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Partnership for a Healthier Fairfax

Community Health Improvement Plan 2013-2018

Annual Evaluation Report – Year Three
October 2015-September 2016

April 14, 2017

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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Introduction

- The **Partnership for a Healthier Fairfax** 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** outlines 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 Community Health Improvement Plan forms the cornerstone of the Live Healthy Fairfax initiative. Live Healthy Fairfax encompasses the activities that the Partnership engages in to make the Fairfax community a healthier place to live. The plan consists of seven priority issues and their respective goals, objectives, and key actions. This **Community Health Improvement Plan Annual Evaluation Report** tracks the completion of key actions throughout implementation. It provides an annual progress update, including activities to-date, timeframes, responsible parties, resources, and measures of success for each key action.

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-September 2018

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Priority Issues

- The Community Health Improvement Plan focuses 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

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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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Priority Issue: Healthy and Safe Physical Environment (HSPE)						
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.					
Key Actions	**Timeframe**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.1.A Educate local government staff and decision makers on the principles of the Health in All Policies (HiAP) approach.	10/13	9/14	Leads: Fairfax County Health Department (FCHD), Neighborhood and Community Services (NCS) HSPE Priority Issue Team (PIT)	Centers for Disease Control and Prevention (CDC) Community Transformation Grant (CTG) $500,000 10/13-9/14 National Association of County and City Health Officials (NACCHO) HiAP Leadership Institute 1/14-6/14 Virginia Department of Health (VDH) Healthy Eating and Active Living (HEAL) Grant $67,410 1/14-9/14	# individuals educated about HiAP: 228 (duplicated count) % participants who have a clear understanding of HiAP approach: Increase from 83% pre-test to 94% post-test	**COMPLETED YEAR ONE** • Representatives from FCHD, the Office of the County Executive, and the Planning Commission participated in a NACCHO HiAP Leadership Institute to build capacity for public health policy dialogue. • Secured a VDH HEAL grant to hire a part-time health planner to promote the HiAP approach to key leaders and decision makers. • Co-sponsored a Healthy Community Design Summit for local government staff and community members (174 participants), followed by a Leadership Briefing for decision makers (54 participants) in 5/14. • Secured Mark Fenton, a national expert on walkable communities, as a keynote speaker for the summit. • Assembled a panel discussion with representatives of the business, university, and human services sectors for the summit. • Participated in stakeholder meetings in 6/14 to provide input on the Economic Advisory Commission's *2015 Strategic Plan to Facilitate the Economic Success of Fairfax County*. • Conducted research and developed a summary of national best practices for active transportation, active community design, and the incorporation of health into planning and development review. • Researched best practices to create HiAP fact sheets for faith communities, employers, and schools.

Objective 1.1 Continued	Increase the number of community, street, transportation and park policies for the environment that support positive community health outcomes.					
Key Actions	**Timeframe**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.1.B Study transportation, planning, zoning, and development review policies and procedures to identify and implement modifications to advance community health initiatives. *(Revised 3/17)*	10/13 10/14	9/14 9/17	Lead: FCHD HSPE PIT Leads: Healthy Environment and Active Living (HEAL) PIT Department of Planning and Zoning (DPZ), Department of Transportation (DOT)	VDH HEAL Grant $67,410 1/14-9/14	# opportunities identified: 1 # participants in interagency meeting: 36	**COMPLETED YEAR ONE** • Identified the transportation proposal for the Richmond Highway Transit Center (RHTC) as an opportunity to conduct a Health Impact Assessment (HIA). • Engaged DOT in 11/13 to partner on the HIA grant proposal. • Held a Healthy Community Design Interagency Meeting in 9/14 engaging 36 representatives from DPZ, DOT, Fairfax County Park Authority (FCPA), and the Department of Public Works and Environmental Services to discuss ways to formally incorporate health into their day-to-day responsibilities and to become champions for changes to county policies and processes. **COMPLETED YEAR TWO** • Combined HSPE and Active Living PITs into the Healthy Environment and Active Living PIT with 3 working groups: Planning and Zoning, Transportation, and Active Living. • Reviewed the Comprehensive Plan and Zoning Ordinance for sections that promote or restrict healthy communities to consider how to incorporate active living into the county's policies and review processes. • Compiled a summary to identify those places in the *Fairfax County Comprehensive Plan: Policy Plan* where health is addressed. **COMPLETED YEAR THREE** • Discussed the potential for expansion of community gardens and urban agriculture to encourage healthy eating for county residents. **PLAN FOR YEAR FOUR** • Organize into three subcommittees to work on closely evaluating policies in the Countywide Comprehensive Policy Plan for opportunities to incorporate health policies throughout. • Establish and empower a subcommittee to review the Policy Plan analysis document and identify potential policy changes that would advance community health initiatives. • Work with the Fairfax Food Council and DPZ to identify needed amendments to the Zoning Ordinance to expand community gardens and farmers markets.

