FAIRFAX COUNTY HEALTH DEPARTMENT

2023 COMMUNITY HEALTH ASSESSMENT

fairfaxcounty.gov/health

DEAR FAIRFAX COMMUNITY,

On behalf of the Fairfax County Health Department and the Partnership for a Healthier Fairfax Steering Committee, I am pleased to present the 2023 Fairfax Community Health Assessment. This report presents a comprehensive assessment of our community's health and includes input from community partners and residents who call Fairfax home. The Fairfax County Health Department's vision is for all Fairfax residents to live in thriving communities where every person has the opportunity to be healthy, safe, and realize their potential. My hope is that this report generates conversation, informs decisions, and inspires coordinated action that will promote health and wellness for all.

This Community Health Assessment would not have been possible without the participation and support of our Community Advisors, community partners, Fairfax residents, the Partnership for a Healthier Fairfax Steering Committee, and our Health Department staff. We are so fortunate to have the expertise and collaboration of many dedicated partners and residents in the Fairfax community.

The Community Health Assessment represents the initial phase of an ongoing process to evaluate and improve the health of our Fairfax community. The role of public health is no longer limited to only preventing illnesses. Throughout this resource, you'll learn more about key factors in our environment, society, and behaviors that influence community health. Please consider joining us as we identify health priority issues and develop strategies to address those issues in our next Community Health Improvement Plan in 2024. Working together, we can create a healthier community for all to live, learn, work, worship, play and age.

Sincerely,

Gloria Addo-Ayensu, MD, MPH
Director of Health
Fairfax County Health Department

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ACKNOWLEDGEMENTS

This Community Health Assessment reflects the work and contributions of many community stakeholders and partners across the Fairfax community, as well as Health Department staff. Sincere appreciation is extended to those who graciously shared their expertise throughout the process. A special note of gratitude is owed to the following individuals for their time, commitment, and insight in the development of this report.

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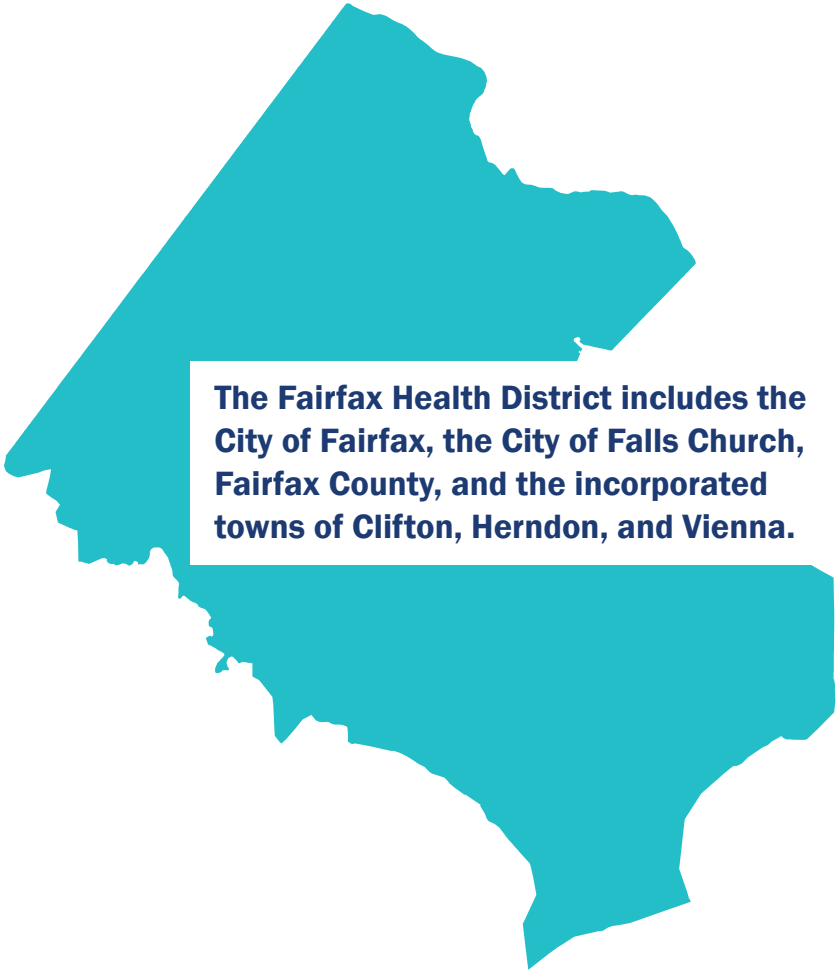
APPROACH

WHAT IS A COMMUNITY HEALTH ASSESSMENT?

Assessing the health status of the community is a core public health function provided by the Fairfax County Health Department. For a community to flourish, it must be healthy, safe, resilient, and provide access to opportunities for all residents to succeed. A Community Health Assessment (CHA) is a careful review of the health-related data and statistics to determine the key issues facing the community. The CHA also highlights health-related strengths in the community and the experiences of community members.

In Fairfax County, the CHA will assist with determining priority health areas to be addressed in the development of the Community Health Improvement Plan (CHIP) in 2024. Information from the CHA can also inspire discussion among government officials and community members to inform decision-making, highlight areas of health that need attention, assist with resource allocation and funding opportunities, and guide policy changes.



The Fairfax Health District includes the City of Fairfax, the City of Falls Church, Fairfax County, and the incorporated towns of Clifton, Herndon, and Vienna.

Visit the Community Health Dashboard at **www.livehealthyfairfax.org** to view the most current data available for more than 100 health-related indicators.

OUR APPROACH TO THE COMMUNITY HEALTH ASSESSMENT

Over a decade ago, the Fairfax County Health Department (Health Department) convened stakeholders from across the Fairfax community to conduct its first comprehensive CHA. This diverse group of individuals, community organizations, schools, healthcare providers, businesses, faith organizations, and government agencies formed the Partnership for a Healthier Fairfax (PFHF) in 2010. Since then, the Health Department and the PFHF have employed a cyclical community strategic planning framework created by the National Association of County and City Health Officials (NACCHO) known as Mobilizing for Action through Planning and Partnerships (MAPP).[1] MAPP provides a framework to assess the health of the community, identify priority issues, and develop a CHIP. The final phase of the MAPP process is ongoing as the plan is implemented and evaluated over time.

During 2022, new Public Health Accreditation Board standards were issued, some of which pertain to developing a new CHA.[2] Additionally, in 2022, revised and updated MAPP assessments were released to assist in evaluating the health of the community. The Health Department decided to utilize the new MAPP assessments in 2023 to review and collect additional data to meet the new accreditation standards.

MAPP Assessments

Community Status Assessment (CSA)	Reviews the quantitative data available in the Fairfax community to identify key health indicators. This data consists of numbers that can tell how many, how much or how often and identifies areas of strength and areas of concern.
Community Context Assessment (CCA)	Reviews qualitative data. This data can help explain why, how, or what happened. The themes for this assessment center around the strengths and assets in the community, the built environment (i.e., the human-made environment), and forces of change (i.e., forces outside of the control of the individual person). It provides a community perspective around the key health indicators identified.
Community Partner Assessment (CPA)	The Community Partner Assessment (CPA) helps identify organizations and agencies working in the Fairfax community, who they serve, their strengths, and how they support community health improvement.

The full assessments can be found in the appendices. Together, these three assessments provide the foundation of this Community Health Assessment. This report contains key highlights from the three assessments, beginning with the CSA on page 13. The summary of the CCA begins on page 44. The summary of the CPA begins on 46.

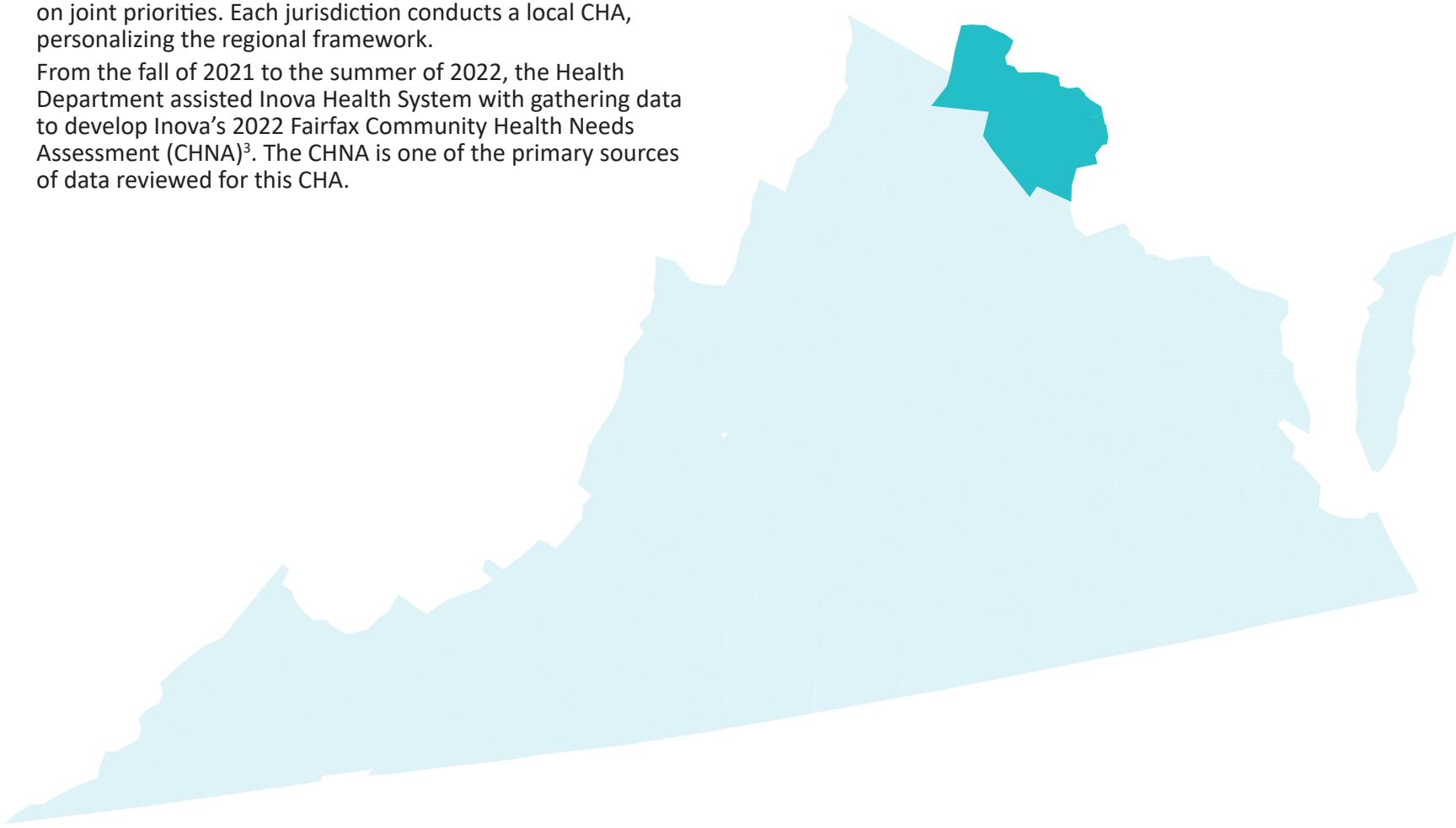
The Partnership for a Healthier Fairfax is a coalition of community members and organizations that are working together to explore new approaches for addressing critical public health issues. To learn more about or join the Partnership for a Healthier Fairfax, email LiveHealthyFairfax@fairfaxcounty.gov.

REGIONAL COMMUNITY HEALTH ASSESSMENT

In 2018, the health departments of Alexandria City, Arlington, Fairfax, Loudoun, and Prince William counties, and the Inova Health System came together to develop a framework for a regional CHA. The framework provides standardized methods that consider each community's unique resources, needs and values. The regional CHA reduces duplication of efforts among the partners and encourages cooperative solutions on joint priorities. Each jurisdiction conducts a local CHA, personalizing the regional framework.

From the fall of 2021 to the summer of 2022, the Health Department assisted Inova Health System with gathering data to develop Inova's 2022 Fairfax Community Health Needs Assessment (CHNA)[3]. The CHNA is one of the primary sources of data reviewed for this CHA.

*** Northern Virginia encompasses the City of Alexandria, Arlington, Fairfax, Loudoun, and Prince William counties.**

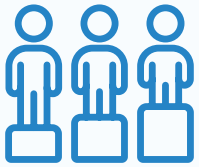


EQUITY FOCUS AND ONE FAIRFAX

While Fairfax County is nationally recognized for its economic strength and high quality of life, persistent disparities by race, neighborhood of residence and other social categories still exist in outcomes related to employment, housing, health, and more. One Fairfax, adopted by the Fairfax County Board of Supervisors and School Board in 2017, is a social and racial equity policy that commits the County and schools to consider equity when making policies, or delivering programs or services. It's a declaration that all residents deserve an equitable opportunity to succeed — regardless of their race, color, nationality, sex, gender identity, sexual orientation, religion, disability, income or where they live. One Fairfax provides a framework for county and school leaders to look intentionally, comprehensively, and systematically at barriers that may be creating gaps in opportunity.[4]

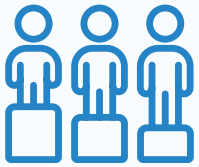
In alignment with One Fairfax, the Health Department is committed to applying a racial and social equity lens to all aspects of our work, policies, and practices, to identify and address root causes of health inequities in the community.[5] The Health Department intentionally reviewed and gathered data within the MAPP assessments with a focus on disparities in health status.

DEFINING EQUITY IN HEALTH



HEALTH EQUITY

The state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable health disparities.[6]



HEALTH DISPARITIES

are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations that have been disadvantaged by their social or economic status, geographic location, and environment.[6]

COMMUNITY ENGAGEMENT

Engaging with community leaders, organizations and residents is vital in developing a CHA. The Health Department accessed data from over 4,500 community stakeholders in a variety of ways. Community Advisors representing diverse communities, the PFHF Steering Committee, and the Multicultural Advisory Council provided guidance, feedback, and their expertise in the development and implementation of the community engagement strategy.

Gathering input from community residents who experience health disparities was important in understanding the context of the quantitative data presented for the key health indicators. This input is found within the Community Status Assessment and the Community Context Assessment.

While the Health Department reviewed existing qualitative data collected by other county agencies and community partners representing community voices, the Health Department also utilized its Community Outreach and Engagement Team, who have established relationships with community partners and residents, to gather additional information from community residents. This information provided a better understanding of the health-related data. Additionally, in-depth interviews with trusted and known community leaders from historically and currently marginalized communities were conducted. While the community perspectives gathered for the Community Context Assessment is not representative of all experiences in the Fairfax community, it does provide insight into the key health-related areas.

