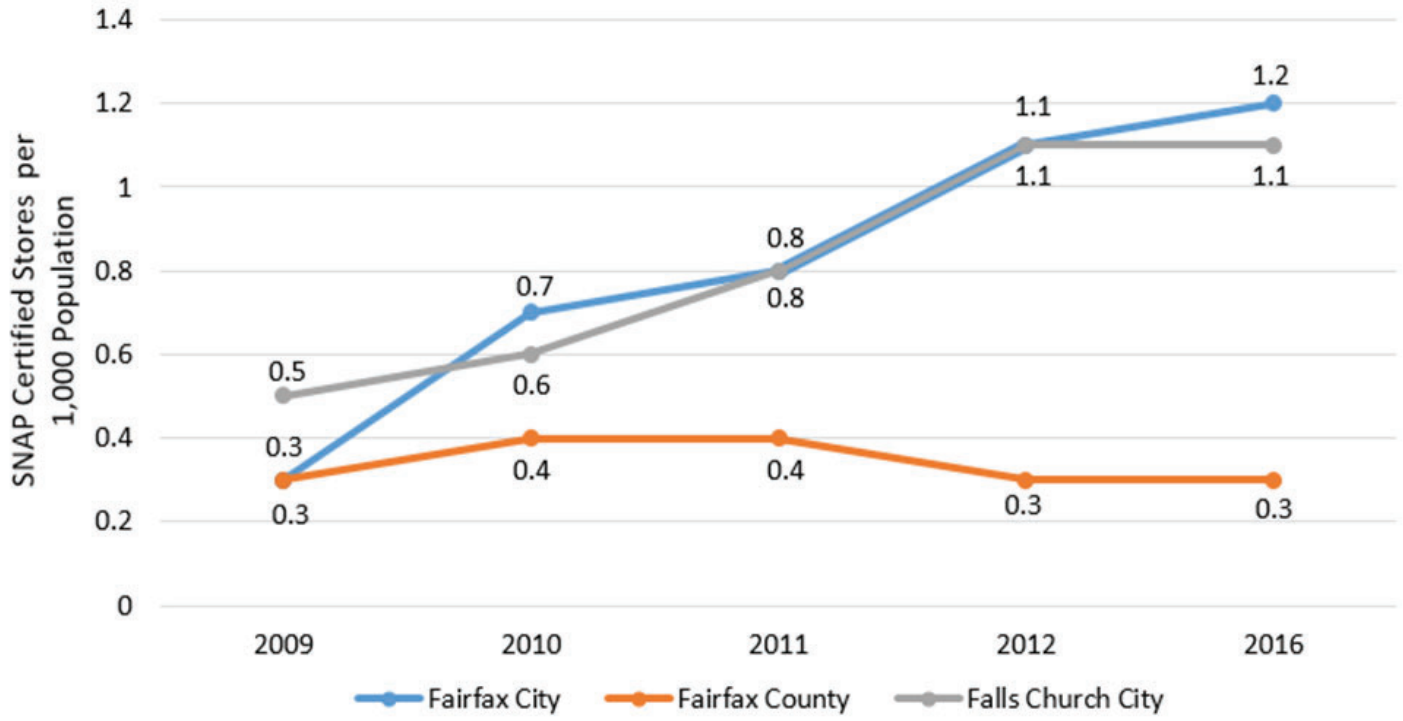
Farmers Market Density

This indicator shows the number of farmers markets per 1,000 population. A farmers market is a retail outlet in which vendors sell agricultural products directly to customers. Fairfax County and the City of Falls Church have been relatively stable since 2009 at 0.02 and 0.07 markets per 1,000 population respectively. The City of Fairfax had been more variable and at the most recent measurement did not have any local markets.



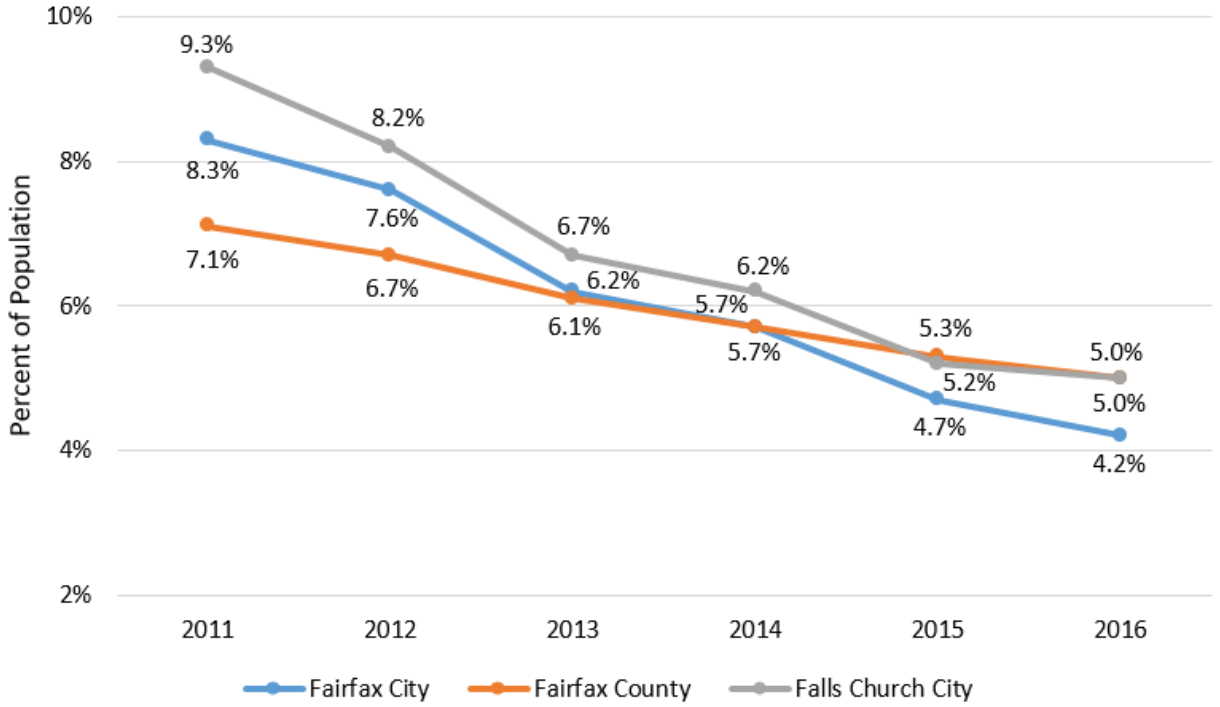
SNAP Certified Stores

This indicator shows the number of stores certified to accept Supplemental Nutrition Assistance Program benefits per 1,000 population. According to the USDA Food Environment Atlas, the rate of SNAP certified stores per 1,000 population had been increasing since 2009 in the Cities of Falls Church and Fairfax. Fairfax County's rate remained relatively stable and was in the lowest 25% of jurisdictions nationwide.



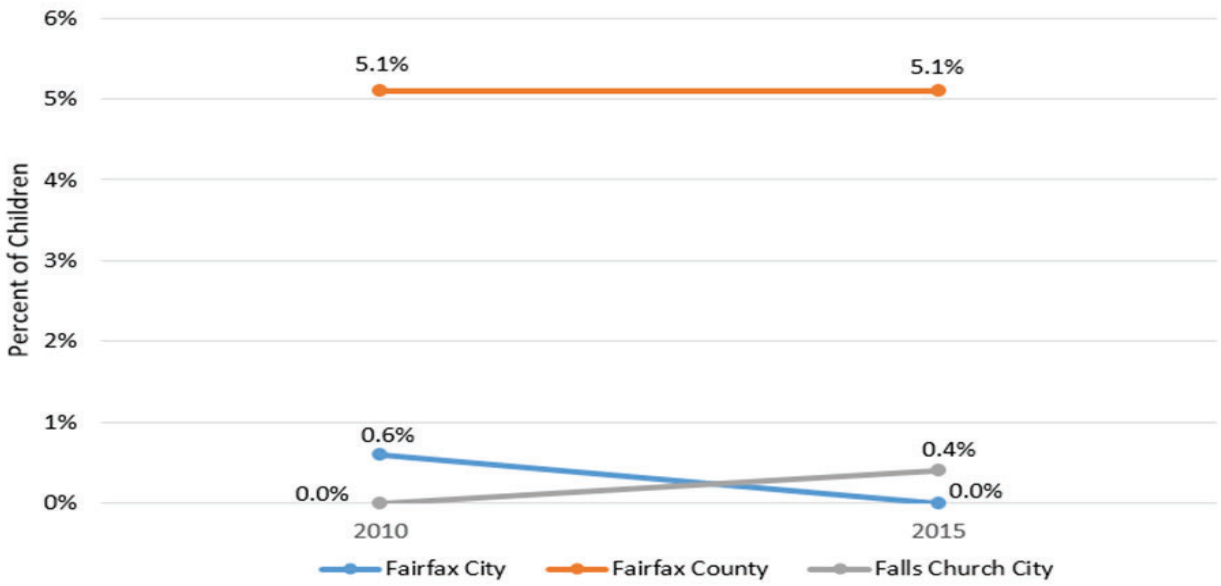
Food Insecurity Rate

Food insecurity is defined as limited or uncertain availability of nutritionally adequate food or the inability to acquire these foods by a socially acceptable manner. This indicator shows the percentage of the population that experienced food insecurity at some point during the year. In 2016, 5% of the residents of Fairfax County and the City of Falls Church experienced food insecurity at some point during the year compared to 4.2% of residents of the City of Fairfax and 12.9% nationally. Across all jurisdictions, the rate has been declining over the past five years of data.