Objective 1.1 Continued	Increase the number of community, street, transportation and park policies for the environment that support positive community health outcomes.					
Key Actions	**Timeframe**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.1.C Develop recommendations using national best practices for health considerations to be integrated into existing policies, plans, and procedures.	1/14 4/15	8/14 9/18	Lead: FCHD HSPE PIT, DOT Leads: HEAL PIT DPZ, DOT	NACCHO HIA Grant $15,000 1/14-6/14	Provision of recommend-ations: Year One – HIA Year Two – *Strategic Plan to Facilitate the Economic Success of Fairfax County*	**COMPLETED YEAR ONE** • Secured a NACCHO HIA Grant to hire a part-time health planner to coordinate the HIA process. • Conducted an HIA for the RHTC project and produced the county's first HIA report, outlining recommendations to improve health outcomes and mitigate potential negative health impacts. **COMPLETED YEAR TWO** • Met with transportation planners to discuss ways to incorporate multimodal analysis into development review. • Incorporated recommendations into the *Strategic Plan to Facilitate the Economic Success of Fairfax County*. **COMPLETED YEAR THREE** • Attended countywide cross-agency meetings on HiAP, an extension of the *Strategic Plan to Facilitate the Economic Success of Fairfax County*. • Worked towards integration of health and equity issues into policies and projects through outreach with various agencies. **PLAN FOR YEAR FOUR** • Examine county policies, such as the *Fairfax County Comprehensive Plan*, zoning regulations, transportation, and the Bicycle Master Plan, to make recommendations for the incorporation of health considerations. • Develop recommendations for the amendment of the Comprehensive Plan and other policies as appropriate. • Provide recommendations and support for the implementation of health-related policies concerning the built environment.

Objective 1.1 Continued	Increase the number of community, street, transportation and park policies for the environment that support positive community health outcomes.					
Key Actions	**Timeframe**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.1.D Conduct an assessment to identify barriers to accessing parks, fields, and recreational facilities in redeveloping, underserved, or economically challenged communities.	10/13	4/16	Lead: FCPA	Funding needed	# assessments completed: 1	**COMPLETED YEAR ONE** • Developed the scope of work for a FCPA needs assessment and completed the procurement process to hire a consulting firm to conduct it. **COMPLETED YEAR TWO** • Conducted a statistically-valid community survey as a part of the Parks Count! Needs Assessment to ascertain the park and recreation needs and desires of county residents. • Reached out to residents in all parts of the county to ensure equitable inclusion of all perspectives. **COMPLETED YEAR THREE** • Secured approval from the Park Authority Board in 4/16 for the Parks Count! Needs Assessment.
1.1.E Develop recommendations for providing parks and non-traditional park amenities for communities that are redeveloping, underserved, or economically challenged.	10/15	9/17	Lead: FCPA HEAL PIT	Funding needed	# new outdoor gyms: 3	**COMPLETED YEAR THREE** • Launched new outdoor gyms at county parks in Lincolnia, Royal Lake, and Gum Springs. • Administered a HiAP training for Park Authority staff to support the upcoming formal review of their policies. • Launched an agency-wide master planning effort to develop goals and recommendations for the Park Authority. **PLAN FOR YEAR FOUR** • Inform the Park Authority's comprehensive year-long plan review with health as an emphasis. • Hold public forums on the draft plan.
1.1.F Evaluate policy alternatives identified as best practice models for community use of athletic fields.	10/16	9/18	Lead: NCS HEAL PIT	None identified	Evaluation of policy alternatives: TBD	**NOT STARTED** **PLAN FOR YEAR FOUR** • Conduct an assessment of best practices in community use and identify gaps between best practices and current local practices.

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.

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Priority Issue: Active Living (AL)						
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 childcare settings to engage in daily physical activity.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.1.A Educate new parents with targeted materials and resources that promote active play for infants and young children at home.	10/15	9/17	Lead: Department of Family Services (DFS) Office for Children (OFC) Healthy Environment and Active Living (HEAL) Priority Issue Team (PIT)	None identified	# new parents reached: TBD	**COMPLETED YEAR THREE** • Created a draft version of the *Eat and Run* educational handbook for families to learn about healthy food and physical activity options. **PLAN FOR YEAR FOUR** • Finalize a version of the *Eat and Run* educational handbook for families.
1.1.B Develop a campaign to increase the number of structured play opportunities and outlets for children ages birth to 5 years.	10/13	9/14	Lead: DFS OFC HEAL PIT	Centers for Disease Control and Prevention (CDC) Community Transformation Grant (CTG) $52,000 6/13-9/13 $26,000 10/13-9/14	Development of materials to promote physical activity for children: Completed # *Eat and Run* books printed: 1,500 in English, 150 in Spanish, and 450 in other languages	**COMPLETED YEAR ONE** • Developed an educational handbook, *Eat and Run*, to provide guidance to family childcare providers on good nutrition practices and structured play options for children from birth to eight years of age. • Translated the book into the four most common languages used by Fairfax County childcare providers: Arabic, Farsi, Spanish, and Urdu. • Garnered national attention from the U.S. Department of Agriculture and the Nemours Foundation, who support the First Lady's *Let's Move* initiative. • Registered the book and its four supplementary translations for copyright through the Library of Congress.