The Health Department also assessed key community agencies and organizations via an online survey to learn more about who is working in the Fairfax community, whom they serve, their strengths, and opportunities to work together to improve community health. This information is found in the Community Partner Assessment. ■

FAIRFAX COMMUNITY PROFILE

Population Size

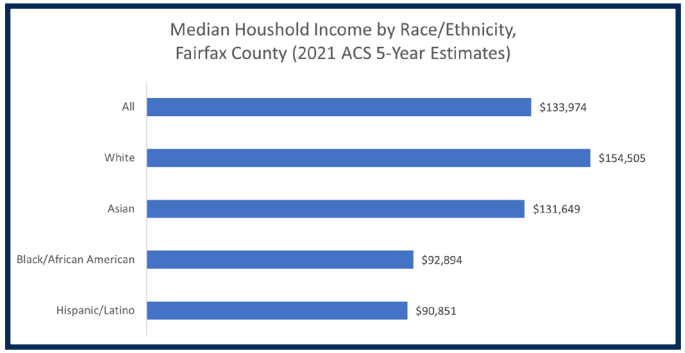
With an estimated population of 1,138,331 in 2022, Fairfax County is the largest jurisdiction in Northern Virginia and the Metropolitan Washington, D.C. area.[7] The Fairfax community includes the cities of Fairfax and Falls Church for a total of nearly 1.2 million residents. Fairfax county has one of the largest immigrant populations in the capital region, with approximately 31% of the resident population born outside of the United States.[7]

Primary Language

Nearly 1 in 3 (31.6%) individuals ages 18 and older in the county report speaking a language other than English in their household.[7] An estimated 44.7% of Fairfax County Public School elementary students speak a foreign language at home.[8] Among the 161 different languages spoken at home, Spanish, Arabic, Korean, Amharic, and Mandarin were the top five reported.[8]

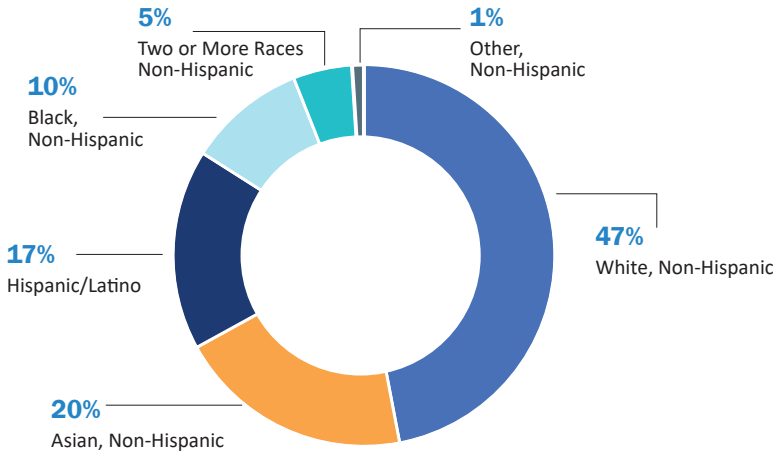
Income

Median household income in Fairfax County ($133,974) is 40% higher than that observed at the state level ($80,615) and 48% higher than that observed nationally ($69,021).[7] The median household income within the Black/African American ($92,894) and Hispanic/Latino ($90,851) communities is around 40% lower than that observed within the White community ($154,505).[7]



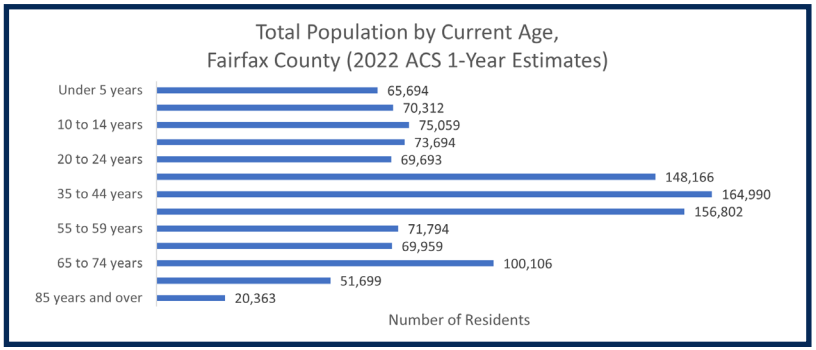
Racial/Ethnic Diversity

The racial/ethnic diversity of Fairfax County has increased over time. Between 2010 and 2022, the percentage non-White population grew in the county from 45% to 53%.[7] Currently comprising 47% of the population, the White community continues to represent the largest racial group in the county.[7] The second largest racial/ethnic group in the county is Asian (20%), followed by the Hispanic/Latino (17%) and Black/African American (10%) communities.[7] Approximately 5% of the county population identifies as 2 or more races.[7]



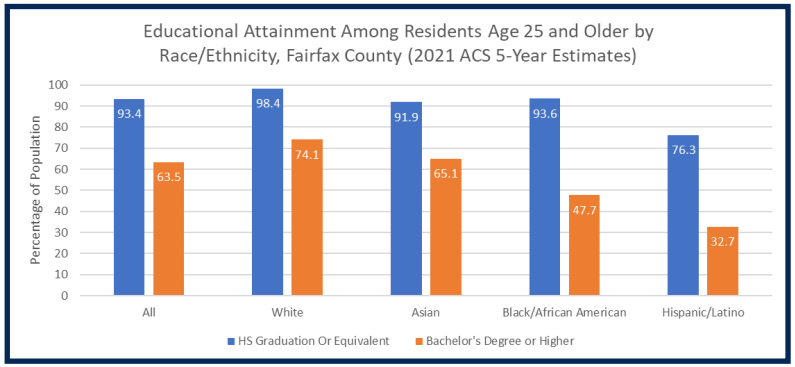
Sex & Age Distribution

The Fairfax County population is evenly split between males (50%) and females (50%).[7] Those under the age of 18 comprise approximately 22.6% of the population, including 5.8% under the age of 5.[7] Similar to national patterns, a significant portion of the county population falls within the 25 to 34 (13.0%), 35 to 44 (14.5%), and 45 to 54 (13.8%) age groups. Representing the fastest growing age group in the county, slightly over 15% of the population is age 65 and older.[7]



Educational Level

Overall, Fairfax County residents are characterized by higher levels of educational attainment than that observed at the state and national levels. Approximately 93.4% of individuals ages 25 and older have graduated high school and 63.5% have received a Bachelor's degree or higher.[7] The percentage of the population ages 25 and older with a Bachelor's degree or higher is substantially lower in the Black/African American (47.7%) and Hispanic/Latino (32.7%) communities when compared to White (74.1%) and Asian (65.1%) populations.[7]



KEY HEALTH-RELATED AREAS

Information presented in the CHA was selected based on data availability at the county level; the ability to make valid comparisons with national benchmarks or track progress over time; level of community burden and impact; and alignment with existing local strategic documents and priorities. While effort was directed toward presenting information on a broad spectrum of health determinants and outcomes, the CHA is not representative of all potential health indicators and is not intended to provide comprehensive data for each selected topic area. An extensive list of local health indicators is available through the Live Healthy Fairfax Community Health Dashboard (www.livehealthyfairfax.org/indicators).

Information presented in the CHA are separated into 8 different categories:

- Social Determinants of Health
- Life Expectancy & Premature Mortality
- Chronic Disease & Conditions
- Healthcare Utilization and Access
- Mental Health
- Substance Use
- Physical Activity, Healthy Eating & Food Insecurity
- Maternal & Child Health

Fairfax consistently ranks among the healthiest communities nationally. **The data for all the Fairfax community often hides health-related concerns and disparities that remain across racial/ethnic groups and geographical regions.** Differences in health determinants and outcomes by race/ethnicity and geography are presented in each key health related area to illustrate the disparities that exist within the Fairfax community. This information is provided to aid in the identification of populations disproportionately impacted by adverse health outcomes.

Given the racial/ethnic diversity within the region, it is important to note that the broad racial/ethnic categories (i.e., White, Asian, Black/African American, Hispanic/Latino) used in the quantitative data do not fully capture the diversity in cultures and experiences within racial/ethnic groups. The ability to further divide racial/ethnic groups by demographic characteristics such immigration status, length of time in the U.S., and country of origin would provide additional insights regarding health disparities and equity, but most available quantitative data does not provide this level of detail. Information gathered from the community during the Community Context Assessment helps provide insight into the key health indicators presented.

Under most of the key health-related areas, data for all the Fairfax community is presented with an indication of how this compares to previous years.


Single arrows indicate the data is trending in a positive direction.


Double arrows indicate the data is trending in a concerning direction.


The equal sign indicates the data trend is stable or fluctuating.

SOCIAL DETERMINANTS OF HEALTH

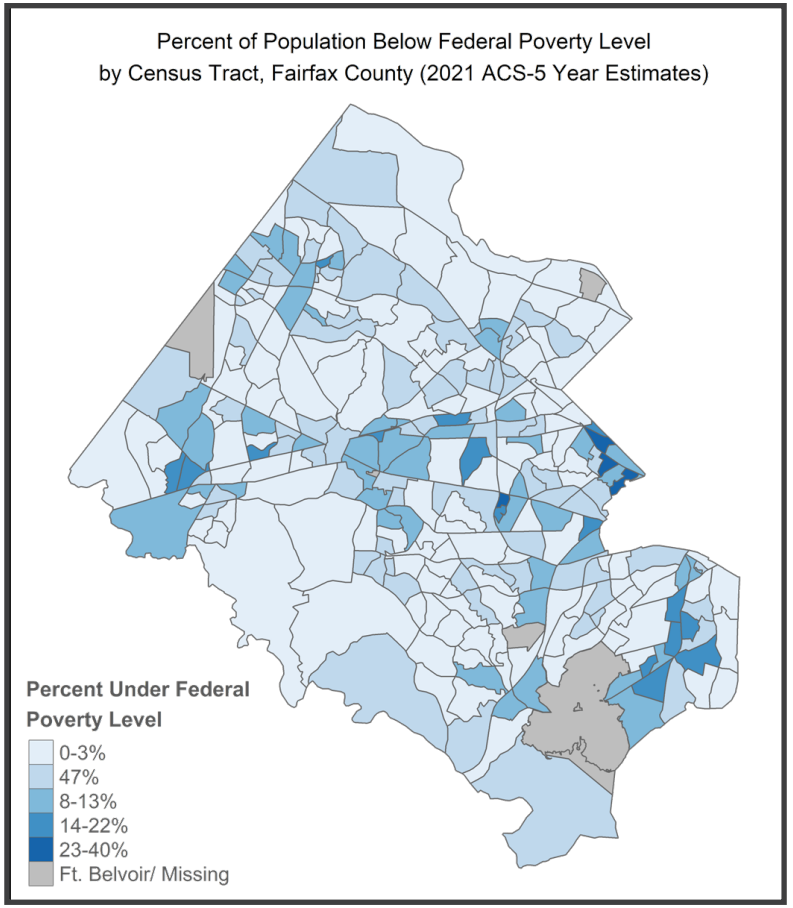
The social determinants of health are the economic, social, and environmental conditions that not only have a significant impact on our exposure to health risks but are also a determining factor in our ability to access and utilize health related resources. Previous research has estimated that social determinants of health account for about 50% of health outcomes. Addressing issues such as economic stability, housing, education, social cohesion, and the built environment are essential in addressing health inequities and improving overall population health.

Population Living Below the Federal Poverty Level

Poverty is strongly associated with higher rates of premature mortality and adverse health outcomes.

Approximately 6.1% of Fairfax County residents live in households with incomes less than the federal poverty level.7 Based on 2021 5-year American Community Survey data, this estimate does not differ substantially from the 5.9% estimate documented in 2020.[7]

- The percentage of the population living below the federal poverty level is over 2 times higher in the Black/African American (10.8%) and Hispanic/Latino (10.3%) communities than that observed in the White community (4.0%).7 Approximately 5.8% of the county Asian population lives below the federal poverty level.[7]
- Poverty rates range from 0% to just under 40% across county census tract with the highest poverty levels observed in the Bailey's Crossroads (4516.01=39.6%), Seven Corners (4515.01=28.5%), and Annandale (4523.01=23.1%) communities.[7]
- Nearly 17% of non-citizen residents live below the federal poverty level.[7]

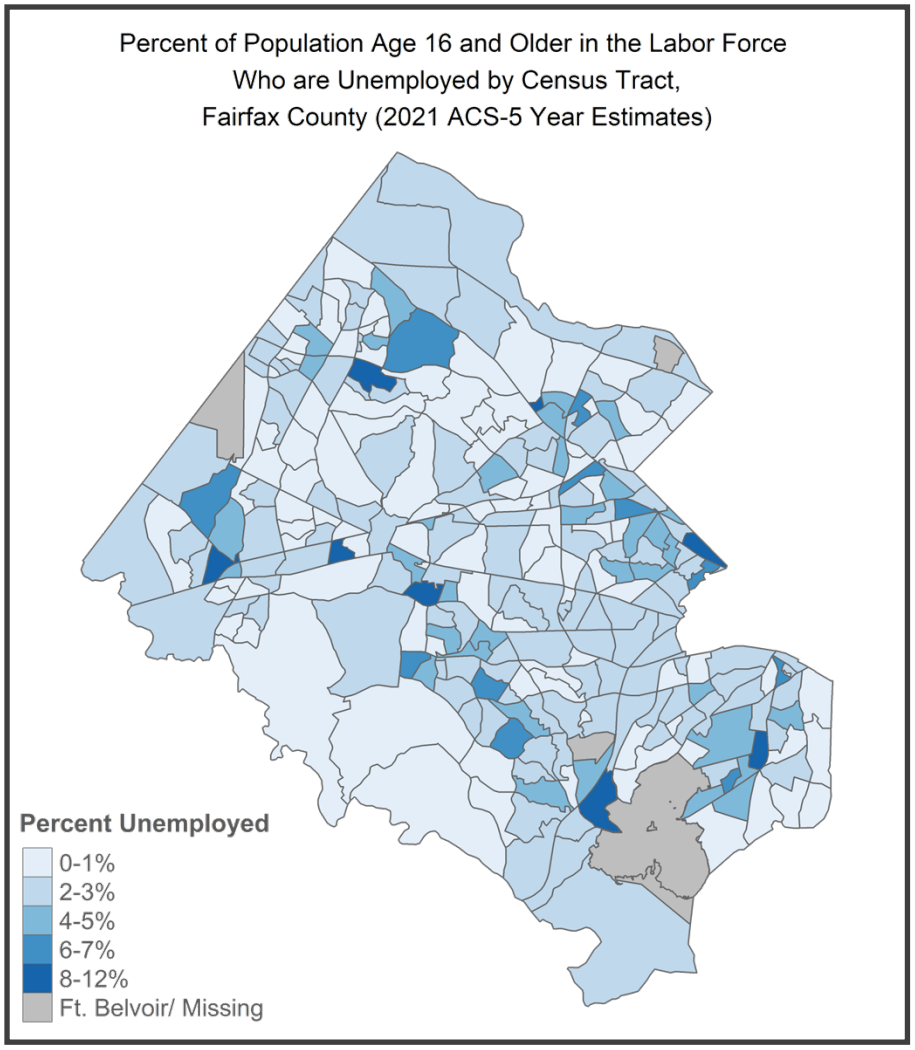


Population ages 16 and Older who are Unemployed

Employment is often a key determinant in access to health insurance.