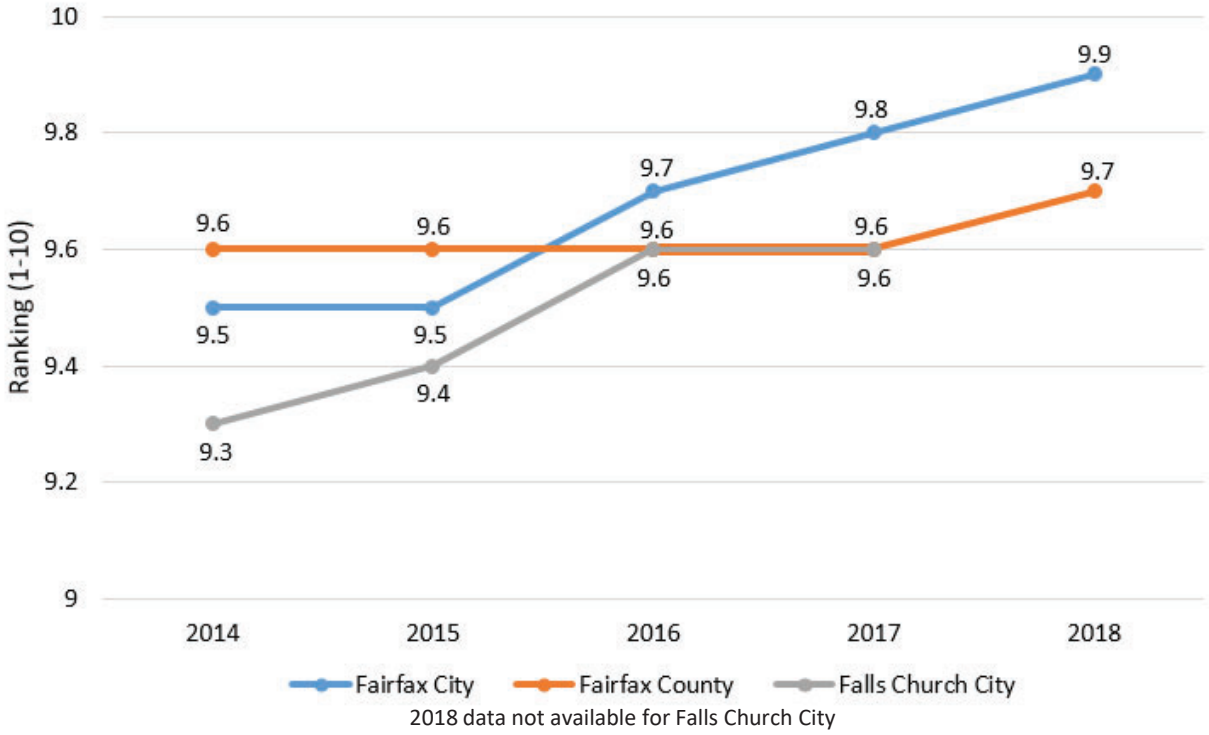
Children with Low Access to a Grocery Store

This indicator shows the percentage of children living more than one mile from a supermarket or large grocery store if in an urban area, or more than 10 miles from a supermarket or large grocery store if in a rural area. Just over 5% of Fairfax County children had low access to a grocery store or supermarket and this remained stable from 2010 to 2015. The Cities of Falls Church and Fairfax had consistently lower rates indicating that most children in those localities had close access to grocery stores.



Food Environment Index

The Food Environment Index combines two measures: those with low-income and low-access to a grocery store, and food insecurity. The index is from 0 (worst) to 10 (best). With index scores above 9.5 at latest measurement, all three jurisdictions ranked much higher than the U.S. as a whole at 7.7.



2018 data not available for Falls Church City

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Tobacco-Free Living

Tobacco-Free Living

- **Goal 1**: Reduce tobacco use and exposure to secondhand smoke and associated unhealthy air contaminants in outdoor recreational environments and multi-unit housing environments.
  - **Objective 1.1**: Increase access to smoke-free parks and outdoor recreational environments.
  - **Objective 1.2**: Increase the number of smoke-free policies that are voluntarily implemented by multi-unit housing neighborhoods.

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Tobacco-Free Living *Reducing tobacco use and exposure to secondhand smoke where community members live, work, and play*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
1. Reduce tobacco use and exposure to secondhand smoke and associated unhealthy air contaminants in outdoor recreational environments and multi-unit housing environments.	1.1 Increase access to smoke-free parks and outdoor recreational environments.	✔	**1.1.A** Contact neighboring jurisdictions to determine best practices for a smoke-free campaign for public parks.	• Implemented Tobacco-Free Play Zone signage at playgrounds, athletic fields, basketball courts, tennis courts, volleyball courts, amphitheaters, marinas, golf courses, trails, Frisbee golf courses, picnic shelters, amusements, and outdoor fitness areas. • Promoted tobacco-free policies and signage at farmers' markets, universities, and community centers. • Presented on tobacco-free play zone initiatives at the Virginia Foundation for Health Youth conference. • Collaborated with Virginia Department of Health (VDH) and other regional tobacco control coordinators across the state. • Held the Northern Virginia Regional Tobacco-Use Control and Prevention meeting in 5/18 to learn about innovative practices for tobacco-free living. • Worked with the Reston Area Chamber of Commerce to encourage more tobacco-free worksites.
		✔	**1.1.B** Educate policymakers and decision makers on the benefits of tobacco-free living environments.	
		✔	**1.1.C** Plan, coordinate, and implement a campaign for playgrounds, athletic fields, and skate parks by promoting the use of signs that read: "Please, No Smoking."	
		✔	**1.1.D** Expand posting of signs for all other public park amenities, such as picnic shelters, marinas, golf courses, and trails.	
		✔	**1.1.E** Form a coalition of Northern Virginia jurisdictions to develop a consensus for consistent tobacco-free living efforts across the region.	

✔ Action Performed ↻ Action In-Progress ⊘ Action Not Started

Tobacco-Free Living (Continued) *Reducing tobacco use and exposure to secondhand smoke where community members live, work, and play*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
1. Reduce tobacco use and exposure to secondhand smoke and associated unhealthy air contaminants in outdoor recreational environments and multi-unit housing environments.	1.1 Increase access to smoke-free parks and outdoor recreational environments.	✔	**1.1.F** Provide technical assistance with tobacco control and prevention activities and events for community stakeholders.	• Worked with the Community Health Care Network to increase the use of the Quit Line fax referral form. • Provided training to Fairfax County Health Department (FCHD) Community Health Outreach team and Kaiser Permanente behavioral staff on the Quit Line and other cessation resources they can share with their clients. • Collaborated with the American Heart Association (AHA) to work on tobacco-use prevention and cessation activities. • Partnered with the Truth Initiative Campaign on youth tobacco-use prevention and cessation activities. • Provided giveaways and educational items to county community centers for countywide Kick Butts Day events for teens. • Promoted the Great American Smokeout in Fairfax County with lobby displays, an email chat, a Facebook Live segment, and other promotional materials. • Met with the Fairfax County Live Well program representative to discuss tobacco-free living initiatives. • Provided an in-service training to FCHD nursing staff on current trends in tobacco use data including e-cigarettes and vaping. • Expanded programmatic support to local schools, places of worship, and mental health facilities.

✔ Action Performed ↻ Action In-Progress ⃠ Action Not Started

Tobacco-Free Living (Continued) *Reducing tobacco use and exposure to secondhand smoke where community members live, work, and play*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
1. Reduce tobacco use and exposure to secondhand smoke and associated unhealthy air contaminants in outdoor recreational environments and multi-unit housing environments.	1.2 Increase the number of smoke-free policies that are voluntarily implemented by multi-unit housing neighborhoods.	✔	**1.2.A** Invite property management, housing, and insurance stakeholders to discuss smoke-free housing.	• Provided technical assistance and support to the Housing and Community Development (HCD) for the expansion of the smoke-free housing program to all HCD communities. • Provided information to local housing groups to support implementation of smoke-free housing throughout HCD communities. • Established a regional tobacco-free coalition to work on multi-sector strategies for the reduction of secondhand smoke exposure and tobacco using in multi-unit housing and at worksites, and support the Quit Now Virginia quit line service. • Created an educational toolkit for residents of multi-unit housing regarding the hazards of smoking, secondhand smoke, and the importance of smoke-free policies. • Provided technical assistance to forums in other HCD communities to identify and address resident concerns about the new smoke-free policy that may impact compliance. • Planned and implemented a smoke-free lease addendum at four HCD housing properties, including two senior housing properties, one apartment community, and one townhome community. • Posted smoke-free policy signs in HCD pilot residential areas and distributed materials and a tailored toolkit for residents for the expansion of the smoke-free policy.
		✔	**1.2.B** Identify smoke-free housing champions and provide education on its benefits.	
		✔	**1.2.C** Conduct an initial survey of residents in multiple housing communities to identify smoking prevalence and support for smoke-free initiatives.	
		✔	**1.2.D** Conduct residential community forums to discuss smoke-free initiatives and implementation considerations needed for success.	
		✔	**1.2.E** Create a community pilot program for a model “clean air” apartment or condominium agreement.	
		✔	**1.2.F** Design a “no tobacco use” education campaign for multi-family housing providers to include posters and signage in multiple languages.	

✔ Action Performed ↻ Action In-Progress ⊘ Action Not Started

Tobacco-Free Living (Continued) *Reducing tobacco use and exposure to secondhand smoke where community members live, work, and play*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
1. Reduce tobacco use and exposure to secondhand smoke and associated unhealthy air contaminants in outdoor recreational environments and multi-unit housing environments.	1.2 Increase the number of smoke-free policies that are voluntarily implemented by multi-unit housing neighborhoods	✔	**1.2.G** Provide technical assistance with tobacco control and prevention activities and events for housing providers.	• Worked with the Fairfax-Falls Church Community Services Board to provide the Dimensions Cessation Training Program for housing staff so that they may offer the program onsite for residents. • Met with Department of Housing and Urban Development staff to offer technical assistance to all Public Housing Authorities in the region. • Provided programmatic support to multi-unit housing complexes on cessation services, VA Quit Line training and resources, and implementation of tobacco-free policies. • Researched best practices for designated smoking areas among other college campuses. • Worked with George Mason University (GMU) to develop an anti-smoking ad and videos targeting students. • Held additional meetings with GMU representatives to encourage implementation of 100% tobacco-free campus policies. • Met with the Young Invincibles to collaborate on prevention and cessation activities on college campuses as well as other activities that target individuals age 18 to 34.
		✔	**1.2.H** Promote tobacco-free living environments on college campuses.	