Objective 1.1 Continued	Increase the number of opportunities for children ages birth to 5 years and those in childcare settings to engage in daily physical activity.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.1.C Promote physical activity guidelines with family childcare providers and childcare centers.	10/13	9/16	Lead: DFS OFC HEAL PIT	Centers for Disease Control and Prevention (CDC) Community Transformation Grant (CTG) $52,000 6/13-9/13 $26,000 10/13-9/14	# workshops held to train providers: Year One – 8 Year Two – 4 Year Three – 4 # childcare providers trained: Year One – 297 Year Two – 114 Year Three – 159 # children reached (based on 5 children per provider): Year One – 1,485 Year Two – 570 Year Three – 774	**COMPLETED YEAR ONE** • Conducted workshops to train providers on how to implement the activities in *Eat and Run*. **COMPLETED YEAR TWO** • Printed *Eat and Run* in Arabic, Farsi, Spanish, and Urdu. • Held additional workshops with providers to promote physical activity guidelines. **COMPLETED YEAR THREE** • Conducted additional *Eat and Run* workshops.

Active Living

- **Goal 1**: Increase the number of children and adolescents who engage in daily physical activity.
  - **Objective 1.2**: Increase the number of elementary schools that participate in the Safe Routes to School program.

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Priority Issue: Active Living (AL)						
Goal 1	Increase the number of children and adolescents who engage in daily physical activity.					
Objective 1.2	Increase the number of elementary schools that participate in the Safe Routes to School program.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.2.A Identify community groups that can partner and provide logistical support in coordinating the Safe Routes to School (SRTS) program.	10/13	9/14	Leads: Linda Hollis, Fairfax County Health Department (FCHD); Sally Smallwood, Fairfax County Public Schools (FCPS) Active Living (AL) Priority Issue Team (PIT)	Centers for Disease Control and Prevention (CDC) Community Transformation Grant (CTG) $500,000 10/13-9/14	Identification of partners to support SRTS program: Completed	**COMPLETED YEAR ONE** • Identified community partners critical to the implementation of the SRTS program in 3/14. These stakeholders include professionals in the fields of transportation, planning, public works, public safety, public health, and parks and recreation; elected and appointed officials; school representatives (officials and parents); concerned citizens, and local advocates.
1.2.B Mobilize resources to educate school communities on safe walking and cycling.	10/13	9/15	Leads: Linda Hollis, FCHD; Sally Smallwood, FCPS AL PIT	CDC CTG $500,000 10/13-9/14	Documentation of resources to educate school communities on safe walking and cycling: Completed	**COMPLETED YEAR ONE** • Worked with Mt. Vernon Woods, Crestwood, and Hybla Valley Elementary Schools to increase the number of students walking and biking to school. • Purchased 2,000 reflective stickers for student backpacks at the three schools and 40 reflective vests for parents who walk students to school. • Held a parent meeting with a video presentation about pedestrian skills for children in English and Spanish. • Arranged for the American Automobile Association's "Otto the Auto" presentation to be given to kindergartners and first graders in 9/14. **COMPLETED YEAR TWO** • Engaged seven schools to participate in Bike to School Day. • Assisted the SRTS program to secure bike helmet donations for school children.