Among those ages 16 and older, 4.2% are currently unemployed.[7] This estimate is relatively similar to that observed in 2020 (4.1%).[7]

- The unemployment rate for Black/African American is 7.2%; Hispanic/Latino 4.5%; Asian 3.7% and White 3.5%.[7]
- Unemployment rates among those ages 16 and older is 7.5% or higher in over 20 census tract areas, predominantly located in the southeastern and central eastern regions of the county.[7]



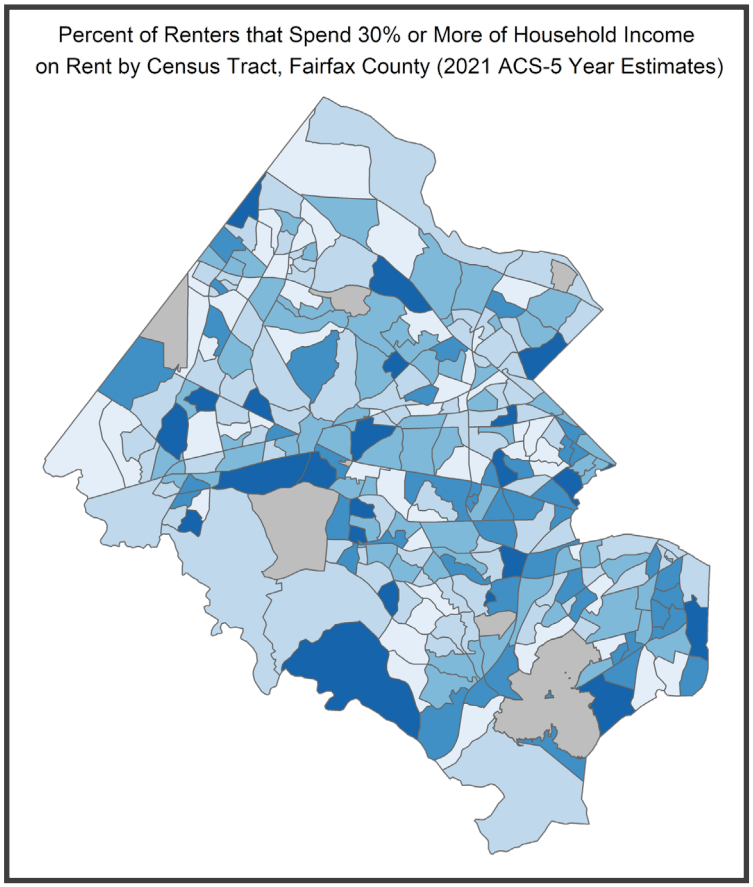
SOCIAL DETERMINANTS OF HEALTH *CONTINUED*

Housing Cost Burden

Defined as spending more than 30% of household income on housing, cost burdened households often have limited financial resources to spend on other essential goods including food, transportation, clothing, and health care.

Approximately 46.1% of renters are cost burdened, a similar estimate to that observed in 2018 (45.8%).[7]

- The highest concentration of communities impacted by housing cost burden is observed in the southern and central regions of the county.

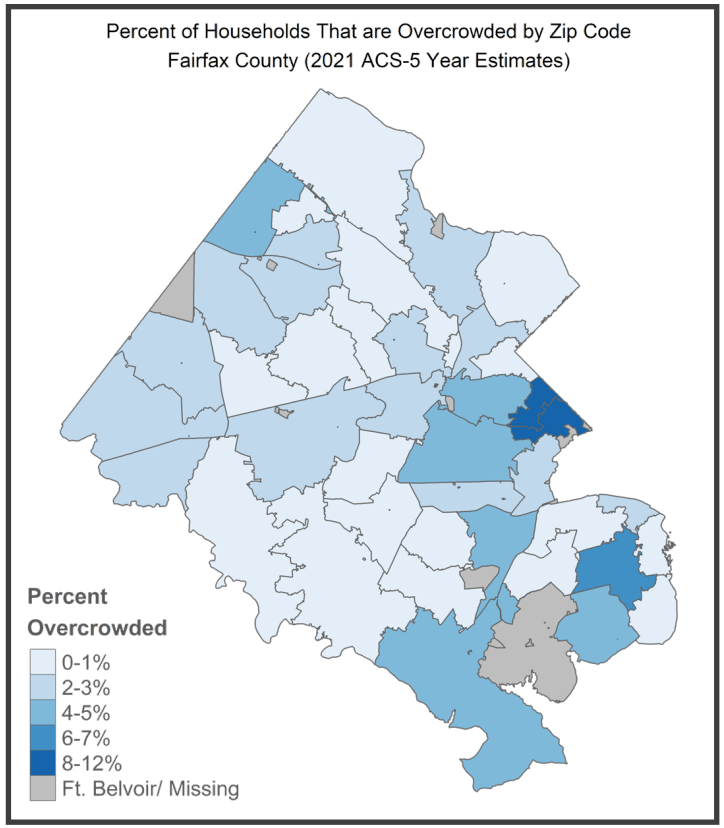


> ***"...we've been continuing to deal with inflation, and I think that it's driving up costs and I think that people are feeling a bit left out of the homebuying process or the opportunity to own a home and to accrue wealth that way ...and if forces aren't prevented, we will see lots more houselessness or individuals who are food insecure and that, of course, will contribute to greater health inequities."***
>
> —Community leader

Household Overcrowding

Defined as households where there are more individuals than rooms, 3.1% of households are overcrowded in Fairfax County based on 2021 estimates.[7] While slightly lower, this estimate does not differ substantially from what was observed in 2018 (3.4%).[7]

- Compared to White households (0.9%), Black/African American (3.8%), Asian (5.3%), and Hispanic/Latino (9.4%) households are substantially more likely to live in overcrowded conditions.[7]
- The highest concentration of communities impacted by housing cost burden is observed in the southern and central regions of the county.[7]



Voices of the Community

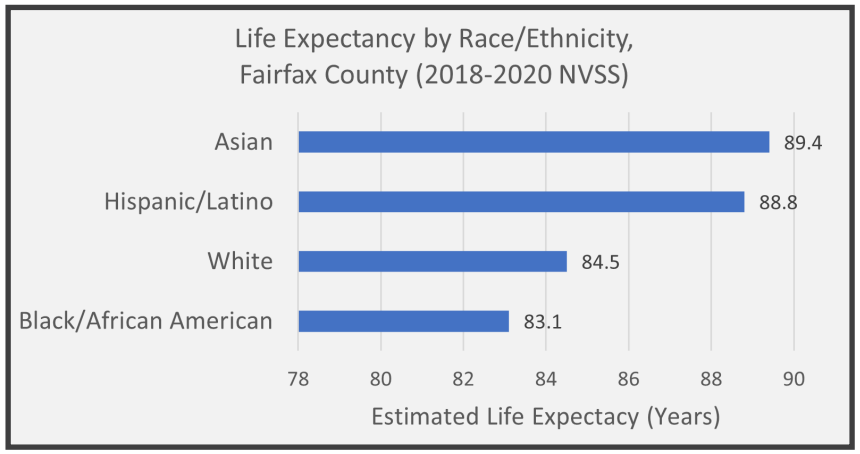
- It was mentioned by residents and community leaders that education and training certifications in immigrants' countries of origin, such as medical training, does not always meet requirements in the United States. An immigrant who worked a high paying job in their home country may now have to work a far lower paying job. There is also high competition among immigrants for those low-paying jobs.
- The financial struggles around housing are frequently cited by residents and community leaders as a significant source of stress and contribute to overall poor mental health.
- Residents and community leaders noted that being housing cost burdened results in having fewer financial resources available for accessing healthcare, purchasing healthy foods, and affording other health-promoting behaviors.

LIFE EXPECTANCY & PREMATURE MORTALITY

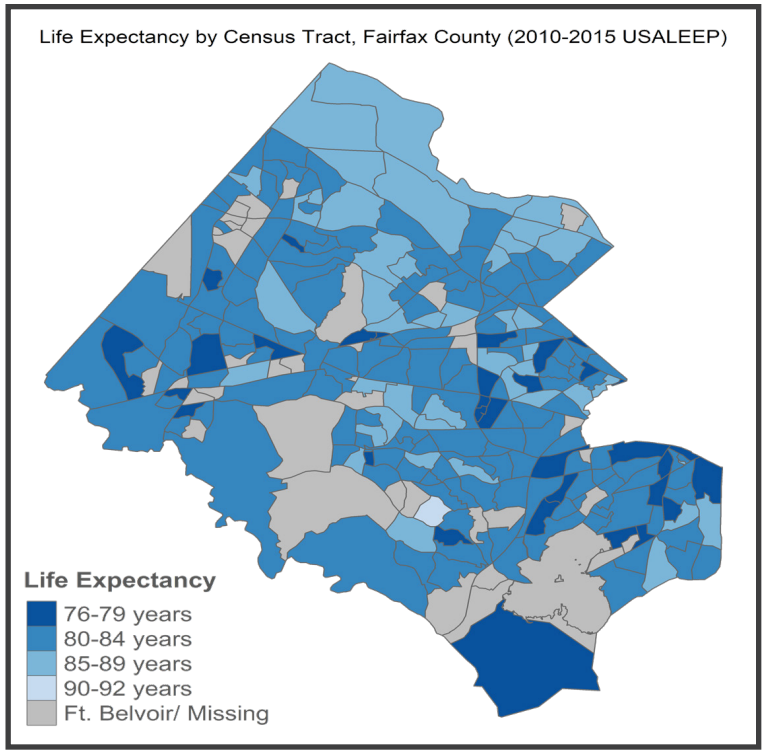
Life expectancy represents the average number of years an individual can expect to live and is impacted by the multiple biological, behavioral, economic, social, and environmental factors individuals face each day.

Based on the most recent estimates produced using data from 2018 through 2020, the life expectancy of Fairfax County residents is 85.2 years.[9] While higher than the national average (78.5 years) and Virginia state average (79.1 years) for the same time period, there are substantial disparities in life expectancy across populations within the county based on race/ethnicity and place of residence.[9]

There is over a six-year gap in life expectancy across racial/ethnic groups, with a higher life expectancy observed in the Asian (89.4 years) and Hispanic/Latino (88.8 years) communities in comparison to the White (84.5 years) and Black/African American (83.1) communities.[9]



The most recent estimates at the census tract level show that there is nearly a 15-year difference in life expectancy across the various neighborhoods in the county, ranging from 76.5 years to 91.1 years.[9]

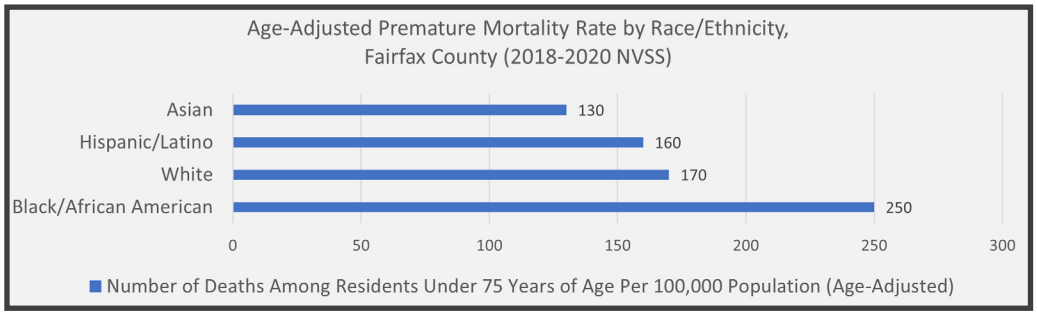


Premature Mortality

Approximately 17,291 deaths occurred among Fairfax residents between 2019 to 2021, with over one-third (39.4%) occurring among individuals less than 75 years of age.[10] Deaths under 75 years of age are considered premature mortality.

The overall age-adjusted premature death rate in Fairfax from 2018 to 2020 was 170 deaths per 100,000 population age 75 and younger.10 Despite being lower than that observed at the state (330 deaths per 100,000 population age 75 and younger) and national (360 deaths per 100,000 population age 75 and younger) levels, substantial disparities are observed across racial/ethnic groups within the county.[10]

- The age-adjusted premature death rate among Black/African American residents (250 deaths per 100,000 population age 75 and younger) is approximately 47% higher than the county average, exceeding that observed among all other racial/ethnic groups.[10]



Voices of the Community

- Some Fairfax residents, particularly those of color, feel a sense of burden from living in a place with significant inequities and drew a direct connection to their state of health.
- Pedestrian safety is a major concern for residents. Residents want more access to safe infrastructure, including well-maintained sidewalks, crosswalks, lighting, and walking areas protected from cars.

LIFE EXPECTANCY & PREMATURE MORTALITY *CONTINUED*

The top ten causes of premature mortality among Fairfax residents in recent years are associated with chronic diseases, COVID-19, substance use, suicide, and accidents. Combined, the top ten causes of premature mortality account for nearly 73% of deaths occurring among those under 75 years of age.[10]

The leading causes of premature mortality by Race/Ethnicity in Fairfax County between 2019-2021 are:

WHITE, NON-HISPANIC	BLACK, NON-HISPANIC	ASIAN, NON-HISPANIC	HISPANIC/LATINO
Cancer	Cancer	Cancer	Cancer
Heart Disease	Heart Disease	Heart Disease	COVID
Unintentional Drug Overdose	COVID	COVID	Heart Disease
Suicide	Unintentional Drug Overdose	Stroke	Stroke
COVID	Stroke	Suicide	Unintentional Drug Overdose
Stroke	Diabetes	Diabetes	Transportation Related Accidents
Diabetes	Chronic Lower Respiratory Diseases	Unintentional Drug Overdose	Chronic Liver Disease
Chronic Liver Disease	Homicide	Transportation Related Accidents	Suicide
Chronic Lower Respiratory Diseases	Kidney Disease	Kidney Disease	Congenital Anomalles[1]
Transportation Related Accidents	Chronic Liver Disease, Hypertension, & Transportation Related Accidents*	Chronic Liver Disease	Conditions Originating in the Perinatal Period[2]

*Tied

[1] Includes congenital malformations, deformations, and chromosomal abnormalities.

[2] Includes conditions that have their origin in the fetal or perinatal period (before birth through the first 28 days after birth)

HEALTH CARE ACCESS & UTILIZATION

Many of the primary diseases and conditions contributing to premature mortality such as heart disease, stroke, diabetes, and certain types of cancer are treatable or manageable with appropriate health care. Early diagnosis and treatment not only have the potential to improve life expectancy but can also reduce the risk of severe complications and disability that often occur as untreated diseases or conditions progress. Other potential benefits of routine health care utilization include the provision of preventive services such as vaccinations that can reduce the risk of certain infections including seasonal flu and COVID-19.

One of the primary barriers to accessing appropriate health care is the lack of health insurance coverage. Individuals without health insurance are often forced to delay or go without needed preventative, disease management, and treatment services due to high cost.

"Before I came to the States, I learned that many prepared foods were ready to eat in this well-developed world, and I thought it would save my time on cooking, which is excellent. However, it took me many years to realize that processed food is not healthy."

—Resident from the Chinese community

"Insurance policies are complicated and it's difficult to understand and apply if there is no professional help, and people like us who don't speak English face more difficulties getting help. Sometimes, we find a phone number to call to get help, but the phone is an automated voice when we call, and it's hard to follow the navigation. I need to talk to a person who understands me and my needs."