✔ Action Performed ↻ Action In-Progress ⊘ Action Not Started

Tobacco-Free Living

- **Population Health Indicators**
  - Adults who smoke
  - Age-adjusted hospitalization rate due to asthma
  - Age-adjusted death rate due to chronic lower respiratory diseases
  - Age-adjusted hospitalization rate due to COPD
  - Lung and bronchus cancer incidence rate

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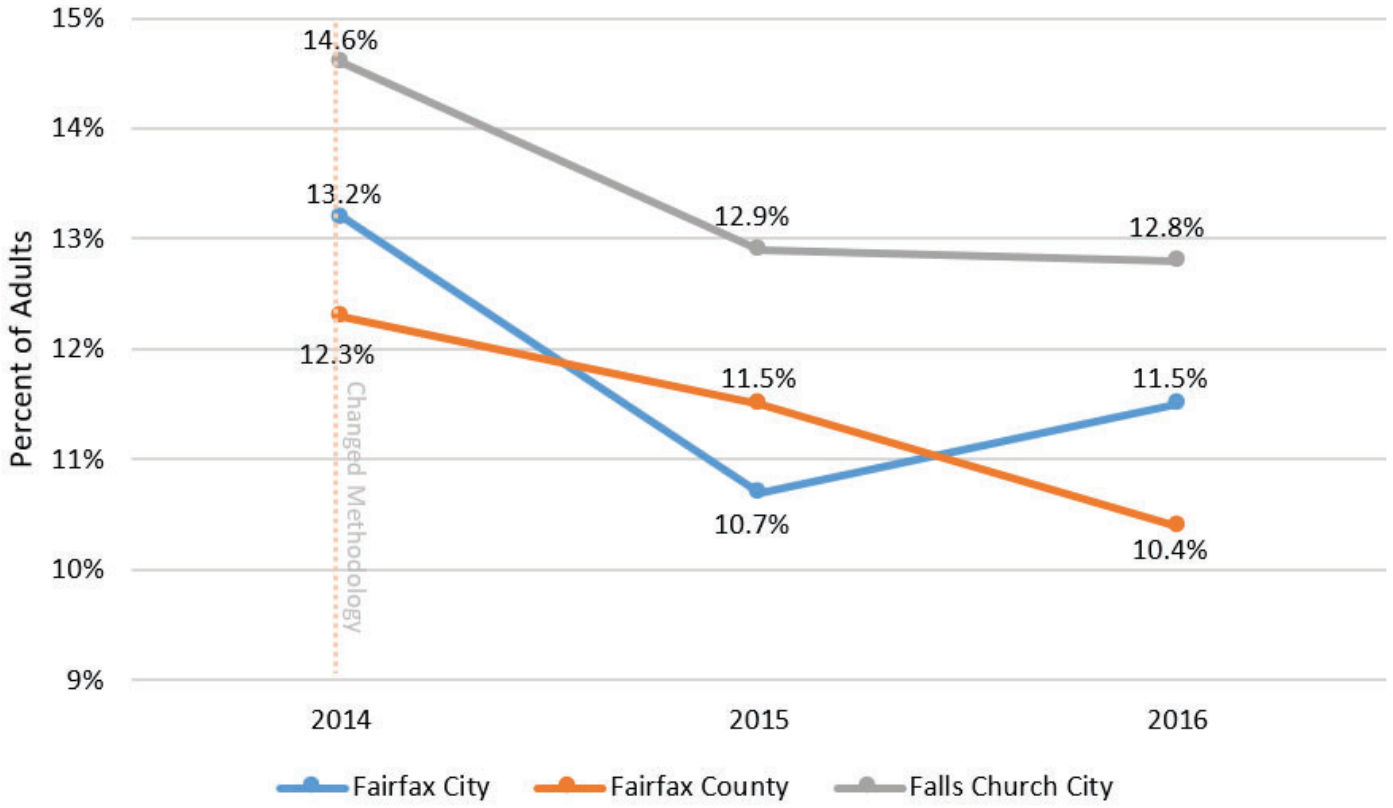
Adults Who Smoke

This indicator shows the percentage of adults who currently smoke cigarettes. All three jurisdictions' rates decreased since 2014 and all were substantially lower than the national average of 17.1%.



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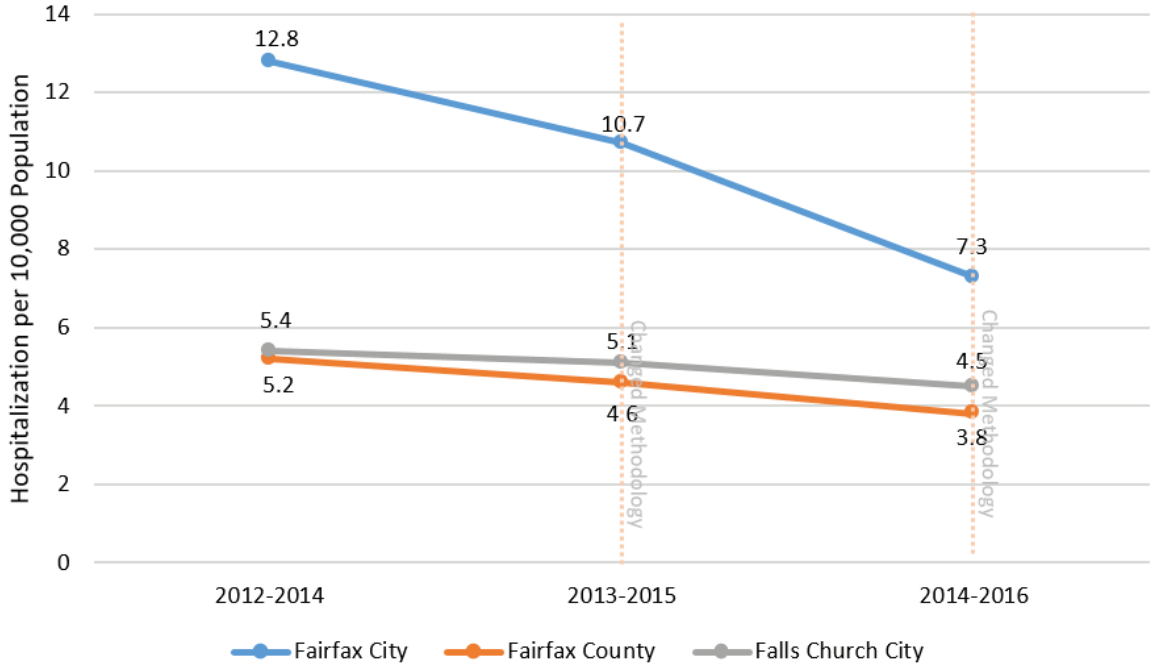
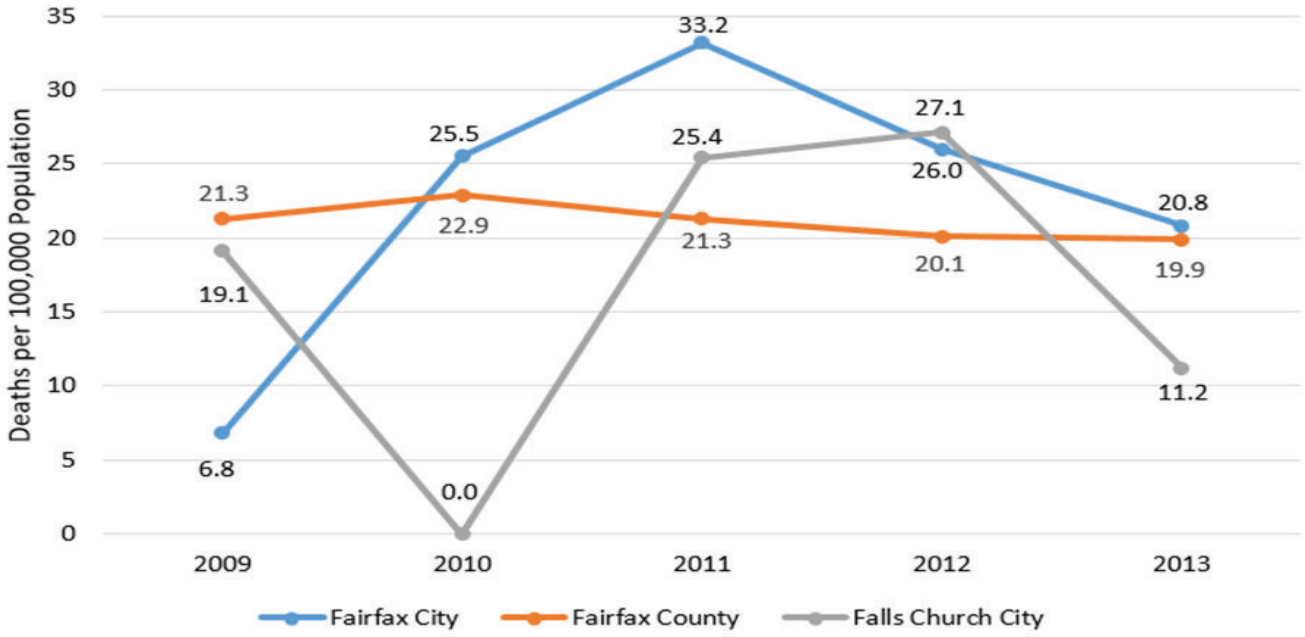
Age-Adjusted Hospitalization Rate due to Asthma

This indicator shows the average annual age-adjusted hospitalization rate due to asthma per 10,000 population. Asthma cases with a secondary diagnosis of cystic fibrosis or other respiratory anomalies were excluded. The rates for Fairfax County and the City of Falls Church were lower than the Virginia rate of 6.6 per 10,000. The City of Fairfax rate decreased since the 2012 data collection to 7.3 per 10,000 population.



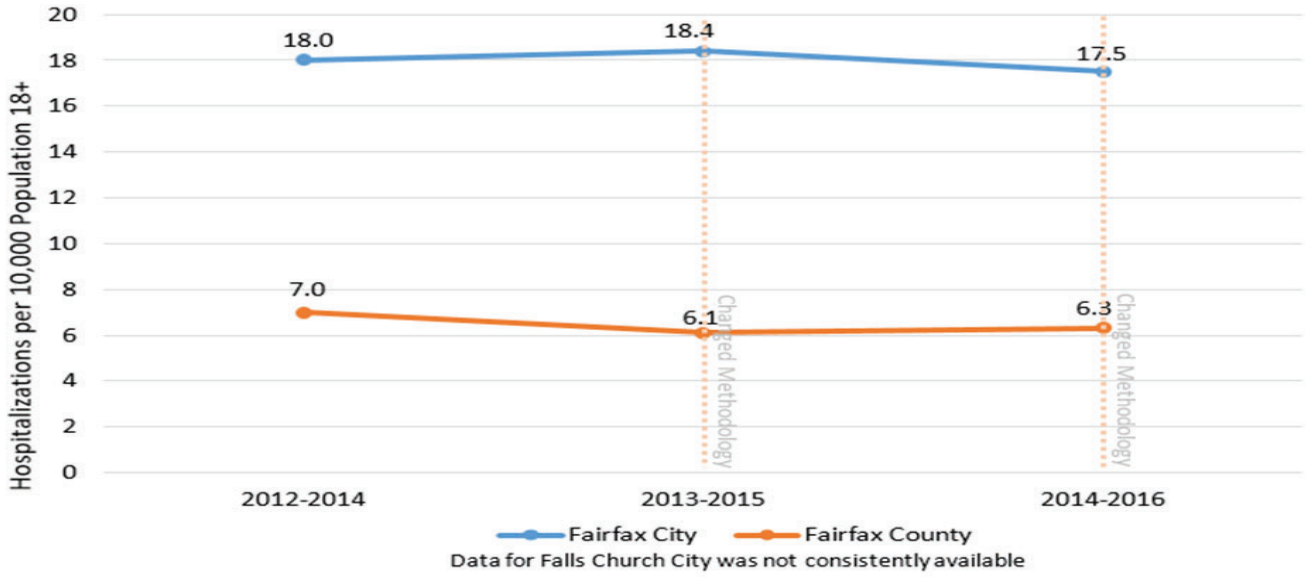
Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases

This indicator shows the age-adjusted death rate per 100,000 population due to chronic lower respiratory diseases. Chronic lower respiratory diseases include asthma, emphysema and all other chronic lower respiratory diseases. These death rates for all jurisdictions of the Fairfax community were less than half of the U.S. rate of 42.1 deaths per 100,000 population.