Objective 1.2 Continued	Increase the number of elementary schools that participate in the Safe Routes to School program.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.2.C Provide guidance for establishing an infrastructure for the Safe Routes to School program in participating schools.	10/13	9/15	Leads: Linda Hollis, FCHD; Sally Smallwood, FCPS AL PIT	CDC CTG $500,000 10/13-9/14	# SRTS workshops: 1 # SRTS workshop participants: 34	**COMPLETED YEAR ONE** • Conducted a SRTS workshop at Mt. Vernon Woods Elementary School in 5/14 for partners to address transportation issues for a school setting, including the creation of safe environments for all students, whether they walk, cycle, or arrive by bus or car. The facilitator was Mark Fenton, an expert on SRTS initiatives and walkable communities. **COMPLETED YEAR TWO** • Secured Marc Fenton to deliver the keynote speech at the Greater Washington DC SRTS Regional Network Annual Meeting in 10/14.
1.2.D Promote the Safe Routes to School program through local public education outlets.	10/13	9/15	Leads: Linda Hollis, FCHD; Sally Smallwood, FCPS AL PIT	CDC CTG $500,000 10/13-9/14	Documentation of the promotion of SRTS through local public education outlets: Completed	**COMPLETED YEAR ONE** • Created the SRTS newsletter to promote the SRTS program and provide education about pedestrian and bicycle safety to administrators, teachers, parents, volunteers, and other interested parties. • Provided information on SRTS, and pedestrian and bike safety for "Meet Your Teacher" day in 8/14 and had exhibits at each school's back-to-school night. • Purchased and posted "Children Walking" signs to promote awareness and safety for children participating in the SRTS program. • Obtained letters of support from three participating schools to expand SRTS implementation to other schools. **COMPLETED YEAR TWO** • Continued to support and promote the SRTS program in schools. • Three schools implementing SRTS were recognized with a Fire Up Your Feet Award from Kaiser.

Active Living

- **Goal 1**: Increase the number of children and adolescents who engage in daily physical activity.
  - **Objective 1.3**: Increase the number of children and adolescents from families of low socioeconomic status participating in organized recreational activities.

Priority Issue: Active Living (AL)						
Goal 1	Increase the number of children and adolescents who engage in daily physical activity.					
Objective 1.3	Increase the number of children and adolescents from families of low socioeconomic status participating in organized recreational activities.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.3.A Examine the current availability of scholarship funds and identify potential funding gaps.	10/13	9/14	Lead: Neighborhood and Community Services (NCS) Community Transformation Grant (CTG) Project Director Active Living (AL) Priority Issue Team (PIT)	Centers for Disease Control and Prevention (CDC) CTG $5,000 10/13-9/14	Evaluation of availability of scholarship funds: Completed	**COMPLETED YEAR ONE** • Formed a team to examine the current funding structure of existing scholarship programs, to address gaps in funding, and to identify affordable transportation options for youth participating in organized recreational activities. • Conducted a facilitated focus group session in 3/14 for community groups and stakeholders to gather input regarding the scholarship application process. • Analyzed feedback from the session to develop proposals for leadership consideration.
1.3.B Leverage resources to fill gaps and identify additional funding sources.	10/15	9/16	Lead: Healthy Eating and Active Living (HEAL) PIT Fairfax County Park Authority (FCPA); NCS	None identified	Identification of additional resources: Completed	**COMPLETED YEAR THREE** • Partnered to provide the Leveling the Playing Field Program, which provides sports equipment for low-income children through donations and purchases of new equipment. • Supported proposed legislation to increase access to physical activity by allowing Flexible Spending Account funds to be used to purchase gym memberships and sports camps.
1.3.C Identify opportunities to promote the availability of scholarships.	10/16	9/17	Lead: NCS HEAL PIT	None identified	Documentation of scholarship promotion: TBD	**NOT STARTED** **PLAN FOR YEAR FOUR** • Streamline the Youth Sports Scholarship Program application process to make it easier for families and sports organizations to apply for county funding to support low income youth playing sports.

Objective 1.3 Continued	Increase the number of children and adolescents from families of low socioeconomic status participating in organized recreational activities.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.3.D Revise transportation guidelines to promote the use of public transportation for commuting to organized sports.	10/13	9/17	Lead: Chris Scales, NCS Regional Manager Fairfax County Department of Transportation (DOT), HEAL PIT	CDC CTG $5,000 10/13-9/14	Issuance of revised transportation guidelines: Completed	**COMPLETED YEAR ONE** • Reviewed best practices for providing free transportation. • Discussed potential policy changes to transportation guidelines with the Fairfax County Board of Supervisors (BOS), DOT, and NCS. **COMPLETED YEAR TWO** • Received FY 2016 budget development guidance from the BOS which directed DOT and NCS to pilot a "Youth Ride Free" policy for the opening of the Providence Community Center. • DOT initiated a Free Student Bus Pass Pilot Program for middle and high school students to ride Fairfax Connector buses for free during designated hours. **COMPLETED YEAR THREE** • Expanded the Free Student Bus Pass Program to all middle and high school students to ride Fairfax Connector and Fairfax Cue buses for free during extended hours. **PLAN FOR YEAR FOUR** • Explore expansion of free bus service to fifth through eighth grade students playing sports. • Work with community youth sports groups to identify promising practices in carpooling and ride sharing opportunities to address transportation barriers.

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.