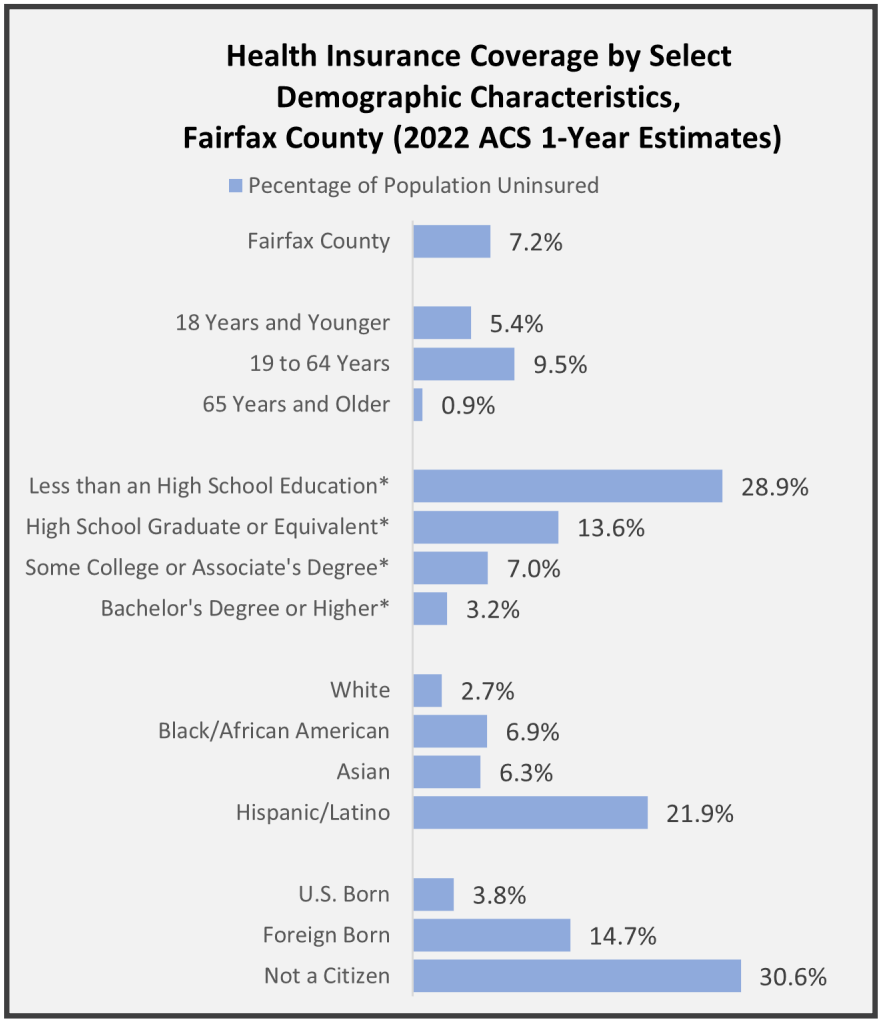
—Community leader

HEALTH CARE ACCESS & UTILIZATION *CONTINUED*

Percentage of Population Uninsured

Defined as spending more than 30% of household income on housing, cost burdened households often have limited financial resources to spend on other essential goods including food, transportation, clothing, and health care.

- According to 2022 estimates from the American Community Survey, approximately 80,502 individuals living in Fairfax County are uninsured, representing 7.2% of the resident population.[7] This marks a decrease from what was observed in 2018 B8%).[7]
- The percentage of uninsured individuals is over 8 times higher in the Hispanic/Latino community (21.9%) compared with the White community (2.7%).[7] The percentage of the population uninsured is also elevated in the Black/African American (6.9%) and Asian (6.3%) communities.[7]
- Compared to U.S. born residents (3.8%), a substantially higher percentage of foreign-born (14.7%) and non-citizen (30.6%) individuals in Fairfax County are uninsured.[7]
- The percentage of the population uninsured varies substantially by educational level, with consistent declines observed as education increases. Nearly 29% of those without a high school degree or equivalent are uninsured, compared with 3.2% of individuals with a Bachelor's degree or higher.[7]



Adults Receiving Routine Check-Up in Last Year

The percentage of individuals 18 years of age and older in Fairfax County reporting that they visited a doctor in the last year for a routine check-up was 73.3% in 2021, an estimate lower than that observed at the Virginia state level (75%).[11] While similar to what was observed in 2020 (72.8%), this estimate marks a decline from 2018 (77.8%).[11]

- Across Fairfax County census tracts, the percentage of individuals 18 years of age and older reporting that they visited a doctor in the last year for a routine check-up ranges from 64.3% to 80.7%.[11] The census tracts with the lowest percentage of residents engaging in routine health care utilization based on this measure are located in the Bailey's Crossroads (4516.01=64.3%), Centreville (4912.02=66.5%), McNair (4811.01=67.0%), Idlewood (4713.01=67.2%), and Herndon (4809.03=67.9%) communities.[11]

Adults Visiting a Dentist in Past Year

Approximately 74% of county residents ages 18 and over visited a dentist in the past year, marking a decrease from what was observed in 2018 (77.4%).[11]

- The lowest levels of annual dental visits among adults 18 and over are observed in the Bailey's Crossroads (4516.01=44.0%) and Seven Corners (4514.00=50.5%) communities.[11]

Voices of the Community

- Navigating insurance – from enrollment to using services - was named as a difficult task for immigrants. Many residents returned to their home countries for medical care rather than struggle with insurance.
- Many needed services were not covered by insurance or required complex navigation through such bureaucracy causing them to be essentially inaccessible.
- Fear of healthcare costs can keep some from even seeking care, including preventive care or emergency services, which has resulted in preventable deaths.
- There are concerns in some communities about not receiving quality medical care due to discrimination. Word spreads quickly within communities when someone has a poor personal experience in a clinical setting.

CHRONIC DISEASES & CONDITIONS

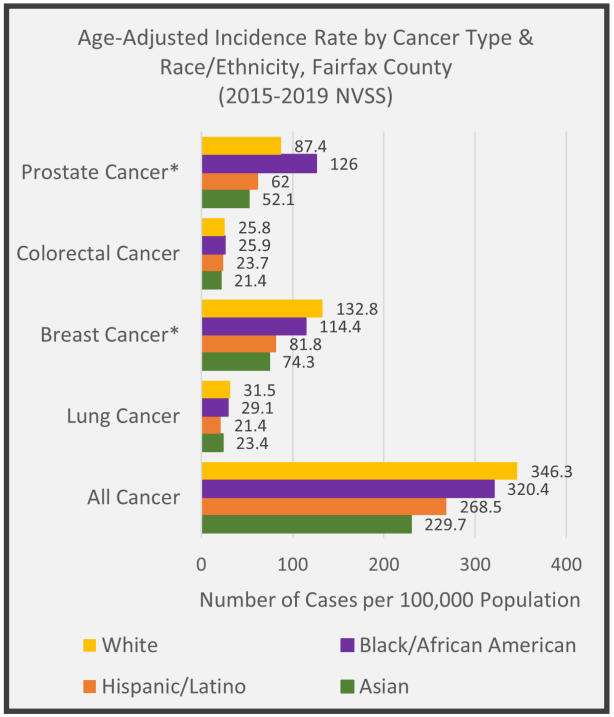
Chronic diseases such as cancer, heart disease, diabetes, and stroke are among the leading causes of disability and death in Fairfax County.

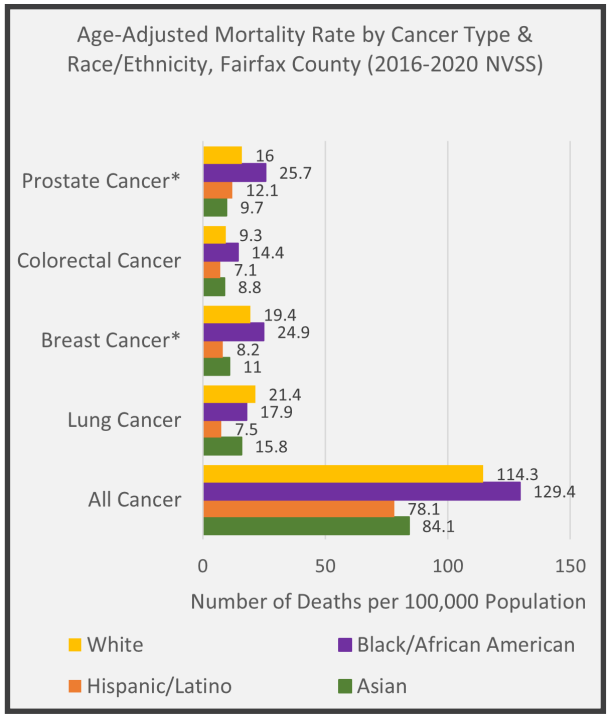
Cancer

Approximately 5.7% of individuals 18 years of age and older in Fairfax County have been diagnosed with cancer.[11]

Based on data from 2016-2020, the age-adjusted cancer mortality rate in Fairfax is 107.3 deaths per 100,000 population, signifying a continued decline from previous time periods.

- Lung cancer, breast cancer, and colon cancer account for over 35% of cancer-related deaths among individuals under 75 years of age.[10]
- While Black/African American residents tend to have lower age-adjusted rates of new cancer diagnoses (i.e., incident cases) compared to White residents, age-adjusted mortality rates tend to be higher.[10, 11] This pattern can partially be attributed to national trends showing that Black/African American individuals with cancer are more likely than White individuals to be diagnosed at later stages of disease progression, making effective management and treatment more difficult.



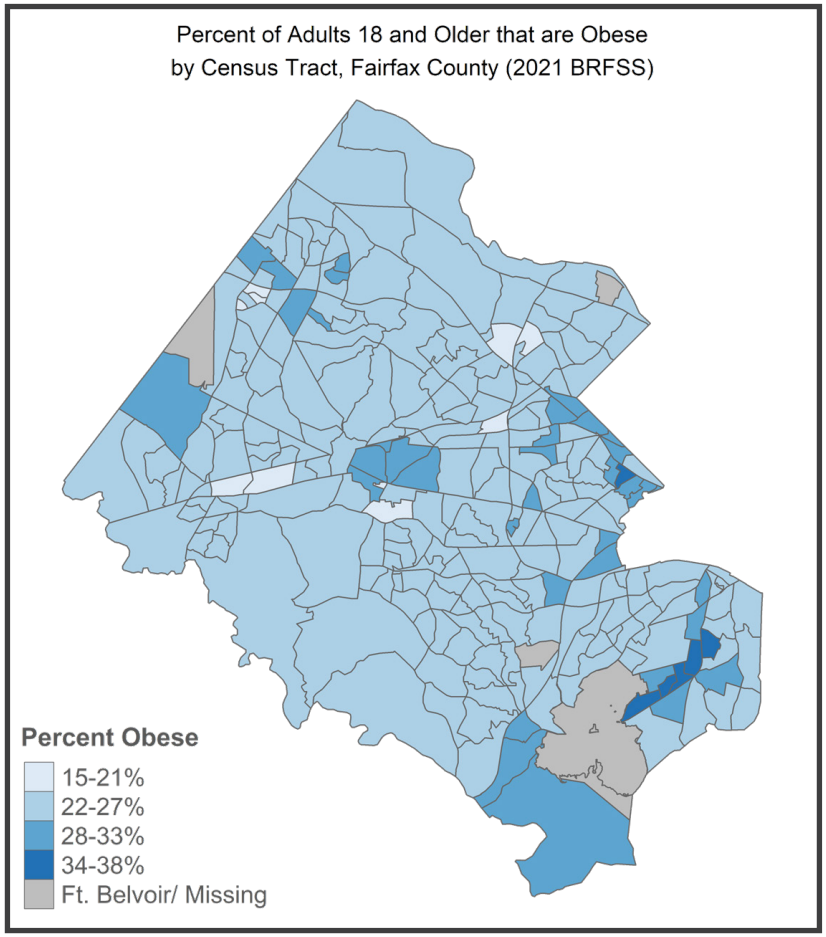


Obesity

An estimated 24.4% of Fairfax County residents ages 18 and older are obese.[11] This marks an increase from 21.8% in 2018.[11]

- The estimated percentage of adults ages 18 and older that are obese ranges from 18.8% to 37.4% across Fairfax County census tracts.[11]

Nearly one-third (31.3%) of kindergarten students are obese.[13] A slight increase from 30.6% in 2018.[13]



Voices of the Community

- Many marginalized populations have concerns about access and quality of health care which contribute to delaying health screenings, resulting in a loss of opportunity for early intervention.
- It was noted by residents and community leaders that getting screenings can be particularly difficult for some, such as day laborers, who cannot afford to lose a day of work by attending a lengthy procedure.
- Fairfax residents of different demographics cited cancer, obesity, high blood pressure, and diabetes as health concerns.

CHRONIC DISEASES & CONDITIONS *CONTINUED*

Heart Disease & Stroke

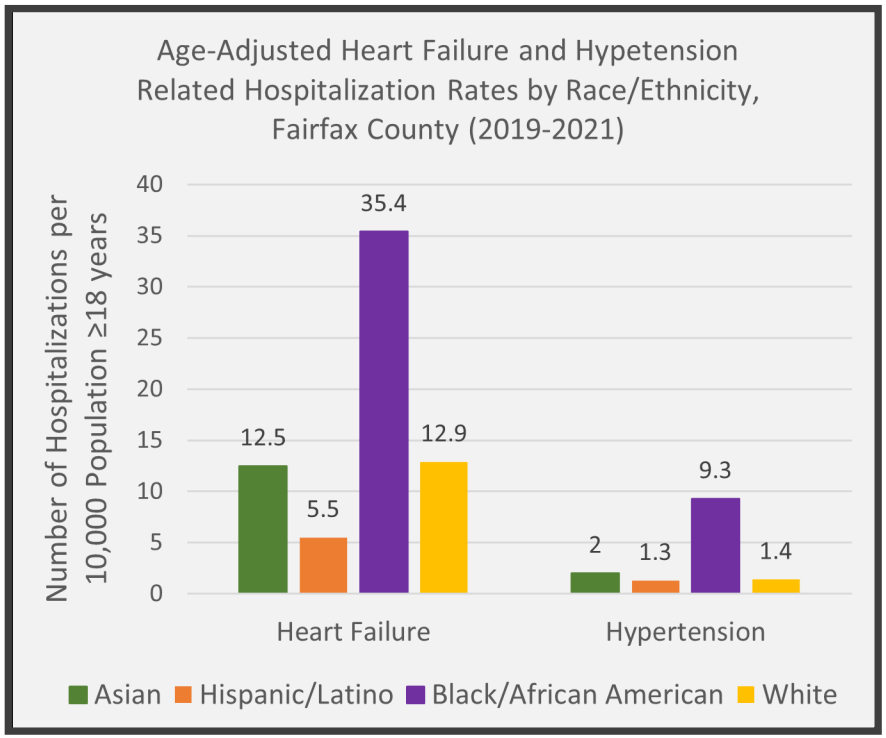
Approximately 3.9% of individuals 18 years of age and older in Fairfax County have been diagnosed with heart disease and 2.2% have previously experienced a stroke.[11]

Based on 2019 through 2021 data, there were approximately 16.0 hospitalizations due to heart failure per 10,000 population 18 years and older, marking a slight decline from the 2017 to 2019 time period (17.1 hospitalizations per 10,000 population 18 years and older).[12]

- Among those ages 18 and older, the hospitalization rate due to heart failure within the Black/African American (35.4 hospitalizations per 10,000 population 18 years and older) community is over twice that observed in the White (12.9 hospitalizations per 10,000 population 18 years and older) and Asian (12.5 hospitalizations per 10,000 population 18 years and older) communities and over six times that observed in the Hispanic/Latino community (5.5 hospitalizations per 10,000 population 18 years and older).[12]