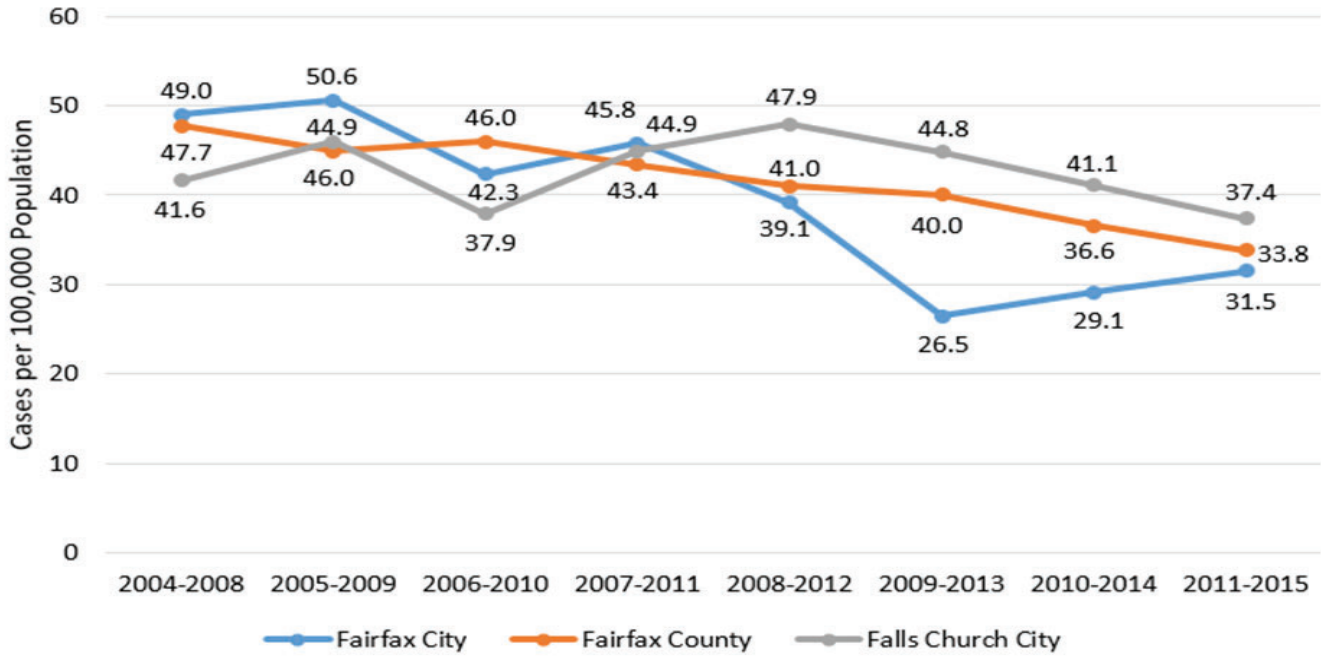
Age-Adjusted Hospitalization Rate due to COPD

This indicator shows the average annual age-adjusted hospitalization rate due to chronic obstructive pulmonary disease (COPD) per 10,000 population aged 18 years and older. COPD cases with a secondary diagnosis of cystic fibrosis or other respiratory anomalies were excluded. There were 6.3 COPD-related hospitalizations per 10,000 Fairfax County residents aged 18 or older from 2014-2016. This rate is almost one-third of the Virginia rate of 16.9. Rates for the City of Fairfax were slightly higher, most recently at 17.5 per 10,000 hospitalizations.



Lung and Bronchus Cancer Incidence Rate

This indicator shows the age-adjusted incidence rate for lung and bronchus cancers in cases per 100,000 population. All three jurisdictions of the Fairfax community recorded fewer than 38 new cases of lung or bronchus cancer per 100,000 residents from 2011-2015, significantly lower than the national average of 60.2. Overall, rates have declined across the Fairfax community since 2004.



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Health Workforce

Health Workforce

- **Goal 1**: Have a health care workforce that is responsive to the health care needs of a diverse population.
  - **Objective 1.1:** Increase the number of sustainable frameworks that support community-based organizations in building capacity to deliver chronic disease prevention and self-management programs through public health professionals and peers/lay workers.
  - **Objective 1.2**: Conduct a baseline survey for health care employers to determine awareness and implementation of the National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care that address workforce composition, cultural competency, and language access.
  - **Objective 1.3**: Increase the percentage of employers that follow the National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care in the areas of workforce composition, cultural competency, and language access using the results of the baseline survey.

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Health Workforce *Expanding the workforce capacity to meet the health care needs of a diverse community*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
1. Have a health care workforce that is responsive to the health care needs of a diverse population.	1.1 Increase the number of sustainable frameworks that support community-based organizations in building capacity to deliver chronic disease prevention and self-management programs (CDSMP) through public health professionals and peers/lay workers.	✔	**1.1.A** Engage key stakeholders to define criteria for and identify specific communities of need that will be targeted.	• Delivered the CDSMP model to the Fairfax County Health Department (FCHD) Community Health Outreach (CHO) team for implementation. • Developed a framework for CDSMP which identified the roles and functions necessary to sustain and expand the program. • Developed a CDSMP Study Site Evaluation Plan concept for monitoring the process and measuring implementation outcomes. • Developed and implemented instruments for conducting pre-tests and post-tests immediately following and at periodic intervals after training events to learn if behavioral changes were initiated and maintained. • Developed a Results-Based Accountability plan for FCHD CHO that includes annual analysis of performance measures for CDSMP.
		✔	**1.1.B** Identify and establish a partnership among organizations in the Fairfax community to coordinate and deliver CDSMP.	
		✔	**1.1.C** Develop a sustainable collaborative infrastructure and coordinated system among organizations to support the maintenance and delivery of the CDSMP in the Fairfax community and identify key champion(s) of CDSMP.	
		✔	**1.1.D** Develop consistent messaging to market the benefit of CDSMP participation to health care providers, community-based organizations and community members.	
		✔	**1.1.E** Implement quality assurance efforts in the implementation of CDSMP.	
		✔	**1.1.F** Educate the public and policymakers about the importance of institutionalizing or embedding the CDSMP program into their existing initiatives.	
		✔	**1.1.G** Demonstrate the value of the CDSMP to health care providers and community-based organizations to help identify consistent, diverse resource providers or funding streams to support the CDSMP.	

✔ Action Performed ↻ Action In-Progress ⊘ Action Not Started

Health Workforce (continued) *Expanding the workforce capacity to meet the health care needs of a diverse community*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
1. Have a health care workforce that is responsive to the health care needs of a diverse population.	1.2 Conduct a baseline survey for health care employers to determine awareness and implementation of the National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care that address workforce composition, cultural competency, and language access.	✔	**1.2.A** Identify key partners and leverage national, state, and local resources to develop the survey.	• Developed, pilot-tested, and revised the survey instrument to examine health care organization awareness and implementation of the CLAS standards that address workforce composition, cultural competency, and language access. • Used the survey findings to recruit additional Health Workforce Priority Issue Team members and engage key audiences in advancing the work. • Shared and discussed the CLAS survey findings at Partnership for a Healthier Fairfax community coalition meetings. • Used the findings to inform the Story Sharing project development.
		✔	**1.2.B** Administer the survey to health care employers.	
		✔	**1.2.C** Analyze and disseminate the survey results.	

✔ Action Performed ↻ Action In-Progress ⃠ Action Not Started

Health Workforce (continued) *Expanding the workforce capacity to meet the health care needs of a diverse community*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
1. Have a health care workforce that is responsive to the health care needs of a diverse population.	1.3 Increase the percentage of employers that follow the National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care in the areas of workforce composition, cultural competency, and language access using the results of the baseline survey.	✔	**1.3.A** Key actions will focus on collaboration and coordination to be determined based on survey results.	• Developed a plan with new key actions to address the results of the CLAS survey. Results identified low awareness of the impact of failing to provide culturally and linguistically appropriate services; the need to engage and empower all parties in ways to provide such services; and the need to better support workforce development. • Recruited 8 diverse patients to serve as story sharers for a multi-day story collection workshop. • Conducted a Digital Story Sharing Workshop with the Virginia Adult Learning Resource Center. • Worked with Story Center and finalized the production of 8 digital patient story videos. • Conducted focus groups to gather feedback that will inform the development of a corresponding curriculum. • Developed a healthcare provider training curriculum that incorporates the patient story videos. • Identified resources and partners to develop curriculum based on the framework submitted. • Promoted the use of the digital stories to foster greater CLAS awareness among healthcare providers.
		✔	**1.3.B** Develop an overarching framework to address the lack of awareness and implementation of CLAS Standards 3, 4, and 7 identified in the CLAS survey results.	
		✔	**1.3.C** Identify champions across sectors, disciplines, and organizations to identify and recruit storytellers from a range of populations represented in Fairfax County.	
		✔	**1.3.D** Produce digital stories to be shared as a part of outreach, education, and advocacy to address CLAS Standards 3, 4, and 7.	
		⃠	**1.3.E** Develop an online, interactive portal for outreach, education, advocacy and resource sharing regarding adherence to CLAS Standards 3, 4, and 7.	
		✔	**1.3.F** Create an awareness campaign, leveraging partners to disseminate information about the survey results and activities, to address areas for improvement.	