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Priority Issue: Active Living (AL)						
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.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
2.1.A Develop and implement public education efforts to highlight opportunities to incorporate physical activity into daily activities.	10/14	9/17	Lead: Healthy Environment and Active Living (HEAL) Priority Issue Team (PIT) Fairfax County Park Authority (FCPA), Fairfax County Department of Transportation	None identified	Implementation of education efforts to incorporate physical activity into daily activities: Completed	**COMPLETED YEAR TWO** • Discussed the use of social media, county information resources, and other forms of marketing to let adults in the Fairfax community know about opportunities for engaging in daily physical activity. • Supported the Park Authority's Take 12 Steps to Health and the City of Fairfax Health Challenge. **PLAN FOR YEAR FOUR** • Develop marketing materials for bicycle and pedestrian outreach.
2.1.B Develop opportunities for businesses to support non-motorized commuting.	10/14	9/17	Lead: HEAL PIT	None identified	# opportunities for businesses to support non-motorized commuting: 1	**COMPLETED YEAR TWO** • Supported the Greater Reston Chamber of Commerce's Healthy Workplaces Initiative. **COMPLETED YEAR THREE** • Received an update on the Countywide Bicycle Master Plan (CBMP) and agreed to support the implementation of the CBMP. **PLAN FOR YEAR FOUR** • Establish a subgroup to explore ways to encourage employers to increase bike friendliness, such as providing shower facilities. • Work to establish the four buildings at the Fairfax County Government Center complex as a "Bicycle Friendly Business" in accordance with Chapter 5 of the CBMP.

Objective 2.1 Continued	Increase the number of adults who engage in walking and biking.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
2.1.C Explore opportunities to expand bicycling in the community by installing bike racks and creating bike-share programs.	10/13	9/17	Lead: HEAL PIT Bicycle Program Coordinator, Fairfax County Department of Transportation	None identified	Documentation of support of expansion of bicycling in the community: Completed	**COMPLETED YEAR ONE** • Submitted a letter to the Fairfax County Planning Commission in 4/14 in support of the CBMP amendment to the Fairfax County Comprehensive Plan, which aims to increase bicycle use for transportation, improve safety, and expand bicycling accommodations across the community. **COMPLETED YEAR TWO** • Provided testimony to the Fairfax County Board of Supervisors (BOS) in support of the CBMP amendment to the Fairfax County Comprehensive Plan, which was adopted by the BOS in 10/14 and includes investments in the bicycle transportation system to enhance safety and to make the community more bicycle-friendly. • Explored two proposals for grant funds to implement the county's Bicycle Master Plan; however, were unable to secure the sponsorship of an outside nonprofit organization. **COMPLETED YEAR THREE** • Supported efforts to gain BOS approval for the implementation of the Fairfax County Capital Bikeshare program in the Tysons and Reston areas. **PLAN FOR YEAR FOUR** • Work to implement additional components of the CBMP.

Active Living

- **Goal 2**: Increase the number of adults who engage in daily physical activity.
  - **Objective 2.2**: Increase the number of opportunities to promote active lifestyles for adults.

Priority Issue: Active Living (AL)						
Goal 2	Increase the number of adults who engage in daily physical activity.					
Objective 2.2	Increase the number of opportunities to promote active lifestyles for adults.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
2.2.A Promote the use of social media to share group physical activity opportunities.	10/14	9/15	Lead: Healthy Environment and Active Living (HEAL) Priority Issue Team (PIT)	None identified	Discussion of social media to share physical activity opportunities: Completed	**COMPLETED YEAR TWO** • Discussed the use of social media, county information resources, and other forms of marketing to let adults in the Fairfax community know about opportunities for engaging in daily physical activity.
2.2.B Develop campaigns and provide materials and resources that emphasize the benefits of families being active together.	10/14	9/17	Lead: HEAL PIT	None identified	Promotion of resources that emphasize the benefits of families being active together: Completed	**COMPLETED YEAR TWO** • Supported the Park Authority's Take 12 Steps to Health, which features family-friendly opportunities for physical activity. **PLAN FOR YEAR FOUR** • Provide support to expand and enhance the Take 12 Steps to Health program for 2018.
2.2.C Partner with commercial entities to provide more active programs targeting families.	10/16	9/18	Lead: HEAL PIT	None identified	Documentation of partnerships formed with commercial entities to provide more active programs targeting families: TBD	**NOT STARTED**

Active Living

- **Goal 2**: Increase the number of adults who engage in daily physical activity.
  - **Objective 2.3**: Promote opportunities for physical activity for older adults.