Based on data from 2019-2021, the age-adjusted hospitalization rate for hypertension is 2.6 hospitalizations per 10,000 population ages 18 years and older.[12] This rate is relatively similar to that observed from 2018-2020, with 2.5 hospitalizations per 10,000 population ages 18 years and older.[12]

- The age-adjusted hospitalization rate for hypertension is substantially higher in the Black/African American community (9.3 hospitalizations per 10,000 population ages 18 years and older) in comparison to other racial/ethnic groups.[12]

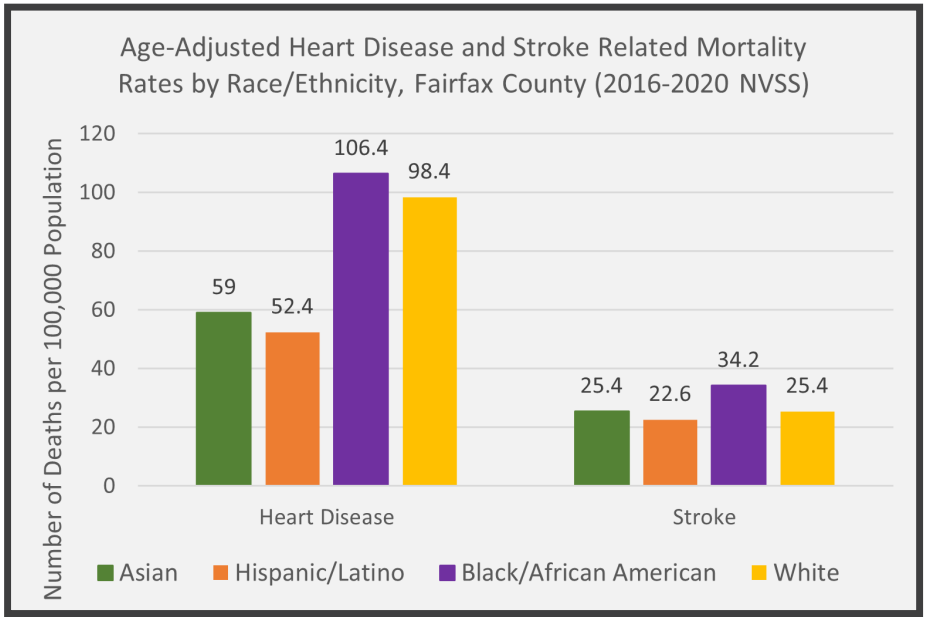


Based on data from 2016-2020, the age-adjusted mortality rate from heart disease is 89.8 deaths per 100,000 population. This marks a decrease from 2014-2018 with 93.4 deaths per 100,000 population.[10]

- The highest age-adjusted mortality rate from heart disease is observed in the Black/African American community (106.4 deaths per 100,000 population), which is over twice the rate observed within the Hispanic/Latino community which has the lowest age-adjusted rate of all racial/ethnic groups in the county (52.4 deaths per 100,000 population).[10]

Based on data from 2016-2020, the age-adjusted stroke related mortality rates are 26.4 deaths per 100,000 population. This is similar to the rate observed in 2014-2018 with 26.9 deaths per 100,000 population.[10]

- Age-adjusted stroke related mortality rates are relatively similar across the White (25.4 deaths per 100,000 population), Asian (25.4 deaths per 100,000 population), and Hispanic/Latino (22.6 deaths per 100,000 population) communities in the county.10 A higher rate is observed in the Black/African American (34.2 deaths per 100,000 population) community relative to other racial/ethnic groups.[10]



CHRONIC DISEASES & CONDITIONS *CONTINUED*

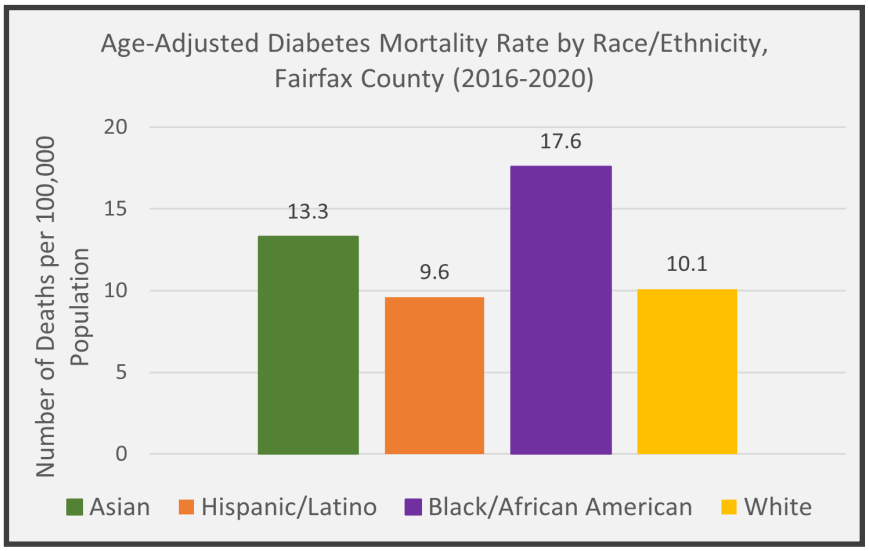
Diabetes

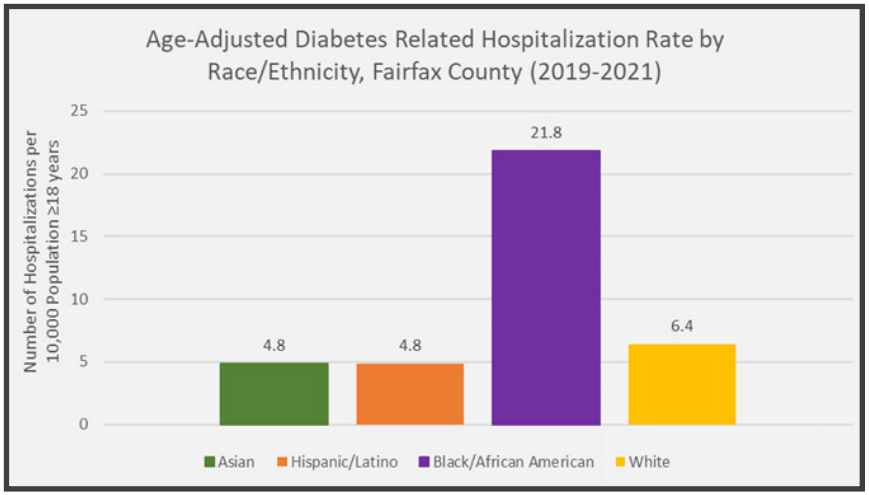
An estimated 8.2% of those ages 18 and older in Fairfax have diabetes (Type 1 & Type 2 Diabetes).[11] This marks a slight increase from what was observed in 2018 (7.7%).[11]

Based on data from 2016-2020, age-adjusted diabetes related mortality rates are 11.3 deaths per 100,000 population.[10] This is similar to the rate observed in 2014-2018 with 11.1 deaths per 100,000 population.[10]

- Age-adjusted diabetes related mortality rates are highest in the Black/African American (17.6 deaths per 100,000 population) community, followed by the Asian (13.3 deaths per 100,000 population), White (10.1 deaths per 100,000 population), and Hispanic/Latino (9.6 deaths per 100,000 population) communities.[10]

- Age-adjusted hospitalization rates for diabetes among those 18 years of age and older are over 4.5 times higher in the Black/African American (21.8 hospitalizations per 10,000 population) community in comparison to the Asian and Hispanic/Latino communities where the lowest rates are observed.[12]





MENTAL HEALTH

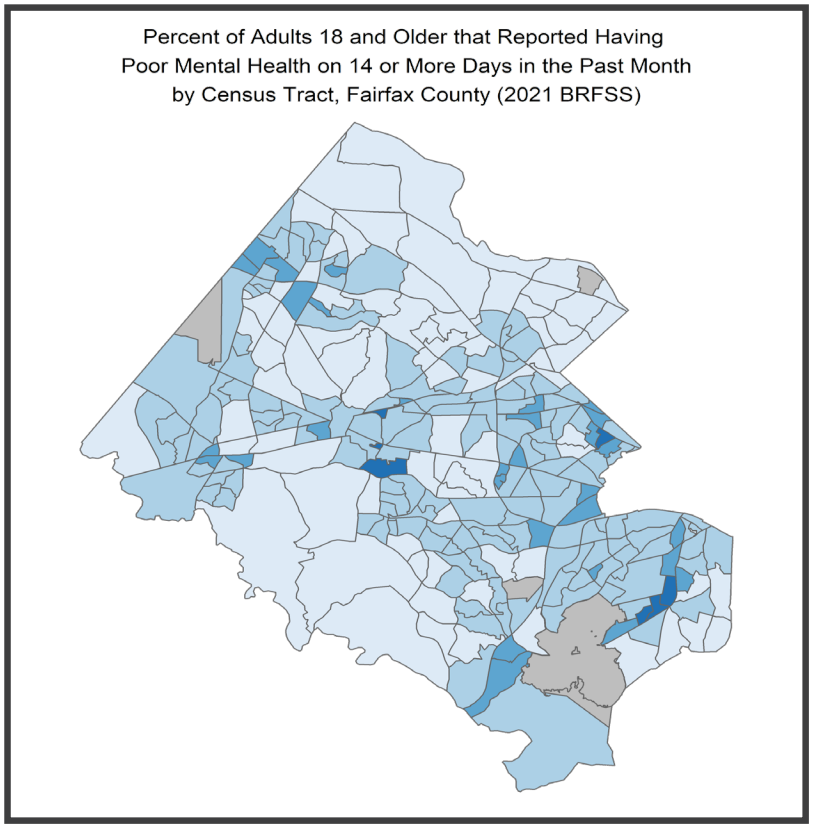
Overall well-being is dependent on physical and mental health.

Adults Reporting Poor Mental Health on 14 or More Days in the Past Month

- The percentage of adults ages 18 and older in Fairfax County reporting that their mental health was not good for 14 days or more in the past month has steadily increased in recent years from 9.9% in 2018 to 11.9% in 2021.[11]

  - There is variation across the county in the percentage of adults ages 18 and older reporting that their mental health was not good for 14 days or more in the past month.[11] In addition to a higher prevalence in the George Mason area (4405.02=19.9%), elevated reports of adverse mental well-being are also observed in the Bailey's Crossroads (4516.01=19.4%), North Buckman (4217.01=18.2%), Mount Vernon (4216=17.9%), and Hybla Valley (4215=17.7%) communities.[11]

- Approximately 16.0% of the adults ages 18 and older in the county report having been diagnosed with depression.11 An increase from 14.8% documented in 2019.[11]



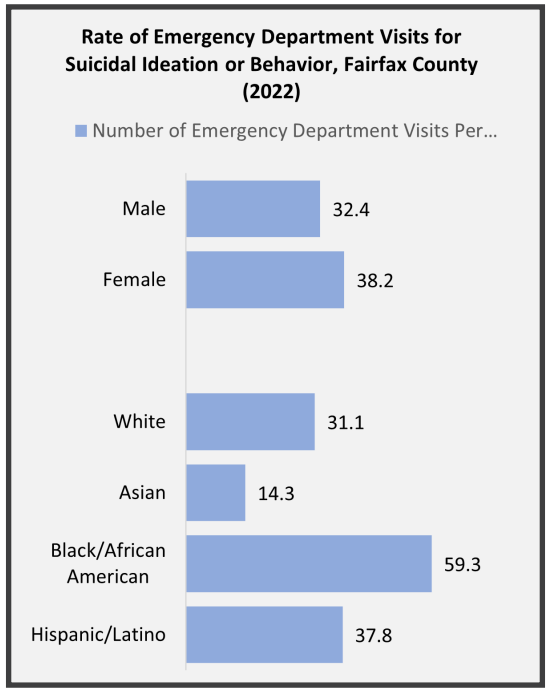
MENTAL HEALTH *CONTINUED*

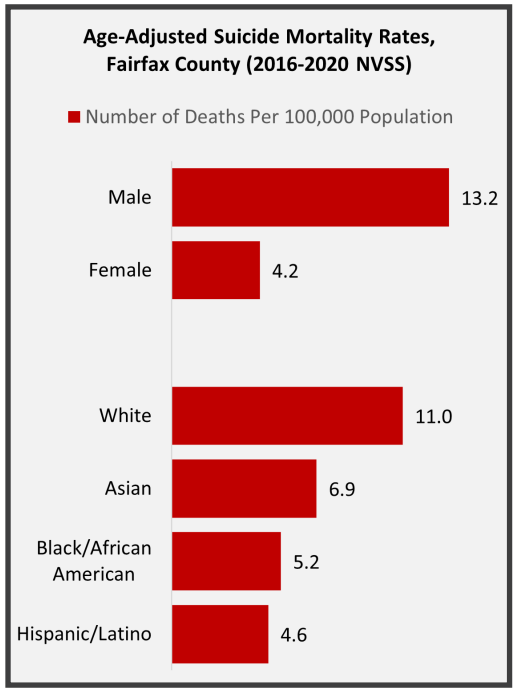
Suicide

There were 506 suicide associated deaths in the county between 2016 and 2020.10 The age-adjusted death rate due to suicide has remained relatively stable in recent years. Based on data from 2016-2020, there are approximately 8.6 suicide-related deaths per 100,000 individuals in Fairfax County.[10]

In 2022, a rate of 35.3 emergency department visits for suicidal ideation or behavior per 10,000 population was observed in Fairfax County, 1.6 times the rate observed in 2015 (22.3 visits per 10,000 population).[14]

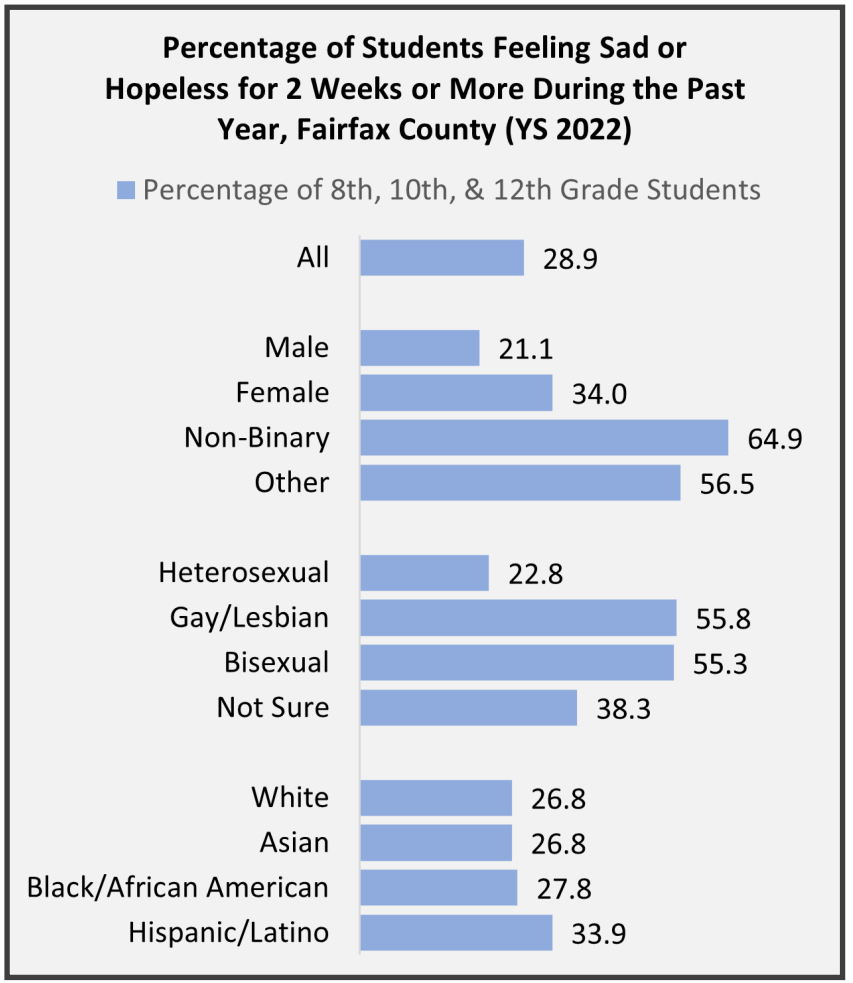
- The highest rate of suicide-related emergency department visits is observed within the Black/African American community in the county, while the highest suicide mortality rate is observed within the community.[14]