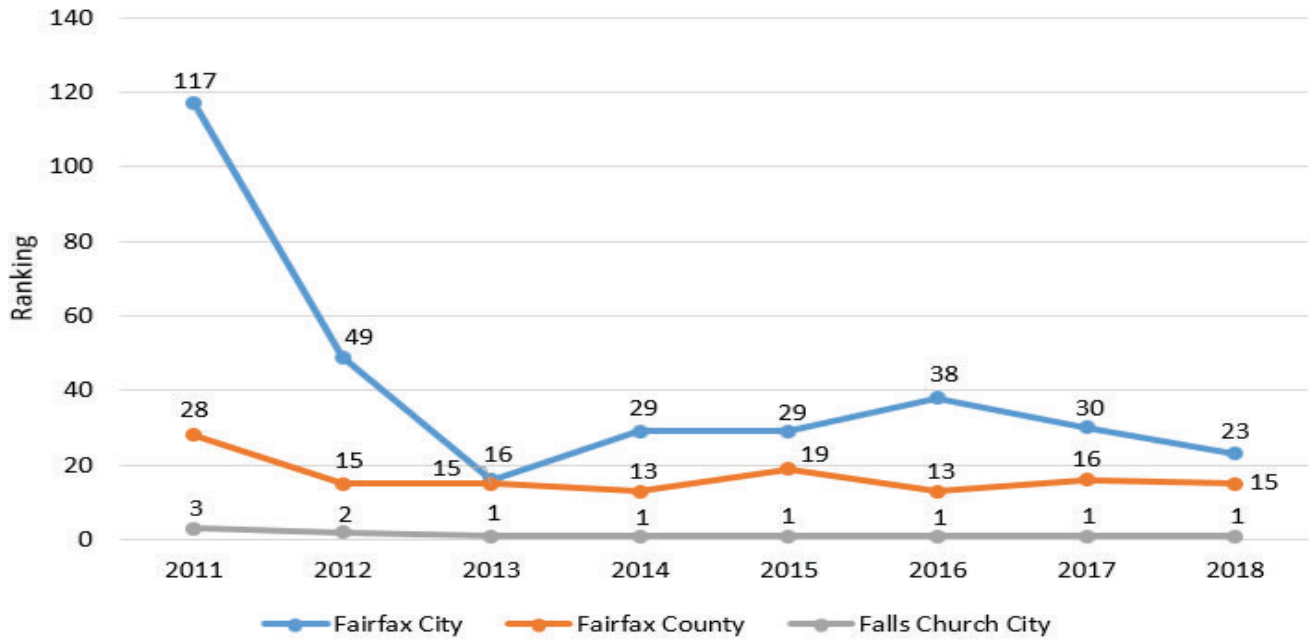
✔ Action Performed ↻ Action In-Progress ⃠ Action Not Started

Health Workforce

- **Population Health Indicators**
  - Clinical care ranking
  - Primary care provider rate
  - Non-physician primary care provider rate

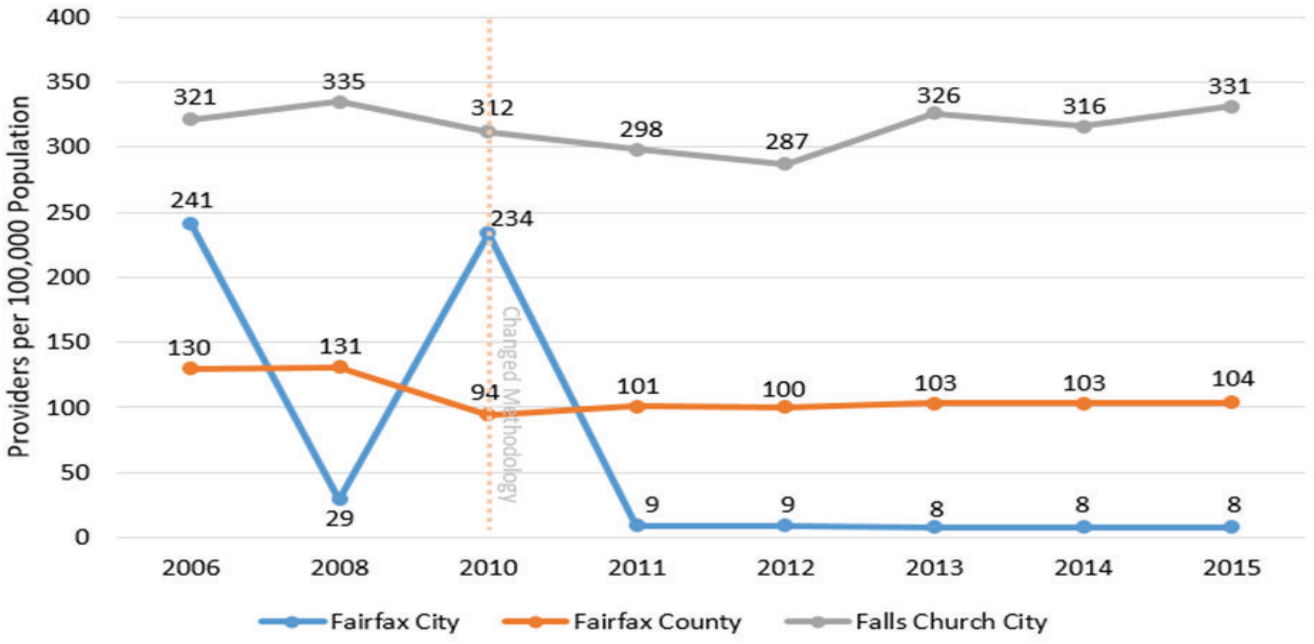
Clinical Care Ranking

The clinical care ranking is a composite score calculated from the following measures: uninsured, primary care physicians, mental health providers, dentists, preventable hospital stays, diabetic monitoring, and mammography screening. People with access to high-quality care are more likely to receive effective treatment for their conditions and enjoy better health. County Health Rankings ranked Fairfax County 15th out of 133 counties in Virginia in regards to clinical care. The City of Falls Church was ranked the best in the state and the City of Fairfax was ranked 23rd.



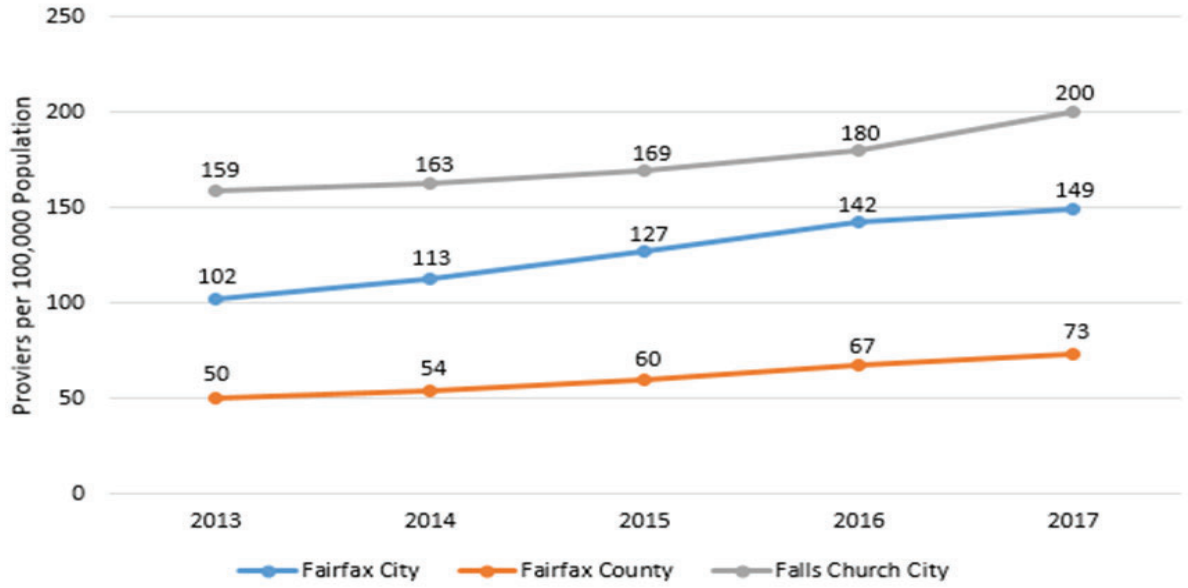
Primary Care Provider Rate

This indicator shows the primary care provider rate per 100,000 population. Primary care providers include practicing physicians specializing in general practice medicine, family medicine, internal medicine, and pediatrics. As of 2015, Fairfax County had 104 primary care providers (PCPs) per 100,000 population compared to 331 in the City of Falls Church. Both of these rates were higher than the Virginia and U.S. rates of 76 and 75 per 100,000 population respectively. The City of Fairfax had only 8 PCPs per 100,000 population in the most recent year of data available.



Non-Physician Primary Care Provider Rate

This indicator shows the non-physician primary care provider rate per 100,000 population which includes primary care providers who are not physicians, such as nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists. Rates have been increasing across the entire Fairfax Community since 2013. While Fairfax County had a lower rate (73) than Virginia (77) and the U.S. (81), both the City of Falls Church and the City of Fairfax had rates that were substantially higher (200 and 149 respectively).



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Access to Health Services

Access to Health Services

- **Goal 1**: Improve access to primary and specialty care, including oral and behavioral care.
- **Goal 2**: Improve access to services that promote social and emotional wellness, prevent suicide, and decrease the stigma associated with mental illness and substance abuse.

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Access to Health Services

- **Goal 1**: Improve access to primary and specialty care, including oral and behavioral care.
  - **Objective 1.1**: Improve the community's capacity to obtain, process, and understand basic health information and services needed to make appropriate health care decisions and engage in health-promoting behaviors.
  - **Objective 1.2**: Increase access to health services through policy and system improvements among providers.

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Access to Health Services *Improving access to and quality of health care services*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
1. Improve access to primary and specialty care, including oral and behavioral care.	1.1 Improve the community's capacity to obtain, process, and understand basic health information and services needed to make appropriate health care decisions and engage in health-promoting behaviors.	✔	**1.1.A** Promote community awareness and understanding of the availability of various types of health insurance coverage, such as Medicaid and marketplace-based coverage; how to obtain health insurance; and how to select an insurance plan.	• Northern Virginia Family Service formed the Northern Virginia Marketplace Consortium, a network of approximately 30 entities conducting outreach and enrollment assistance for the Virginia Marketplace that share best practices and information and coordinate events. • Coordinated 88 public outreach events educating over 2,000 individuals about health insurance coverage. • Recruited, trained, and deployed 81 volunteer Certified Application Counselors who provided over 3,000 hours of direct service to community members. • Assisted 2,045 households in selecting insurance plans through the Health Insurance Marketplace. • Enroll Virginia provided outreach and enrollment assistance for the Health Insurance Marketplace, and is also working with partners to identify strategies to increase health literacy around accessing and appropriately using health care services, especially among diverse populations and the first-time insured. • Expanded the Chronic Disease Self-Management Program.
		✔	**1.1.B** Enroll eligible individuals and small businesses in health insurance by promoting the use of health system navigators to increase enrollment in Medicaid and other eligibility-based social services.	
		✔	**1.1.C** Provide ongoing education, assistance, and support to community members on how to use health insurance and health services effectively to make appropriate health care decisions and engage in health-promoting behaviors.	
		✔	**1.1.D** Increase community awareness of chronic disease and risk factors to empower individuals to take control of their health.	