Priority Issue: Active Living (AL)						
Goal 2	Increase the number of adults who engage in daily physical activity.					
Objective 2.3	Promote opportunities for physical activity for older adults.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
2.3.A Promote the use of social media to share group physical activity opportunities for older adults.	10/14	9/15	Lead: Healthy Environment and Active Living (HEAL) Priority Issue Team (PIT)	None identified	Discussion of social media to share physical activity opportunities for older adults: Completed	**COMPLETED YEAR TWO** • Discussed the use of social media, county information resources, and other forms of marketing to let adults in the Fairfax community know about opportunities for engaging in daily physical activity.
2.3.B Collaborate with community partners to provide physical activities that promote aging in place for older adults, including those with physical limitations.	10/13	9/16	Lead: HEAL PIT	None identified	Documentation of collaboration with community partners to provide physical activities that promote aging in places for older adults: Completed	**COMPLETED YEAR ONE** • Submitted a letter in 5/14 to the Fairfax County Board of Supervisors 50+ Committee in support of the Fairfax 50+ Community Action Plan. The plan was adopted in 9/14 and outlines a number of initiatives to address the needs of older adults in the community, including opportunities for physical activity in urban park settings. **COMPLETED YEAR THREE** • Renovated one and developed two new Outdoor Fitness Stations to allow communities enhanced access to fitness opportunities. • Implemented a 50+ Portal to improve access to recreation and wellness opportunities for the 50+ population.

Objective 2.3 Continued	Promote opportunities for physical activity for older adults.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
2.3.C Support the development of organized active recreation opportunities such as individual fitness competitions, adult-based sports organizations, and local competitions.	10/16	9/18	Lead: HEAL PIT	None identified	Documentation of support for the development of organized active recreation opportunities: TBD	**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.

Priority Issue: Active Living (AL)						
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.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
3.1.A Convene community stakeholders to review policies and procedures related to community use of fields and facilities for physical activity.	10/14	9/16	Lead: Neighborhood and Community Services (NCS) Healthy Environment and Active Living (HEAL) Priority Issue Team (PIT)	None identified	Inclusion of stakeholder input in policy review: Completed	**COMPLETED YEAR TWO** • Conducted extensive outreach to the athletic community to gather input into the county's allocation polices for gym and field use.
3.1.B Identify polices that may be inconsistently implemented.	10/14	9/16	Lead: NCS HEAL PIT	None identified	Review and revision of polices: Completed	**COMPLETED YEAR TWO** • Reviewed and revised the county's Field Allocation Policy in 3/15. **COMPLETED YEAR THREE** • Reviewed and revised the county's Gym Allocation Policy in 9/16.
3.1.C Identify barriers that discourage physical activity.	10/14	9/15	Lead: NCS HEAL PIT	None identified	Identification of barriers: Completed	**COMPLETED YEAR TWO** • Identified barriers to physical activity, including inequitable access to synthetic turf fields, transportation, language access, and participation costs.
3.1.D Create an action plan to minimize barriers.	10/15	9/16	Lead: NCS HEAL PIT	None identified	Development of an action plan: Completed	**COMPLETED YEAR THREE** • Worked on implementation of the recommendations developed by the 2013 Turf Field Task Force to improve equitable access to turf fields.

Objective 3.1 Continued	Implement policies and procedures that support physical activity in the community.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
3.1.E Develop accountability mechanisms.	10/16	9/17	Lead: NCS HEAL PIT	None identified	Development of performance measures: TBD	**NOT STARTED** **PLAN FOR YEAR FOUR** • Develop and report on performance measures for accountability.

Active Living

- **Goal 3**: Promote sustainability of programs and facilities that promote physical activity.
  - **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.

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Priority Issue: Active Living (AL)						
Goal 3	Promote sustainability of programs and facilities that promote physical activity.					
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.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
3.2.A Review existing legislation and policies that affect funding.	10/13	9/15	Lead: Healthy Environment and Active Living (HEAL) Priority Issue Team (PIT)	None identified	Identification of legislation and policies that affect funding: Completed	**COMPLETED YEAR ONE** • Identified the Countywide Bicycle Master Plan (CBMP) amendment to the Fairfax County Comprehensive Plan as a policy that could increase funding for infrastructure to promote bicycle use for transportation, improve safety, and expand bicycling accommodations across the community. **COMPLETED YEAR TWO** • Reviewed the Comprehensive Plan and Zoning Ordinance for sections that promote or restrict healthy communities to consider how to incorporate active living into the county's policies and review processes.
3.2.B Determine desired funding levels for maintenance of existing and future facilities, trails, and equipment.	10/15	9/16	Lead: Fairfax County Park Authority	None identified	Documentation of desired funding levels for maintenance of existing and future facilities, trails, and equipment: Completed	**COMPLETED YEAR THREE** • Evaluated park facilities and trails to determine the current backlog of maintenance and life cycle replacements. • Projected resource needs for the next five years, some of which will be included in the 2016 park bond referendum.