Students Feeling Sad or Hopeless for 2 Weeks or More During the Past Year

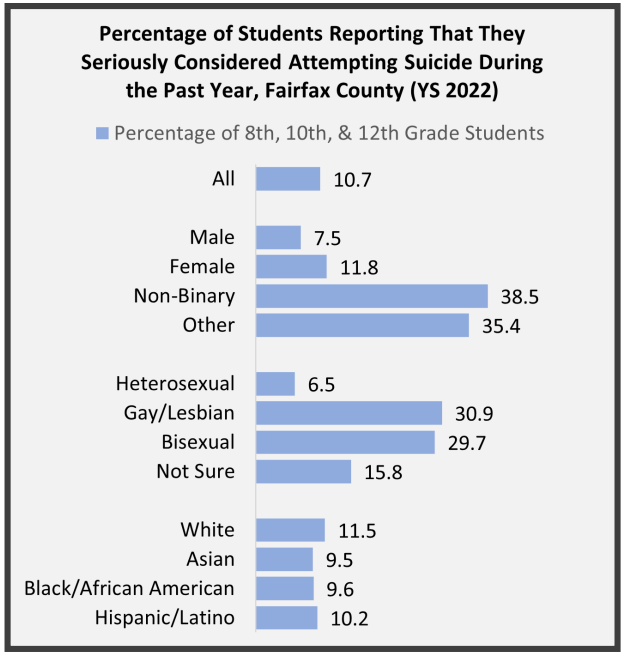
- Slightly under 29% of 8th, 10th, and 12th grade students reported feeling sad or hopeless for 2 weeks or more during the past year, marking a decline from the spike observed in 2021 (38.1%).
- A higher percentage of Hispanic/Latino (33.9%) students report feeling sad or hopeless in comparison to other racial/ethnic groups.[15]
- Feelings of sadness or hopelessness was more prevalent among female students (34.0%) than male students (21.1%).[15] Nearly two-thirds of non-binary students (64.9%) reported such feelings.[15]
- Over half of gay/lesbian (55.8%) and bisexual (55.3%) students experienced feelings of sadness or hopelessness during the past year, more than twice that observed among heterosexual students (22.8%).[15]



MENTAL HEALTH *CONTINUED*

Student Reporting Seriously Considered Attempting Suicide During the Past Year

- Over 10% of 8th, 10th, and 12th grade students participating in the 2022 Fairfax Youth Survey reported seriously considering attempting suicide during the past year. This estimate is lower than that observed in previous survey years and marks a substantial decline from the peak observed in 2021 (16.5%).[15]
- A slightly higher percentage of White (11.5%) students reported seriously considering attempting suicide in comparison to other racial/ethnic groups.[15]
- With regards to gender differences, non-binary (38.5%) and students identifying as other (35.4%) were substantially more likely to report suicidal thoughts in comparison to their male (7.5%) and female (11.8%) peers.[15]
- Gay/Lesbian (30.9%) and bisexual (29.7%) students were nearly 5 times more likely to report seriously considering suicide in comparison to heterosexual students (6.5%).[15]



Voices of the Community

- Mental health was noted as a top concern, particularly for Black/African American communities, youth, immigrants, and older adults. Poor mental health in the community was linked to multiple challenges by many residents and community leaders.
- Mental health stigma remains a significant challenge toward seeking care, particularly for some, such as Black/African American communities.
- Concerns about youth mental health were brought up frequently. Youth in the county are acutely aware of the issues related to depression and anxiety affecting their peers and many adults and youth stressed the importance of normalizing conversations about mental health for all. Many drew direct connections between their peers' mental health and opioid use.

SUBSTANCE USE

Substance use includes behaviors related to tobacco, alcohol, and illicit drug use. Such behaviors are significant contributors to preventable disease, disability, and death.

Vaping

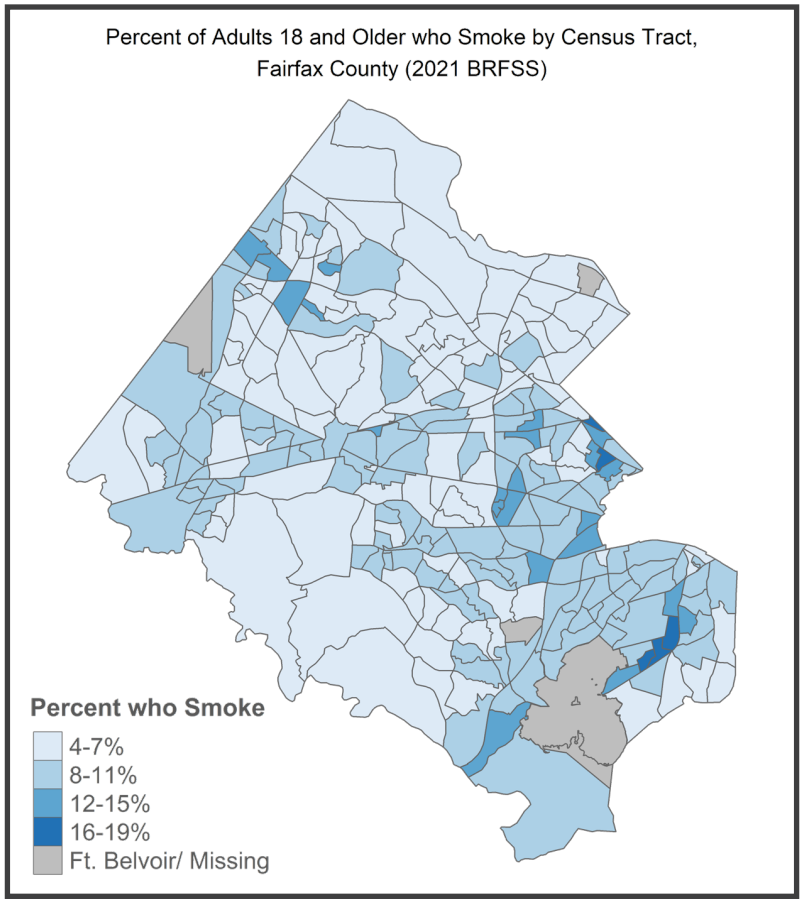
While 10.9% of 8th, 10th, and 12th grade students participating in the 2022 Fairfax Youth Survey reported having tried vaping at some point in their lives, only 5.4% reported current use in the past month.[15] This is a decline from the 19.8% of students reporting current vaping in 2018.[15]

- A higher percentage of female students (6.1%) reported vaping in the past month in comparison to male students (4.5%).[15]
- The percentage of students reporting current vaping use was highest within the Hispanic/Latino (6.9%) and White (6.3%) populations, with lower current use documented among Black/African American (4.2%) and Asian (2.5%) students.[15]

Tobacco Use

8.3% of Fairfax County residents ages 18 and older report that they currently smoke cigarettes.[11]

- The prevalence of smoking ranges from 5.3% to 18.9% across census tracts. Those communities exhibiting the highest rates of cigarette use include Bailey's Crossroads (4516.01=18.9%), Mount Vernon (4216=17.9%), Woodlawn (4217.01=17.6%), and Hybla Valley (4215=17.1%).[11]



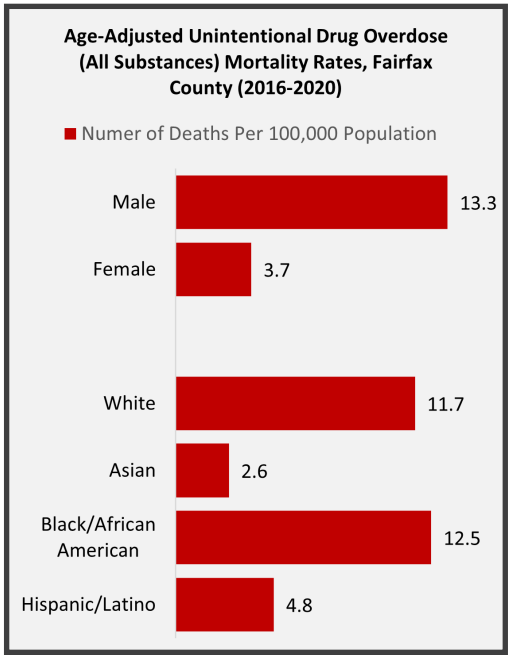
SUBSTANCE USE *CONTINUED*

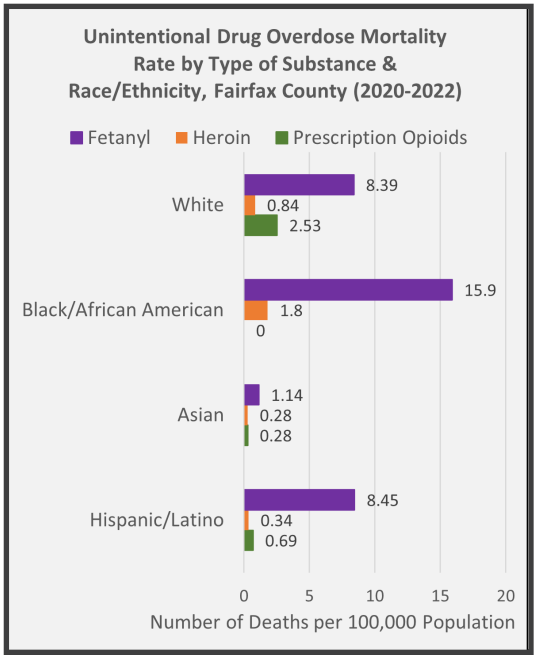
Unintentional Drug Overdoses

Unintentional drug overdoses are the 4th leading cause of premature mortality in the county, the majority of which are attributable to opioids.[10]

The age-adjusted unintentional drug overdose death rate in Fairfax County was 8.3 deaths per 100,000 population from 2016 through 2020, compared with 7.2 deaths per 100,000 population from 2014-2018.10

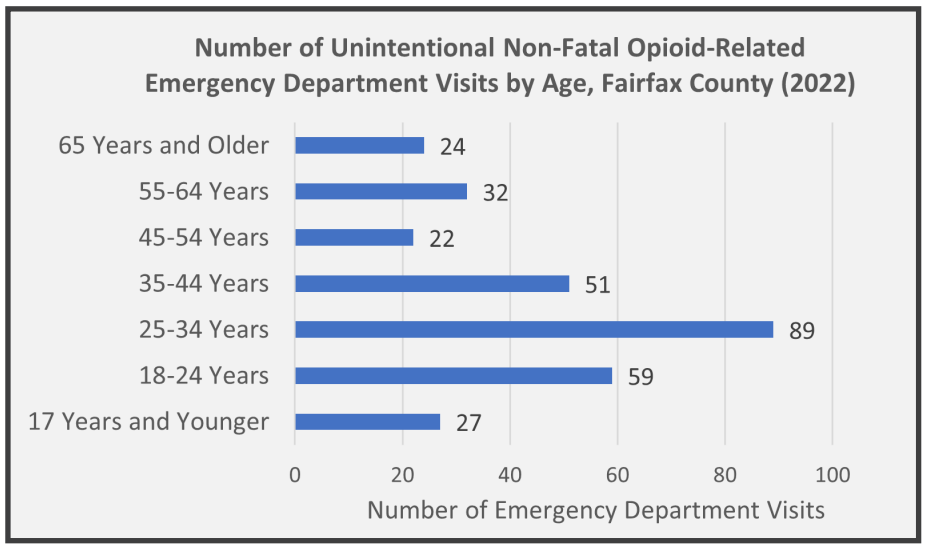
- Based on 2016 through 2020 data, the age-adjusted unintentional drug overdose death rate among males (13.3 deaths per 100,000 population) is over 3 times higher than that observed among females (3.7 deaths per 100,000 population).[10]
- Age-adjusted unintentional drug overdose rates are substantially higher within the Black/African American (12.5 deaths per 100,000 population) and White (11.7 deaths per 100,000 population) communities when compared to the Hispanic/Latino (4.8 deaths per 100,000 population) and Asian (2.6 deaths per 100,000 population) communities.[10]
- Across all racial/ethnic groups, fentanyl accounts for the majority of unintentional drug related overdose deaths in the county.[10]





The number of non-fatal opioid-related overdoses among youth under 18 years of age has increased in recent years, more than doubling between 2021 (12 cases) and 2022 (27 cases).[14]

- Based on 2022 emergency department data, the majority of non-fatal opioid-related overdoses occur among residents 25 to 34 years of age.[14]
- Through September of 2023, 44 non-fatal opioid related emergency department visits have been documented among youth.[14]



Voices of the Community

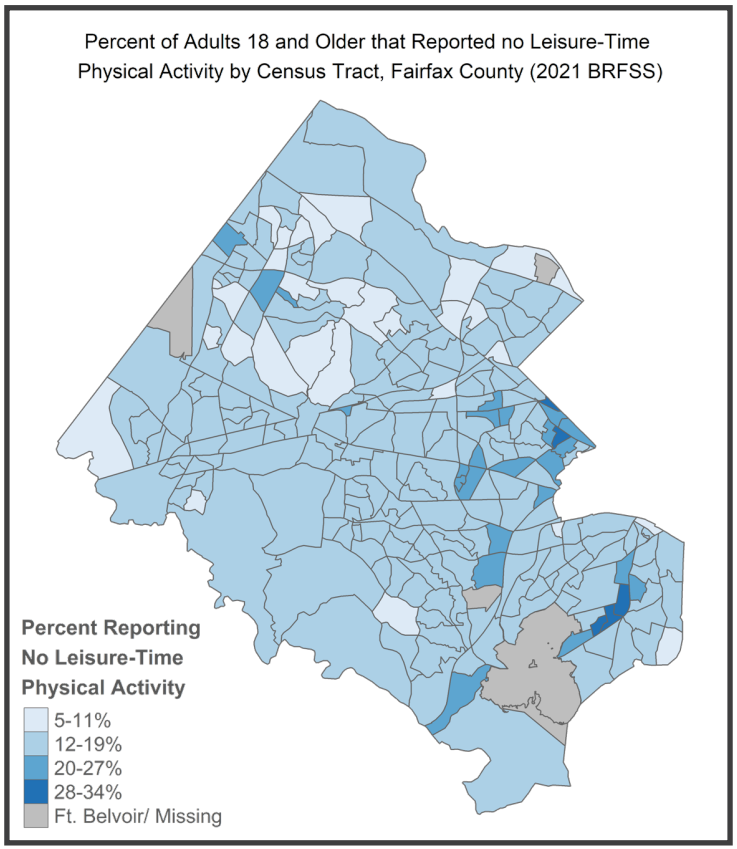
- Overdose concerns were brought up by many residents and community leaders.
- Youth are getting drugs, like marijuana, which can be laced with fentanyl and potentially lead to accidental overdose.
- Emphasis on the need to continue conversations about mental health and preventing substance use.