Access to Health Services (Continued) *Improving access to and quality of health care services*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
1. Improve access to primary and specialty care, including oral and behavioral care.	1.2 Increase access to health services through policy and system improvements among providers.	✔	**1.2.A** Integrate primary health care with behavioral health, oral health, social services, specialty care, and public health.	• Implemented integrated and co-located services for several county-operated primary care and behavioral health clinics and Federally Qualified Health Centers. • Trained over 100 pediatricians in Fairfax County to screen for and manage behavioral health issues to increase the capacity of the local provider community to serve kids with behavioral health needs. • Collaborated with government safety net providers to streamline eligibility and intake processes. • Implemented the Mobility Access Project and the 50+ Action Plan. • Developed recommendations and tools to support the integration of youth behavioral health and primary care services.
		✔	**1.2.B** Improve collaboration among community support networks and safety net providers through changes such as streamlined eligibility systems.	
		✔	**1.2.C** Improve the availability and accessibility of alternatives to long-term institutional care, including home- and community-based services.	

✔ Action Performed ↻ Action In-Progress ⊘ Action Not Started

Access to Health Services

- **Goal 2**: Improve access to services that promote social and emotional wellness, prevent suicide, and decrease the stigma associated with mental illness and substance abuse.
  - **Objective 2.1**: Improve the capacity of the community to deliver services that promote social and emotional wellness.
  - **Objective 2.2**: Improve awareness of mental illness and how to promote mental health among the public and community-based organizations.

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Access to Health Services (Continued) *Improving access to and quality of health care services*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
2. Improve access to services that promote social and emotional wellness, prevent suicide, and decrease the stigma associated with mental illness and substance abuse.	2.1 Improve the capacity of the community to deliver services that promote social and emotional wellness.	✔	**2.1.A** Bring together critical stakeholders to create and implement a community-wide comprehensive suicide prevention agenda.	• Developed a regional suicide prevention plan based on the National Strategy for Suicide Prevention. • Formed the Suicide Prevention Alliance of Northern Virginia (SPAN), a regional coalition of the Alexandria, Arlington, Fairfax-Falls Church, Loudoun, and Prince William Community Services Boards (CSBs) and other groups in Northern Virginia to raise awareness and share resources on suicide prevention. • Launched a regional website, www.suicidepreventionnva.org, which hosts the plan, engages and educates the public, and provides tools and resources for stakeholders to implement the plan. • Established a Youth Suicide Review Team to review child deaths by suicide to inform and improve suicide prevention efforts. • Disseminated population-specific suicide prevention resources and messaging through SPAN. • Developed guidance and resources for community-based organizations on responding to suicide. • Developed an inventory of resiliency activities to identify gaps and expand on existing efforts. • Developed and implemented strategies in response to a CDC Epi-Aid Report on Youth Suicide in Fairfax County. • Established the Healthy Minds Fairfax initiative, including a new cross-sector committee to advise on funding and programming for the youth behavioral health system of care. • Implemented a new messaging campaign for Three to Succeed, to provide parents, youth-serving organizations, and others with information on how to promote resilience among kids.
		✔	**2.1.B** Build on existing school-based mental health activities to implement community-based and coordinated efforts to develop resiliency and coping skills and prevent and respond to depression, suicide, and bullying among youth.	

✔ Action Performed ↻ Action In-Progress ⃠ Action Not Started

Access to Health Services (Continued) *Improving access to and quality of health care services*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
2. Improve access to services that promote social and emotional wellness, prevent suicide, and decrease the stigma associated with mental illness and substance abuse.	2.1 Improve the capacity of the community to deliver services that promote social and emotional wellness.	✔	**2.1.C** Implement evidence-based behavioral health screenings and make appropriate referrals in health care provider offices, schools, and other settings.	• Conducted pilot training for primary care providers to implement intimate partner violence screenings for women in FCHD clinics. • Worked with GMU to validate the intimate partner violence screening tool. • Held an intimate partner violence screening workshop. • Trained over 100 pediatricians in Fairfax County to screen for and manage behavioral health issues, increasing the capacity of the local provider community to serve kids with behavioral health issues. • Implemented the Lifelines, Signs of Suicide, Safe Dates, Parents Raising Safe Kids, Strengthening Families, Parenting Wisely, Project Towards No Tobacco Use, and Project Towards No Drug Use prevention programs through the Partners in Prevention Fund (PIPF).
		✔	**2.1.D** Offer high-quality, community-based prevention programs designed to increase social and emotional wellness and behavioral health among individuals and families.	

✔ Action Performed ↻ Action In-Progress ⊘ Action Not Started

Access to Health Services (Continued) *Improving access to and quality of health care services*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
2. Improve access to services that promote social and emotional wellness, prevent suicide, and decrease the stigma associated with mental illness and substance abuse.	2.2 Improve awareness of mental illness and how to promote mental health among the public and community-based organizations.	✔	**2.2.A** Train community-based organizations to recognize signs of mental illness and depression and make appropriate referrals.	• Increased offerings of Mental Health First Aid trainings to the public, school communities, youth-serving organizations, public safety agencies, the military/veteran community, and older adult-serving organizations. • Purchased a suite of online suicide prevention training products developed by Kognito that is available to county residents, and required for Fairfax County Public Schools (FCPS) teachers and Neighborhood and Community Services youth-serving staff. • Added Kognito training for high school students (Friend 2 Friend) and included it in the 10th grade health curriculum. • Published a one-page trauma fact sheet/resource guide. • Established a Fairfax Trauma-Informed Community Network (TICN) to share resources and best practices and to develop and implement shared training opportunities. • Launched TICN trainings and reached over 4,000 individuals on: trauma awareness, trauma-informed supervision, and secondary trauma. • Conducted trauma-informed training sessions for senior leaders in Health and Human Services and FCPS, and worked with all HHS agencies to develop trauma-informed agency plans. • Facilitated screenings of the film "Resilience: The Biology of Stress and the Science of Hope" and made the film available to others to host screenings. To date, over 6,000 people have viewed the film through these screenings. • In November 2017, the Board of Supervisors adopted a resolution stating that Fairfax County is a Trauma-Informed Community. • Developed and distributed three PSAs to promote access to mental health services and to destigmatize mental illness. • Awarded four rounds of mini-grants for youth-led initiatives to combat stigma around mental illness. • Developed a System of Care website to help families navigate the behavioral health care system.
		✔	**2.2.B** Train community-based organizations to implement trauma-informed care practices, ensuring that program staff recognize the presence of trauma symptoms in clients and acknowledge how trauma can impact their lives.	
		✔	**2.2.C** Increase community awareness of mental illness, including how to get help and ways to promote mental health to connect people with services and reduce the stigma of mental illness.	

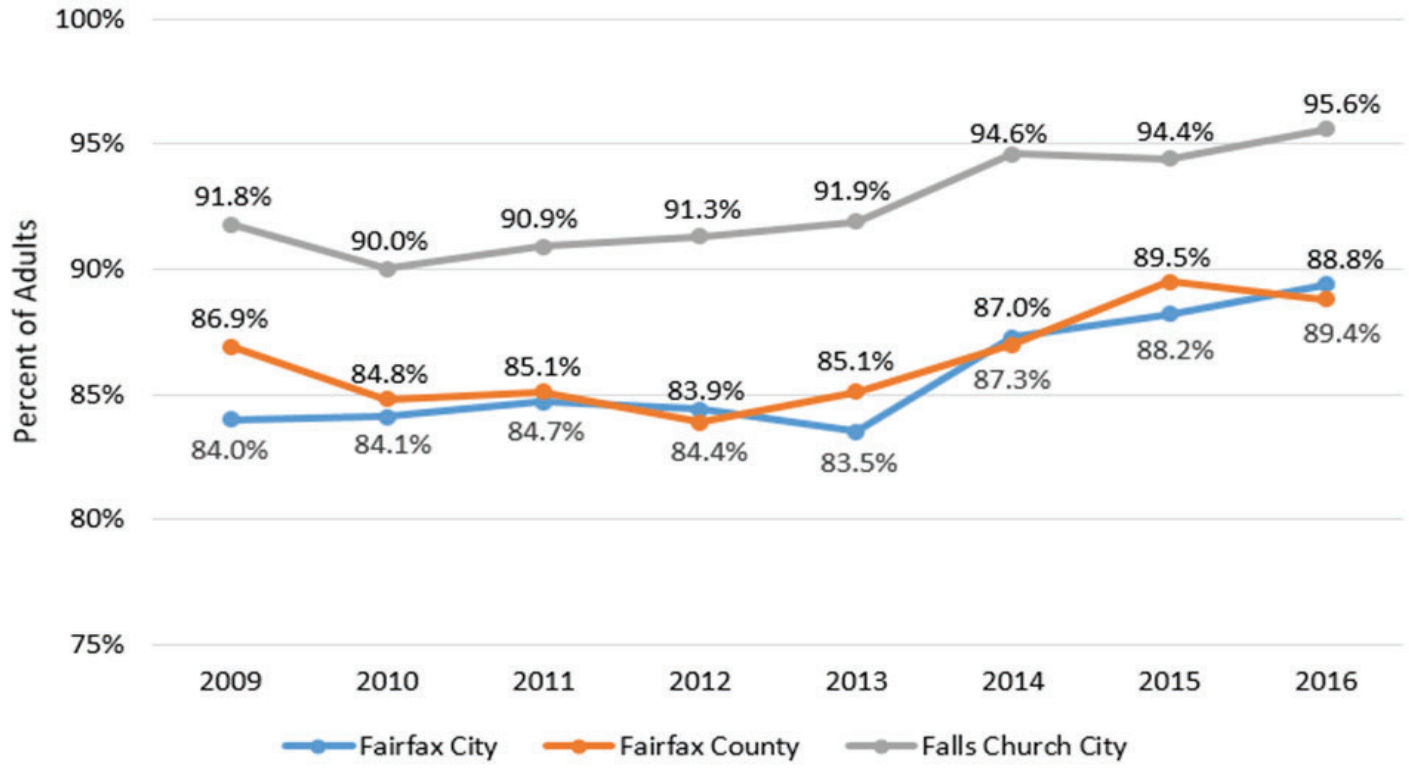
✔ Action Performed ↻ Action In-Progress ⊘ Action Not Started

Access to Health Services

- **Population Health Indicators**
  - Adults with health insurance aged 18-64
  - Age-adjusted death rate due to suicide
  - Frequent mental distress
  - Preventable hospital stays: Medicare population
  - Children with health insurance

Adults with Health Insurance Ages 18-64

This indicator shows the percentage of adults ages 18-64 years that have any type of health insurance coverage. The City of Falls Church was reported closest to the Healthy People 2020 goal of 100% coverage (95.6% in 2015); however, both the City of Fairfax and Fairfax County remained under 90%.