Objective 3.2 Continued	Identify consistent funding streams to maintain current and future facilities, trails, and equipment so that community members have access to safe physical activity.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
3.2.C Seek funding partners in the community.	10/14	9/17	Lead: HEAL PIT	None identified	Acquisition of funding: TBD	**COMPLETED YEAR TWO** • Explored two proposals for grant funds to implement the CBMP; however, were unable to secure the sponsorship of an outside nonprofit organization. • Secured voter approval in 11/14 for a $100 million transportation bond referendum, which includes funding for pedestrian and bicycle improvements that enhance connectivity throughout the county and increase safe opportunities for active transportation. **PLAN FOR YEAR FOUR** • Secure voter approval in 11/16 for a park bond referendum in the amount of $94 million, of which $7 million is earmarked for land acquisition, $27 million for new park development, $53 million for park renovation and upgrades, and $7.7 million for natural and cultural resource stewardship.
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.	10/13	9/16	Lead: HEAL PIT	None identified	Identification of legislation and policies that need revision or creation: Completed	**COMPLETED YEAR ONE** • Identified the transportation bond referendum in 11/14 as legislation that could provide needed resources for pedestrian and bicycle infrastructure improvements to promote physical activity. **COMPLETED YEAR THREE** • Identified the park bond referendum in 11/16 as an opportunity to secure needed resources for park facilities and trails.
3.2.E Promote needed changes with appropriate stakeholders.	10/13	9/15	Lead: HEAL PIT	None identified	Documentation of promotion of needed changes with appropriate stakeholders: Completed	**COMPLETED YEAR ONE** • Submitted a letter to the Fairfax County Planning Commission in 4/14 in support of the CBMP amendment to the Fairfax County Comprehensive Plan. **COMPLETED YEAR TWO** • Provided testimony to the Fairfax County Board of Supervisors (BOS) in support of the CBMP amendment to the Fairfax County Comprehensive Plan, which was adopted in 10/14. • Submitted an editorial to local newspapers and news websites in support of the transportation bond referendum in 11/14.

Active Living

- **Goal 3**: Promote sustainability of programs and facilities that promote 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.

Priority Issue: Active Living (AL)						
Goal 3	Promote sustainability of programs and facilities that promote 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.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
3.3.A Explore opportunities for facility use with local institutions of higher learning, faith-based communities, and businesses.	10/16	9/17	Lead: Neighborhood and Community Services (NCS) Healthy Environment and Active Living (HEAL) Priority Issue Team (PIT)	None identified	Documentation of research on opportunities for facility use with local institutions of higher learning, faith-based communities, and businesses: TBD	**NOT STARTED** **PLAN FOR YEAR FOUR** • Benchmark best practices and available opportunities in Fairfax. • Develop resources and templates that support community organizations and members in identifying and accessing facilities, including examples of successful partnerships.
3.3.B Establish memorandums of understanding for facility use by the community for physical activity.	10/16	9/17	Lead: NCS HEAL PIT	None identified	Establishment of memorandums of understanding for facility use by the community for physical activity: TBD	**NOT STARTED**
3.3.C Publicize partnerships.	10/16	9/17	Lead: NCS HEAL PIT	None identified	Documentation of publicity of partnerships: TBD	**NOT STARTED**

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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.

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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.

Priority Issue: Healthy Eating (HE)						
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.					
Key Actions	**Timeframe**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.1.A Establish membership and charter a food policy council.	10/13	9/16	Lead: Fairfax County Health Department (FCHD) HE Priority Issue Team (PIT)/Fairfax Food Council (FFC)	Kaiser Foundation (KF) Grant $14,994 8/14-6/15 American Association of Retired Persons (AARP) Grant $1,000 9/15-9/16 Virginia Foundation for Healthy Youth (VFHY) $30,000 per year 7/16-6/18	Establishment of the FFC: 10/15 Number of FFC members: 190 Number of FFC Steering Committee members: 25	**COMPLETED YEAR ONE** • Received a KF grant through FCHD for a limited-term Healthy Eating Project Coordinator to work with the HE PIT on establishing the FFC and setting priorities. **COMPLETED YEAR TWO** • Reapplied for the KF grant (not awarded). • Submitted two grant proposals in partnership with Cornerstones, one to Inova and one to the U.S. Department of Agriculture (not awarded). • Received a small grant from AARP through the Virginia Food System Council to support FFC efforts. • Developed a vision, mission, and governance document in 7/15 to establish the FFC Steering Committee and its working groups. • Planned for the launch of the FFC in 10/15 to advocate for and promote food system and policy changes to increase the consumption of healthier food and lower the consumption of less nutritious food. **COMPLETED YEAR THREE** • Hired part-time a FFC Project Coordinator funded by the VFHY grant. • Appointed a FFC Chair and Executive Committee. • Increased community involvement in FFC with approximately 190 members, 25 people serving on the FFC Steering Committee, and over 30 individuals actively participating in work groups. • Branded FFC through the creation of a new logo and Facebook page.