PHYSICAL ACTIVITY, HEALTHY EATING & FOOD INSECURITY

Physical activity and proper nutrition are essential components of health and well-being, aiding in the prevention of multiple chronic health conditions, disability, and premature death. For those with existing chronic conditions such as heart disease, stroke, and diabetes, regular physical activity and a healthy diet are key behavioral factors associated with effective disease management and the reduction in the risk of complications.

Physical Activity — Adults

- Approximately 15.6% of adults ages 18 and older report not engaging in any leisure-time physical activity in 2021, down from 16.9% in 2018.[11]
- The percentage of adults ages 18 and older reporting no leisure-time physical activity ranges from 9.8% to 34% across census tracts, with Bailey's Crossroads (4516.01=34%), Seven Corners (4514=31.7%), Mount Vernon (4216=28.4%), Woodlawn (4217.01=28.2%), and Hybla Valley (4215=28.1%).[11]



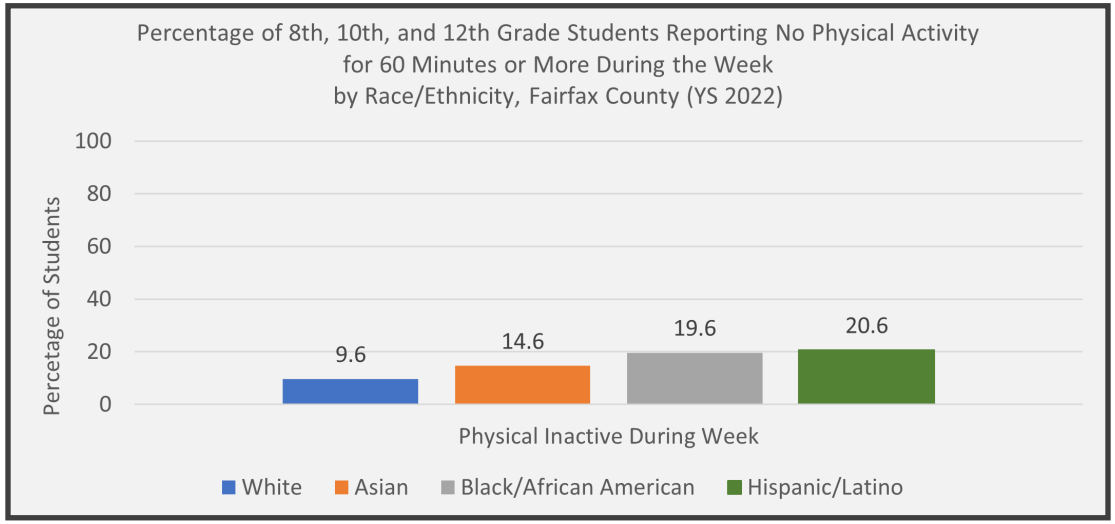
Physical Activity — Youth

Guidelines issued by the U.S. Department of Health and Human Services recommend 60 minutes of exercise every day for children and adolescents.[17]

- Only 17.1% of 8th, 10th, and 12th grade students in the county report engaging in physical activity for at least an hour on 7 days per week.[15] This estimate does not differ substantially from what was observed in 2018 (17.7%).[15]

- Approximately 14.3% of 8th, 10th, and 12th grade students report not participating in any physical activity or exercise, similar to that observed in previous survey years.[15]

  - The percentage of Black/African American (19.6%) and Hispanic/Latino (20.6%) 8th, 10th, and 12th grade students reporting not engaging in physical activity for 60 minutes or more on any day of the week is over twice that observed among their White (9.6%) peers.[15]

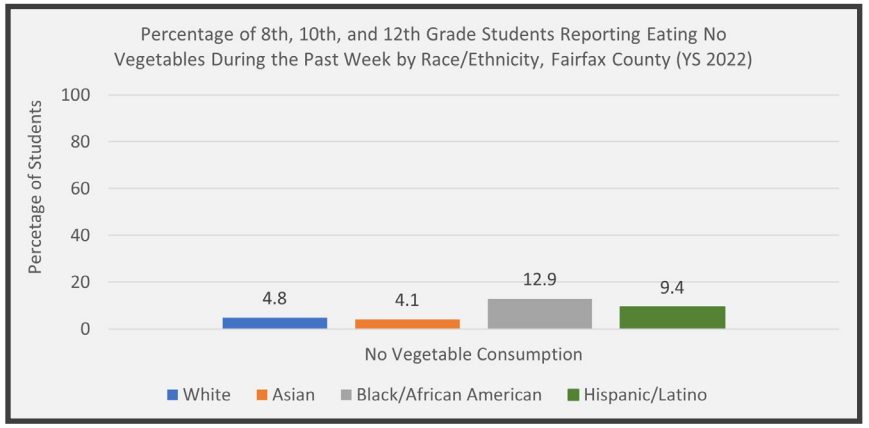


PHYSICAL ACTIVITY, HEALTHY EATING & FOOD INSECURITY *CONTINUED*

Healthy Eating

Slightly over half (51.1%) of 8th, 10th, and 12th grade students report eating vegetables daily, with a lower percentage reporting the daily consumption of fruits (45.9%).15 Approximately 6.4% reported not eating any vegetables during the week and 7% did not consume any fruits.[15]

- The percentage of Black/African American students (12.9%) that reported not eating any vegetables during the week was over 3 times higher than that among Asian students (4.1%) and 2.5 times higher than that observed among White students (4.8%).[15] A higher percentage of Hispanic/Latino students (9.4%) also reported not eating any vegetables during the week in comparison to their White and Asian peers.[15]



> ***"Before I came to the States, I learned that many prepared foods were ready to eat in this well-developed world, and I thought it would save my time on cooking, which is excellent. However, it took me many years to realize that processed food is not healthy."***
>
> **—Resident from the Chinese community**

Food Insecurity — Overall Population

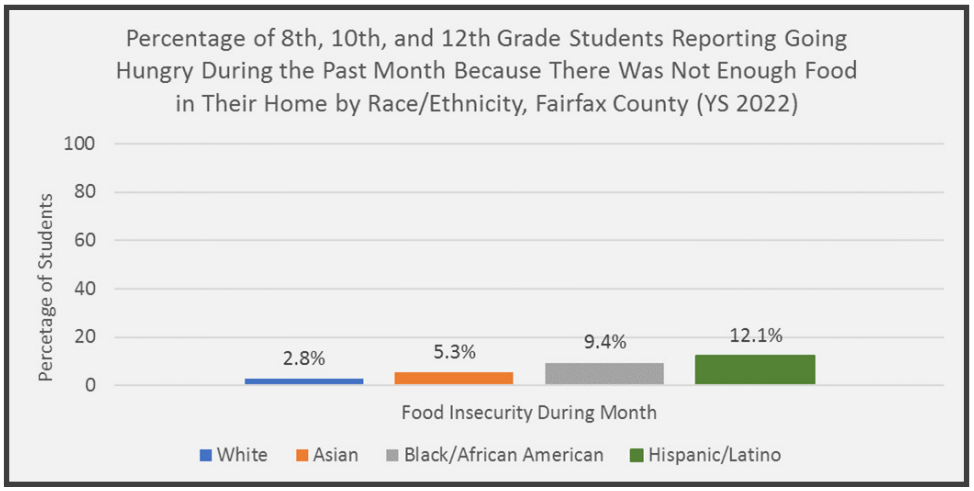
An estimated 5.8% of Fairfax County residents experienced food insecurity, defined as limited access or uncertain ability to acquire adequate food to support daily nutritional needs. This estimate is similar to what was observed in recent years.[18,19]

- While only 2% of the White community in Fairfax experienced food insecurity in 2021, this estimate increases to 11% in the Hispanic/Latino community and 13% in the Black/African American community.[18]

8th – 12th Grade Students Experiencing Food Insecurity

Slightly under 7% of 8th, 10th, and 12th grade students reported going hungry sometimes, most of the time, or always during the past month because there was not enough food in their home.[15] A similar estimate to what was documented in previous survey years.[15]

- The percentage of Hispanic/Latino (12.1%), Black/African American (9.4%), and Asian (5.3%) students reporting having experienced food insecurity was substantially higher than that observed among White students (2.8%).[15]



Voices of the Community

- Emergency food distributions do not necessarily include fresh vegetables or fruit and can include foods that are highly processed with high sodium. During and after the pandemic, the availability of fresh vegetables and fruit at food distribution events improved.
- The eligibility criteria for some food insecurity programs does not match the level of need, as some people or families do not meet eligibility criteria because they earn above the threshold but are still food insecure.
- All segments of the community expressed interest in walking. Access to outdoor walking paths in nature is appreciated or desired.

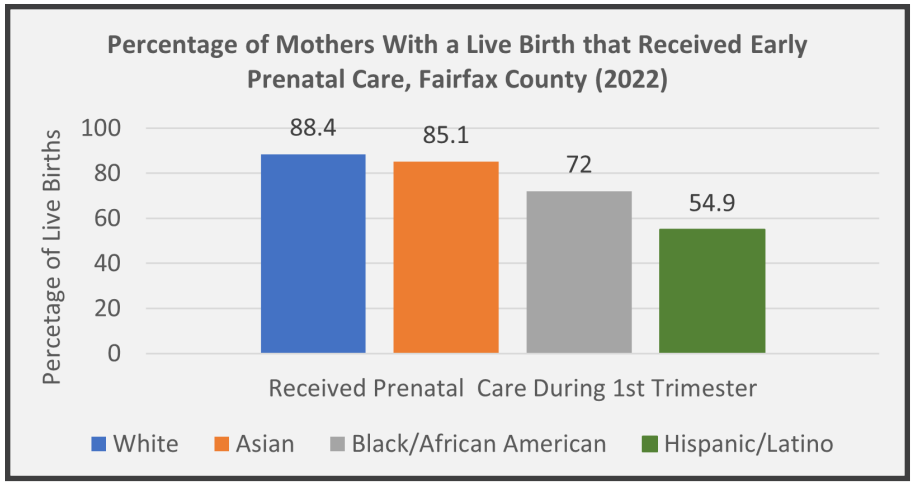
MATERNAL & CHILD HEALTH

Ensuring the optimal well-being of mothers, infants, and children requires attention to multiple issues centering around women's health, reproductive health, and child health. Key health indicators in maternal and child health are impacted by the intersection of the physical, mental, emotional, and social well-being of women prior to, during, and after pregnancy; as well as the extent to which critical physical and mental developmental processes are promoted during infancy and early childhood.

Mothers Receiving Prenatal Care

Prenatal care provides the opportunity to reduce the risk of pregnancy and birth related complications through the early identification of health-related concerns, promotion of healthy maternal behaviors, and monitoring of fetal development.

- Approximately 77.6% of women with a live birth in 2022 received prenatal care during the first trimester of pregnancy, slightly down from 78.3% in 2018.[20]
- Only 54.9% of Hispanic/Latino women giving birth in 2022 received prenatal care during the first trimester, compared with 88.4% among White women, 85.1% among Asian women, and 72.0% among Black/African American women.[20]

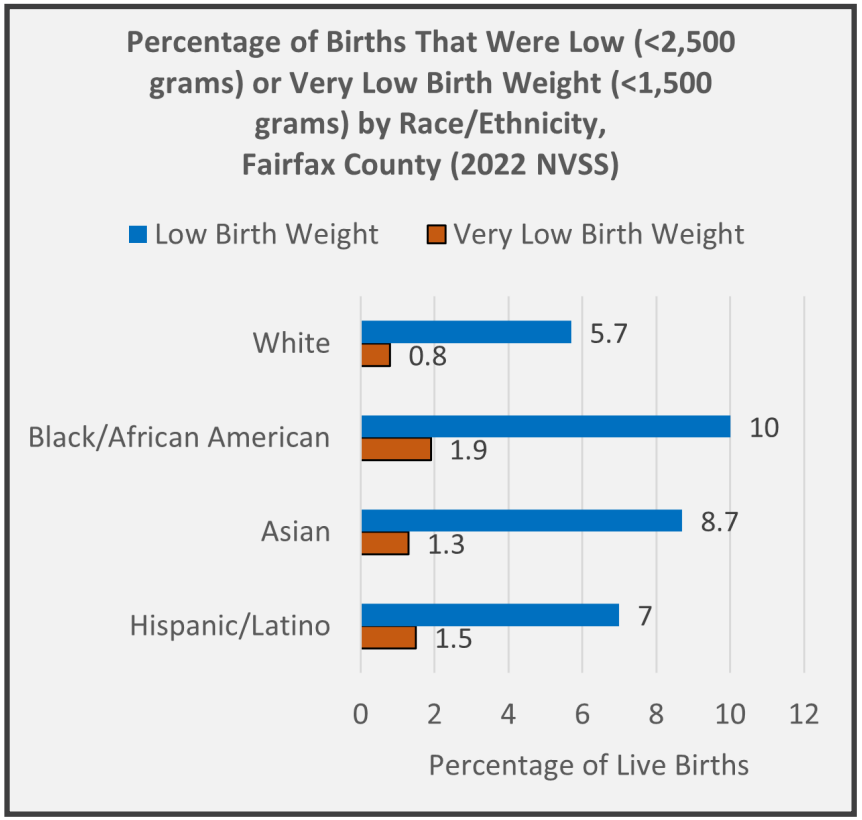


Low Birthweight Births

While some babies with low birthweight are healthy, weighing less than 2,500 grams (5 pounds, 8 ounces) at birth increases the risk of infections, respiratory disorders, developmental delays, and death. Additionally, research has documented associations between being born low birthweight and the risk of developing chronic diseases in adulthood. In addition to often being related to preterm birth, or birth prior to 37 weeks gestation, low birthweight can also result from stopped or delayed fetal growth during pregnancy.

In 2022, there were 869 low birthweight births in the county, representing 7.0% of all births.[20]

- Consistent with national trends, local data indicates a higher risk of low birthweight births among non-White women. Black/African American (10.0%) women have the highest percentage of low birthweight births, followed by Asian (8.7%) and Latino/Hispanic (7.0%) women.[20]



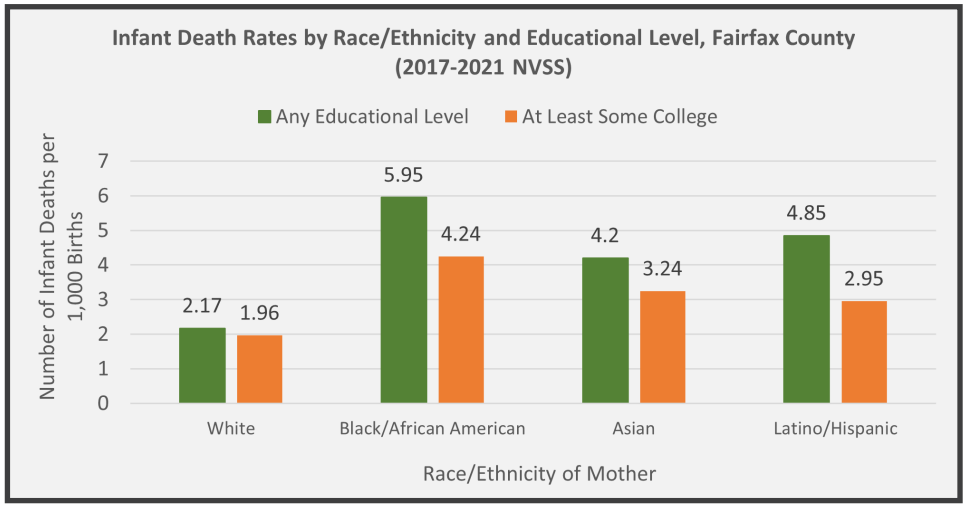
MATERNAL & CHILD HEALTH *CONTINUED*

Infant Mortality

Defined as the death of an infant before reaching 1 year of age, infant mortality is a key indicator of unmet maternal and child health needs.