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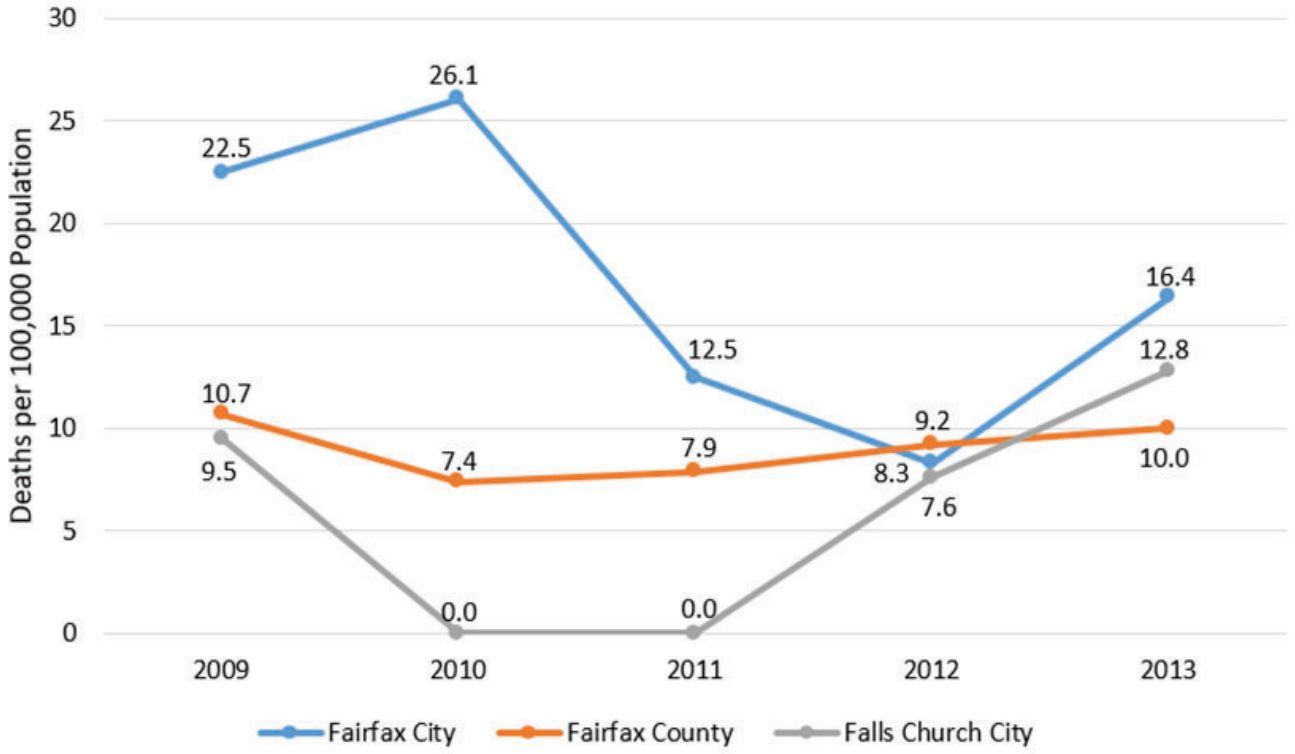
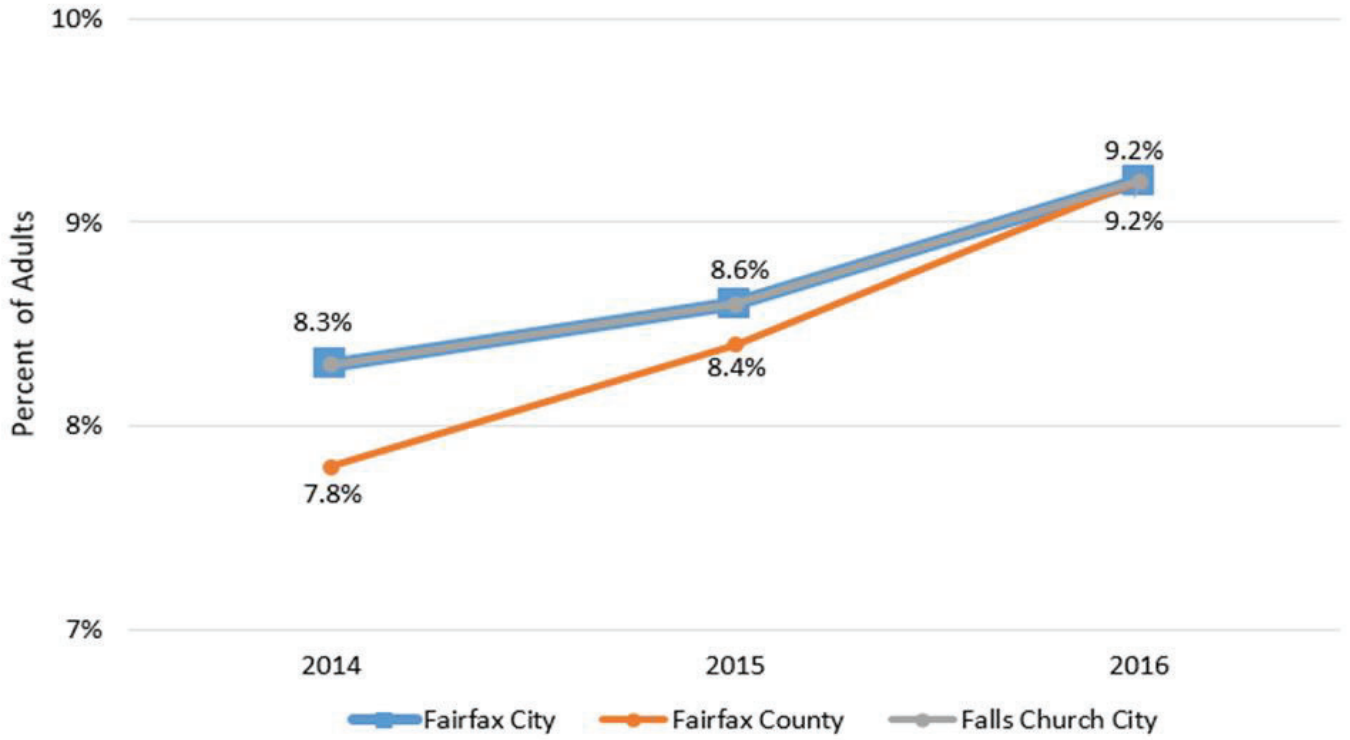
Age-Adjusted Death Rate due to Suicide

This indicator shows the age-adjusted death rate per 100,000 population due to suicide. Suicide-related death rates across the Fairfax community ranged from 10 to 16.4 per 100,000 population in 2013, the most recent year of data available. Fairfax County's rate (10.0) was lower than either the Virginia and U.S. rates of 12.2 and 12.6 per 100,000 population respectively.



Frequent Mental Distress

This indicator shows the percentage of adults who stated that their mental health, which includes stress, depression, and problems with emotions, was not good for 14 or more of the past 30 days. In 2016, 9.2% of Fairfax community residents reported experiencing mental distress for 14 out of the past 30 days. This was lower than the Virginia and U.S. averages of 11% and 15% respectively.



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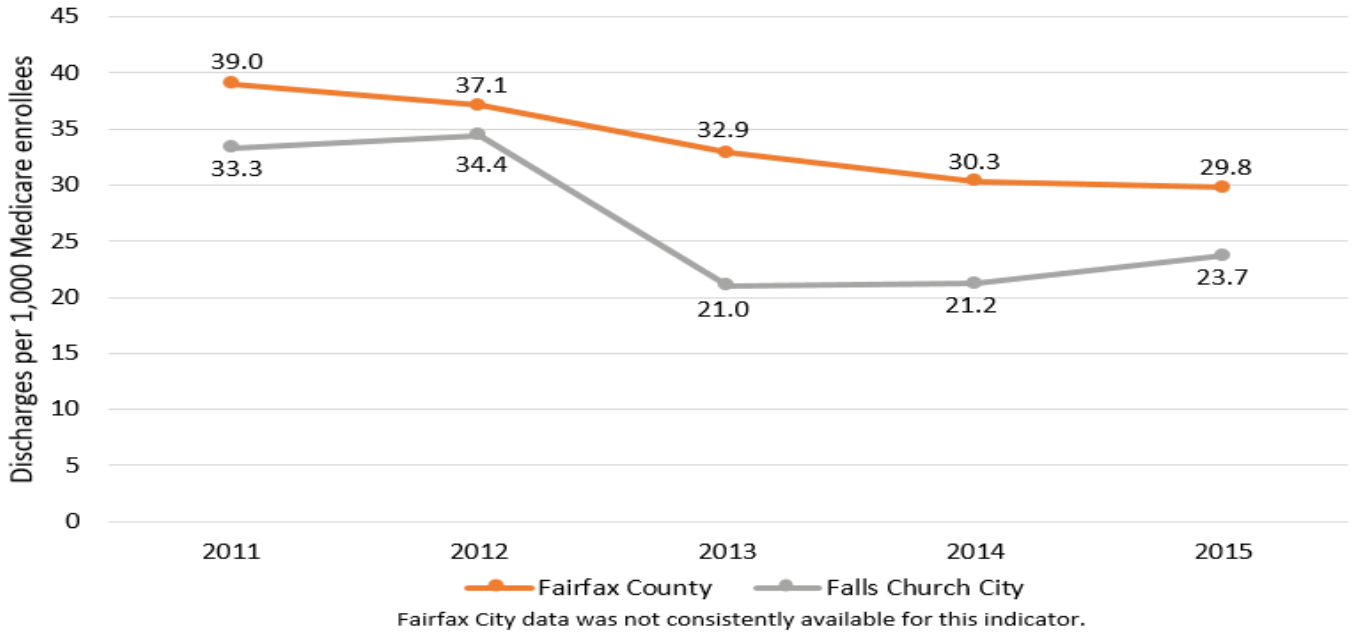
Preventable Hospital Stays: Medicare Population

This indicator shows the hospital discharge rate for ambulatory care-sensitive conditions (ACSC) per 1,000 Medicare enrollees. In 2015, there were 29.8 and 23.7 preventable hospital stay discharges per 1,000 Medicare enrollees in Fairfax County and the City of Falls Church respectively. Both rates were better than the national average of 49.4 preventable hospital stay discharges and have been trending downward since 2011.



Fairfax City data was not consistently available for this indicator.

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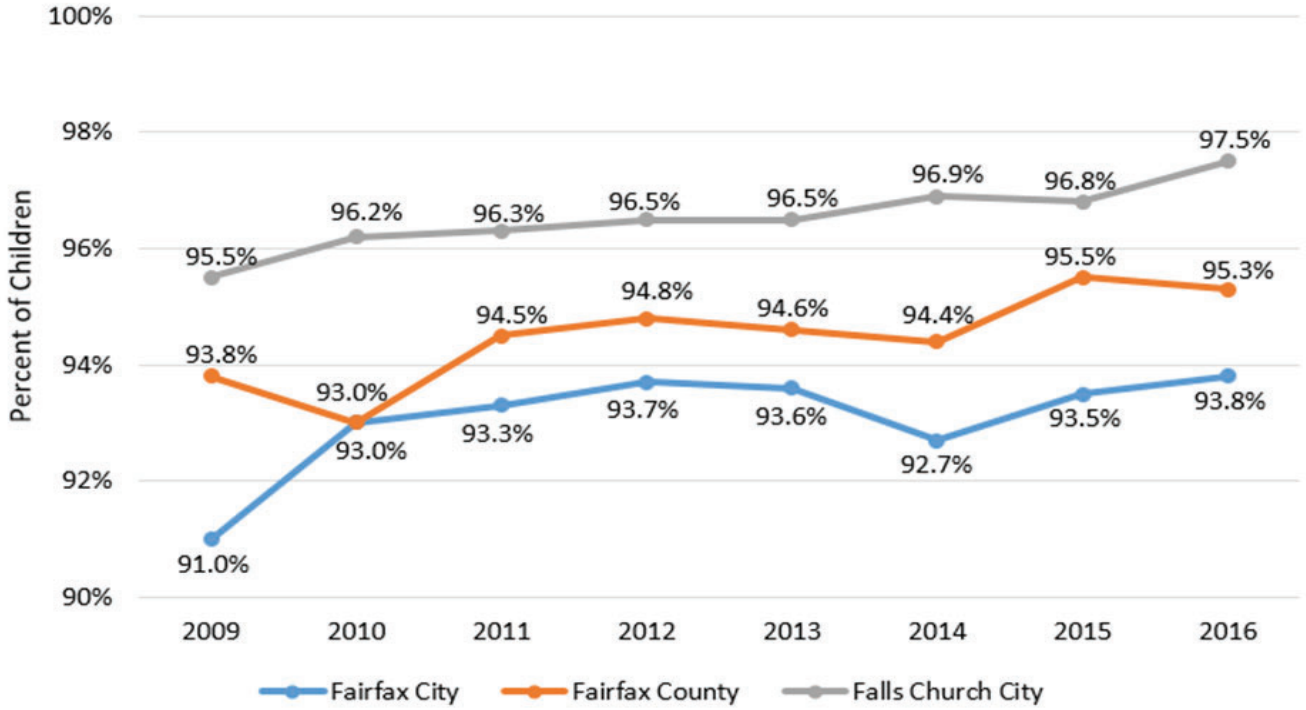
Children with Health Insurance

This indicator shows the percentage of children under age 19 that have any type of health insurance coverage based on the definition of "qualifying child" under the Affordable Care Act. The percent of children under 19 with health insurance has been trending higher across the Fairfax community since 2009. As of 2016, the City of Falls Church had the highest percentage of coverage, followed by Fairfax County and the City of Fairfax.



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Data

Data

- **Goal 1**: Develop recommendations for a comprehensive public health data collection, monitoring, analysis, and reporting system to support evaluation of health outcomes.
  - **Objective 1.1**: Establish a set of community health indicators to measure health outcomes that may be influenced by Community Health Improvement Plan (CHIP) programs and initiatives.
  - **Objective 1.2**: Integrate the identified community health indicators into a comprehensive public health monitoring, analysis, and reporting system that is accessible to the community.

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Data *Integrating public health data to improve monitoring, analysis, reporting, and evaluation of community health*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
1. Develop recommendations for a comprehensive public health data collection, monitoring, analysis, and reporting system to support evaluation of health outcomes.	1.1 Establish a set of community health indicators to measure health outcomes that may be influenced by Community Health Improvement Plan (CHIP) programs and initiatives.	✔	**1.1.A** Identify health outcomes targeted by Community Health Improvement Plan programs and initiatives; identify community health indicators relevant for measuring changes in community health outcomes over time.	• Identified and selected health indicators for an integrated local community health dashboard for each priority issue area of the CHIP. • Compiled a list of community health indicators and data sources classified by national, state, county, local, and private sources. • Identified and secured hospitalization data from Virginia Health Information (VHI) for inclusion on the site with analysis to demonstrate where health disparities exist. • Documented gaps in data availability in a Community Transformation Grant (CTG) project report to explain the background and need for an integrated local community health data system.
		✔	**1.1.B** Evaluate and reconcile the existing compilation of data sources (including national, state, county, local, and private data sources for public health data) to identify the availability of gaps in public health data needed to support the Community Health Improvement Plan.	
		✔	**1.1.C** Identify community health indicators at the sub-county level aligned with the Community Health Improvement Plan that support identification and measurement of health disparities.	
		✔	**1.1.D** Report findings in gaps of data and provide recommendations to address these gaps to measure changes that may be influenced by the Community Health Improvement Plan.	

✔ Action Performed ↻ Action In-Progress ⊘ Action Not Started

Data (Continued) *Integrating public health data to improve monitoring, analysis, reporting, and evaluation of community health*				
Goals	**Objectives**	**Key Actions**		**Progress-to-Date**
1. Develop recommendations for a comprehensive public health data collection, monitoring, analysis, and reporting system to support evaluation of health outcomes.	1.2 Integrate the identified community health indicators into a comprehensive public health monitoring, analysis, and reporting system that is accessible to the community.	✔	**1.2.A** Work with multi-sector public health data stakeholders and technical experts to encourage the inclusion of identified community health indicators in a comprehensive public health data collection, monitoring, analysis, and reporting system.	• Completed a requirements analysis of potential platforms for a Community Health Dashboard (CHD). • Launched the CHD to report health indicators and CHIP progress to the community. • Added data to the CHD for Collective Impact for Successful Children and Youth to inform the work of the Successful Children and Youth Policy Team. • Supported the addition of regional data for Northern Virginia by the CHD vender. • Shared dashboard best practices with Northern Virginia jurisdictions to expand implementation across the region. • Presented the CHD as a community health assessment resource at the Partnership for a Healthier Fairfax Meeting. • Added Health and Human Services Report Card data to show system- and population-level indicators for six results areas. • Created and posted video tutorials to teach site users about the functionality of resources of the CHD. • Added Northern Virginia regional hospitalization data. • Completed and posted the 2017 Fairfax Community Health Assessment.
		✔	**1.2.B** Work with multi-sector public health data stakeholders and technical experts to identify specific options to address limitations of data collection, monitoring, analysis, and reporting.	
		✔	**1.2.C** Establish an action plan for the Fairfax County community partners to improve data collection, monitoring, analysis, and reporting on community health indicators specific to the Community Health Improvement Plan.	
		✔	**1.2.D** Report findings of population health assessments and analyses based upon trends in community health indicators and the Community Health Improvement Plan program evaluation metrics for targeted health improvements and overall population health.	

✔ Action Performed ↻ Action In-Progress ⊘ Action Not Started

Conclusion

The Community Health Improvement Plan 2013-2018 was designed to transform the Fairfax community into a place where all may lead healthier, more productive lives. With the completion of the fifth and final year of implementation, much progress has been made in addressing the seven identified priority issues. **Of the 125 key actions in the CHIP, 90% of the actions were performed, 2% were in progress, and 8% had not been started.** While this body of work is quite impressive, achieving improved health outcomes takes time, resources, and the dedication of many individuals. Diverse community stakeholders and county partners have committed to continuing to work together to achieve optimal health and well-being for all who live, work , and play in the Fairfax community. To this end, the Partnership for a Healthier Fairfax has developed its second Community Health Improvement Plan which will be implemented during 2019-2023.

- **Learn more** at: http://www.fairfaxcounty.gov/livehealthy/
- Track health indicators on the **Community Health Dashboard**: http://www.livehealthyfairfax.org/
- **Get involved** with an email to: LiveHealthy@fairfaxcounty.gov

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Population Health Indicator Sources

- Healthy and Safe Physical Environment
  - Physical Environment Ranking: County Health Rankings
  - Recreation and Fitness Facilities: U.S. Department of Agriculture - Food Environment Atlas
  - Access to Exercise Opportunities: County Health Rankings
- Active Living
  - Adults Engaging in Physical Activity: Virginia Behavioral Risk Factor Surveillance System
  - Adults Who Are Overweight or Obese: Virginia Behavioral Risk Factor Surveillance System
  - Workers Who Walk to Work: American Community Survey
  - Adults 20+ Who Are Sedentary: County Health Rankings
- Healthy Eating
  - Farmers Market Density: U.S. Department of Agriculture - Food Environment Atlas
  - SNAP Certified Stores: U.S. Department of Agriculture - Food Environment Atlas
  - Food Insecurity Rate: Feeding America
  - Children with Low Access to a Grocery Store: U.S. Department of Agriculture - Food Environment Atlas
  - Food Environment Index: County Health Rankings

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Population Health Indicator Sources

- Tobacco-Free Living
  - Adults Who Smoke: County Health Rankings
  - Age-Adjusted Hospitalization Rate Due to Asthma: Virginia Health Information
  - Age-Adjusted Death Rate Due to Chronic Lower Respiratory Diseases: Virginia Department of Health, Division of Health Statistics
  - Age-Adjusted Hospitalization Rate Due to COPD: Virginia Health Information
  - Lung and Bronchus Cancer Incidence Rate: National Cancer Institute
- Health Workforce
  - Clinical Care Ranking: County Health Rankings
  - Primary Care Provider Rate: County Health Rankings
  - Non-Physician Primary Care Provider Rate: County Health Rankings
- Access to Health Services
  - Adults with Health Insurance ages 18-64: Small Area Health Insurance Estimates
  - Age-Adjusted Death Rate Due to Suicide: Virginia Department of Health, Division of Health Statistics
  - Frequent Mental Distress: County Health Rankings
  - Preventable Hospital Stays – Medicare Population: The Dartmouth Atlas of Health Care
  - Children with Health Insurance: Small Area Health Insurance Estimates

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Community Health Improvement Plan 2013-2018
Annual Report – Year Five
October 2017-December 2018

A Fairfax County, VA., publication. April 2019.
For more information, or to request this information in an alternate format, call the Fairfax County Health Department at 703-246-2411, TTY 711.
http://www.fairfaxcounty.gov/livehealthy/