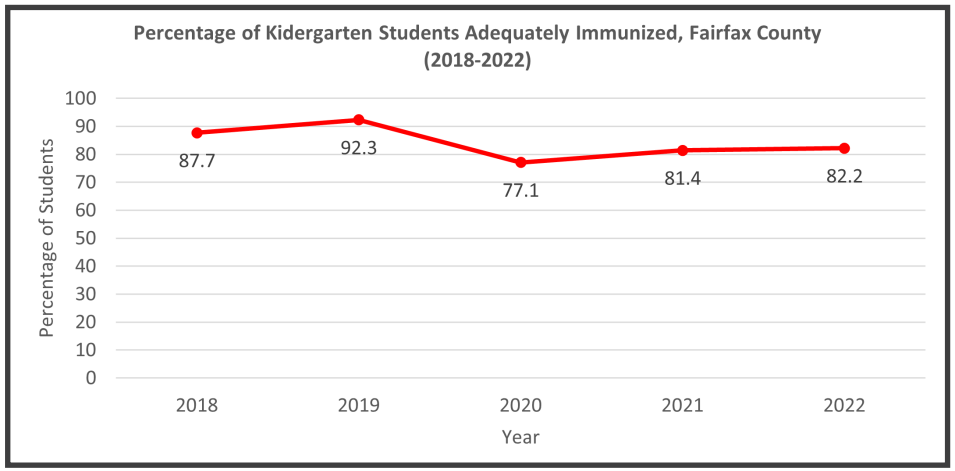
The overall infant mortality rate in Fairfax County from 2017-2021 was 3.8 deaths per 1,000 births, differing little from what was observed during the 2014 through 2018 time period (3.9 deaths per 1,000 births).[21]

- The highest infant mortality rate is observed in the Black/African American community at 5.95 deaths per 1,000 births, a rate over twice that observed in the White community (2.17 deaths per 1,000 births).[21] Such racial/ethnic disparities persist even when maternal educational level is considered.[21]



Childhood Vaccinations

Similar to national trends, childhood vaccination rates declined during the COVID-19 pandemic. The current childhood vaccination rate (82.2%) remains below pre-pandemic levels.[22]



Voices of the Community

- Many immigrants who come from indigenous communities do not have prenatal care in their countries of origin and are used to giving birth at home.
- Medical racism is a concern of community members. Some Black/African American women have expressed the desire to avoid pregnancy because of their awareness of poor maternal health outcomes for Black/African American women and mistrust of the medical system. Alternate systems of care, such as doulas, are at times preferred over the traditional medical routes because of mistrust.

> If you are someone of color or from another community like the LGBTQ community, it's hard to say, especially in the environment that we live now, where you feel safe or where you feel comfortable. It really is difficult.... because you just don't know...There's an example of what just happened in Jacksonville [the racially-motivated mass shooting of black shoppers by a white gunman in a Dollar General Store]."
>
> — Leader with connections to the Black community in Fairfax County

COMMUNITY CONTEXT ASSESSMENT THEMES

The Community Context Assessment (CCA) consists of qualitative data gathered from the community. There were three themes of focus: community strengths and assets, (i.e., the human-made environment), and forces of change (i.e., forces outside of the control of the individual person). While the community perspectives gathered for the Community Context Assessment is not representative of all experiences in the Fairfax, it does provide additional information on the health-related issues in the community.

Community Strengths and Assets in Fairfax

- Universally, neighbors and family were named as major community assets. Helping others is highly valued and frequently cited for when people feel socially connected to their community.
- Young people are interested and motivated to volunteer. Community events, both broad and targeted, are also appreciated.
- Many known, trusted, and well-connected community organizations provide concrete support for the community, broadly or focused on a particular population.
- Across all demographics, residents appreciate the rich cultural diversity present within the county.
- The Fairfax County community is seen as a leader across the country and can take bold steps on major issues.

Built Environment in Fairfax

- Spaces must be accessible and any barriers that hamper a person's ability to have full participation should be removed. Sensory-friendly rooms and offering closed-captioning were named as examples of ways to provide accessibility.
- Language access, through multi-lingual signs or the use of pictograms, is a high priority due to the large number of languages spoken in Fairfax County.
- Gender-neutral bathrooms can help make a space welcoming for members of the LGBTQIA+ communities.
- Residents want features including playgrounds, sport fields, outdoor walking paths, walkable access to resources, and greater access to health clinics, farmers' markets, and community gardens.
- Pedestrian safety is a major concern as residents cited unsafe speed limits, poor lighting, poorly maintained and disconnected sidewalks, and lack of crosswalks.
- Across demographics, residents seeing people who look like them greatly affects their perception of whether they will be safe and welcomed into a space. For people of color, it is an important marker of safety.
- Residents expressed appreciation of non-judgmental spaces where people of different demographic backgrounds can connect, outside of work or the home, such as cafes, community centers, restaurants, and libraries.

Forces of Change in Fairfax

- The level of affordability of the county is a theme across different demographics. Residents connected economics with access to resources that support health. Low-income families or undocumented immigrants are particularly vulnerable.
- Civic unrest and potential targeted violence is a significant theme raised by county residents and community leaders, pointing to incidents of racially charged violence which have occurred around the country and expressed concerns over safety.
- Lack of trust in government and/or public health is a challenge to public health initiatives, such as the COVID-19 vaccination campaign. The best way to build trust is by having "boots on the ground" in the community.
- Gentrification resulting in displaced residents or businesses is a strong concern, particularly by Black/African American and Vietnamese communities in the Route 1 corridor and the East End Small Area Plan for Eden Center.
- People of color, elderly, and low-income residents are most affected from issues including rain/flooding, heat, disease-carrying insects, water scarcity, breathing concerns, and food availability. Youth also expressed grave concerns about climate change.[3]
- In light of the COVID-19 pandemic, the influence of misinformation and disinformation is a key health factor.
- Equity initiatives are often seen as unfair by others. Some marginalized communities have great skepticism over equity initiatives having a meaningful impact.

> ***"Accessibility is an invitation to participate."***
>
> —Community leader with the disability community

COMMUNITY PARTNER ASSESSMENT

COMMUNITY PARTNER ASSESSMENT

The organizations and agencies (referred to as community partners) who serve the Fairfax community are an essential component in improving community health. The Community Partner survey, the assessment tool provided in MAPP's CPA, helps gather information about the community partners. Seventy-nine community partners completed the survey. There were several different types of community partners represented with non-profit organizations being the largest survey respondents.

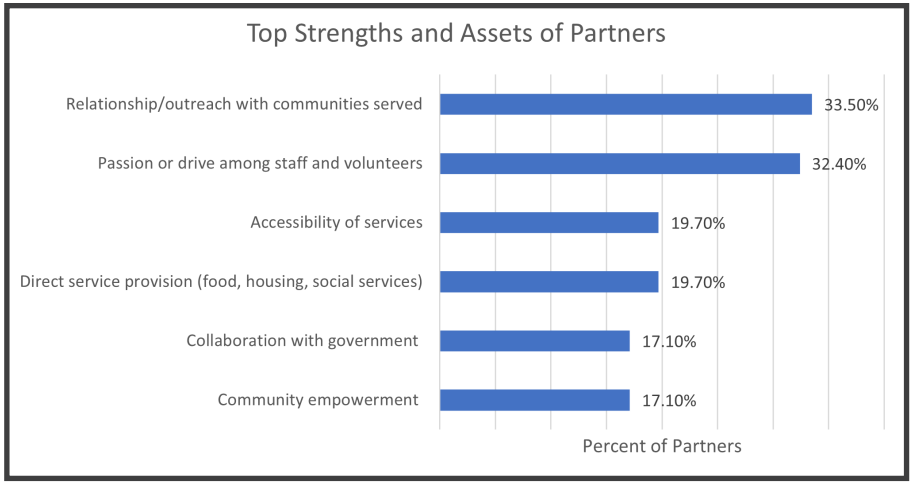
Community Partners in Fairfax

While the findings from the Community Partner survey are not representative of all community partners in the Fairfax community and reflect only the community partners who completed the survey, several themes emerged.

Overall, the community partners reported serving or engaging with many different populations in the Fairfax community. However, many community partners provide general services that all populations can use, but do not specifically serve all populations, such as people with disabilities and the LGBTQIA+ population. Community Partners reported working on a wide range of health topics with the largest being mental or behavioral health, healthy food and nutrition, and immunizations and screenings.

Community partners were asked to identify their organization or agency's priority populations that they serve or engage with in the Fairfax community. The top responses were people with low income or socio-economic status, immigrants and/or undocumented population, people with disabilities, and the Hispanic/ Latino population.

Community partners reported many strengths for their agency or organization and common themes appeared. Relationships and outreach with the communities served and passion or drive among staff and volunteers were the most reported strengths from community partners, followed by accessibility of services and direct service provision (food, housing, social services). All responses from community partners demonstrate the wide range of assets available in the Fairfax community.



NEXT STEPS

This Community Health Assessment (CHA) reaffirmed that the Fairfax community, overall, ranks among the healthiest jurisdictions in Virginia and in the United States. It illustrates the many factors contributing to the region's high quality of life – racial and ethnic diversity, well-educated residents, and high per capita income. However, these indicators often hide the people in the community who carry a disproportionate burden of poverty, poor health, and premature death. These disparities in socioeconomic conditions, access to care, and health outcomes must be explored further to advance health equity. Additional data analyses for specific populations and geographies are needed to target strategies to those with the greatest needs.

The completion of this community profile marks the transition from the assessment phase to the planning phase of the Mobilizing for Action through Planning and Partnerships (MAPP) process. The Community Health Improvement Plan (CHIP) takes the information contained in this CHA to prioritize health issues for community action. Community input for the development of the CHIP is essential to creating a viable, impactful, and successful plan.

Every community partner and Fairfax resident is invited to participate in this process. The Health Department and the Partnership for a Healthier Fairfax will be intentional about going into the community to gather input on the CHIP development, especially in geographic areas or in populations that are experiencing health disparities. The Fairfax community is fortunate to have caring, motivated residents and hardworking, passionate community partners who have relationships with residents who are most impacted. Working together, we can ensure that all residents live in thriving communities, where every person has the opportunity to be healthy, safe and realize their potential.

CHIP Development Process

APPENDIX

ACRONYMS

- ACS – American Community Survey
- BRFSS – Behavioral Risk Factor Surveillance Survey
- CCA – Community Context Assessment
- CHA – Community Health Assessment
- CHNA – Community Health Needs Assessment
- CPA – Community Partner Assessment
- CSA – Community Status Assessment
- CHIP – Community Health Improvement Plan
- MAPP – Mobilizing for Action through Planning and Partnerships
- NACCHO – National Association of County and City Health Officials
- PFHF – Partnership for a Healthier Fairfax
- YS – Fairfax County Youth Survey

REFERENCES

1. National Association of County and City Health Officials. (2023). Mobilizing for Action through Planning and Partnerships (MAPP). Retrieved from https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp
2. Public Health Accreditation Board. (n.d). Version 2022. Retrieved from https://phaboard.org/accreditation-recognition/version-2022
3. Inova. (2023). Inova Community Health Needs Assessments and Implementation Plans. Retrieved from https://www.inova.org/about-inova/inova-your-community/community-health-needs-assessments
4. Fairfax County. (n.d.). One Fairfax. Retrieved from https://www.fairfaxcounty.gov/topics/one-fairfax
5. Fairfax County Health Department. (2023). Fairfax County Health Department CY 2023 Equity Impact Plan. Retrieved from https://www.fairfaxcounty.gov/topics/sites/topics/files/assets/documents/one-fairfax/2023/hd-cy-2023-eip.pdf
6. U.S. Centers for Disease Control and Prevention, Office of Health Equity. (2022). What is Health Equity? Retrieved from https://www.cdc.gov/healthequity/whatis/index.html
7. U.S. Census Bureau. (2023). American Community Survey Data. Retrieved from https://www.census.gov/programs-surveys/acs/data.html
8. Fairfax County. (n.d.). Languages Spoken at Home by Fairfax County Elementary Students. Retrieved from https://www.fairfaxcounty.gov/demographics/languages-spoken-home-fairfax-county-elementary-students
9. U.S. Centers for Disease Control and Prevention, National Center for Health Statistics. (2023). National Vital Statistics System. Retrieved from https://www.cdc.gov/nchs/nvss/index.htm

10. U.S. Centers for Disease Control, CDC WONDER. (2023). National Center for Health Statistics Mortality Data on CDC WONDER. Retrieved from https://wonder.cdc.gov/Deaths-by-Underlying-Cause.html
11. U.S. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. (2023). Annual Survey Data [Behavioral Risk Factor Surveillance System]. Retrieved from https://www.cdc.gov/brfss/annual_data/annual_data.htm
12. Conduent. (2023). Fairfax Community Health Dashboard. Retrieved from www.livehealthyfairfax.org
13. Fairfax County Public Schools. (2021). Body Mass Index Surveillance Data
14. Virginia Department of Health, Division of Surveillance and Investigation, Office of Epidemiology, Syndromic Surveillance Data. Retrieved from http://www.vdh.virginia.gov/surveillance-and-investigation/syndromic-surveillance
15. Fairfax County. (2022). Fairfax County Youth Survey. Retrieved from https://www.fairfaxcountyyouthsurvey.com/
16. U.S. Centers for Disease Control. (2022). How much physical activity do adults need? Retrieved from https://www.cdc.gov/physicalactivity/basics/adults/index.htm
17. U.S. Department of Health and Human Services. (2018). Physical Activity Guidelines for Americans, 2nd edition. Retrieved from https://health.gov/sites/default/files/2019-09/Physical_Activity_Guidelines_2nd_edition.pdf
18. Feeding America. (2023). Food Insecurity among Overall (all ages) Population in Fairfax County. Retrieved from https://map.feedingamerica.org/county/2021/overall/virginia/county/fairfax
19. U.S. Department of Agriculture. (2023). Definitions of Food Security. Retrieved from https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/definitions-of-food-security
20. U.S. Centers for Disease Control, CDC WONDER. (2023). Natality Information. Retrieved from https://wonder.cdc.gov/natality.html
21. U.S. Centers for Disease Control and Prevention, National Center for Health Statistics. (2023). Linked Birth and Infant Death Data. Retrieved from https://www.cdc.gov/nchs/nvss/linked-birth.htm
22. Virginia Department of Health. (n.d) Annual School Self-Reports of Immunization Coverage. Retrieved from https://www.vdh.virginia.gov/immunization/datamanagement/sisreports/

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