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.					
Key Actions	**Timeframe**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.1.B Set priorities for areas of the local food system to examine.	10/14	9/16	Lead: FCHD HE PIT/FFC	KF Grant $14,994 8/14-6/15 AARP Grant $1,000 9/15-9/16	# priorities set by the Fairfax Food Council: 3	**COMPLETED YEAR TWO** • Conducted community food assessments with George Mason University students in the Bailey's Crossroads, Mt. Vernon, and Reston/Herndon communities to understand existing conditions of the food system and identify gaps and barriers to be addressed. • Finalized the 2015 Community Food Assessment (CFA) report. • Identified three priority areas – Food Access, Community Gardens, and Food Literacy/Nutrition Education. **COMPLETED YEAR THREE** • Formed three working groups to develop strategies around food access, community gardens, and food literacy. • Distributed the CFA, developed a one-page summary of the report, and posted them online.
1.1.C Promote food system and policy changes to increase the consumption of healthier foods. *(Added 1/16)*	10/16	9/18	Leads: FCHD, Arcadia Center for Sustainable Food and Agriculture FFC	VFHY $30,000 per year 7/16-6/18 Northern Virginia Health Foundation (NVHF) $75,000 12/16 -12/17	Implementation of activities that promote food system and policy changes: TBD	**NOT STARTED** **PLAN FOR YEAR FOUR** • Empower community leaders to be healthy living advocates. • Hire nutrition coordinator and garden coordinator as part of NVHF grant to support activities in Bailey's Crossroads area. • Provide support, resources, and training to communities where health disparities are evident. • Explore and provide input on existing county zoning regulations as they relate to famers markets and community gardens/urban agriculture.

Healthy Eating

- **Goal 1**: Increase the accessibility and affordability of healthy food.
  - **Objective 1.2**: Increase the amount of healthy food that is donated to pantries.

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Priority Issue: Healthy Eating (HE)						
Goal 1	Increase the accessibility and affordability of healthy food.					
Objective 1.2	Increase the amount of healthy food that is donated to pantries.					
Key Actions	**Timeframe**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.2.A Develop guidelines and recommendations for healthy food donations.	10/13	9/14	Leads: Neighborhood and Community Services (NCS) Community Transformation Grant (CTG) staff, Fairfax County Health Department (FCHD) staff HE Priority Issue Team (PIT)	Centers for Disease Control and Prevention (CDC) CTG $500,000 10/13-9/14 Virginia Department of Health (VDH) Healthy Eating and Active Living (HEAL) Grant $67,410 1/14-9/14 Kaiser Foundation (KF) Grant $14,994 8/14-6/15	Development of guidelines for food pantry donations: 6/14 # guideline brochures printed: 5,000	**COMPLETED YEAR ONE** • Developed and printed the "Guidelines for Food Pantry Donations" brochure, which included information on food insecurity in Fairfax County, the Food Providers Network, and guidelines to consider when donating food to a pantry.

Objective 1.2 Continued	Increase the amount of healthy food that is donated to pantries.					
Key Actions	**Timeframe**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.2.B Promote guidelines and recommendations to local food providers.	6/14	9/17	Lead: FCHD Food Providers Network, HE PIT/Fairfax Food Council (FFC) Food Literacy Workgroup	CDC CTG $500,000 10/13-9/14 VDH HEAL Grant $67,410 1/14-9/14 KF Grant $14,994 8/14-6/15	Promotion of guidelines for food pantry donations: Completed	**COMPLETED YEAR TWO** • Distributed guideline brochures to local food providers, residents, and other interested parties via the Food Providers Network. • Posted the guidelines on the Live Healthy Fairfax website in 11/14. • Distributed a press release about the guidelines in 1/15. • Presented to faith community representatives at the United Methodist Church regional meeting and at Herndon/Reston FISH regarding gardening and support for food pantries. **COMPLETED YEAR THREE** • Developed and conducted a survey of food pantries at St. Vincent de Paul Food Pantry in Chantilly in 9/16. **PLAN FOR YEAR FOUR** • Use data from the food pantry survey to adapt and develop nutrition education resources centered on four topic areas: sugar-sweetened beverages, fruit and vegetable consumption, kid-friendly cooking, and building a healthy plate. • Pilot nutrition education resources along with a Healthy Habits Bag Program where food pantry recipients receive healthy recipes and a bag of groceries with the necessary ingredients.
1.2.C Create and disseminate a listing of food pantries accepting fresh produce. *(Added 1/16)*	10/14	9/16	Lead: HE PIT/FFC	None identified	Dissemination of food pantry listing: Completed	**COMPLETED YEAR TWO** • Developed a listing of food pantries accepting fresh produce and their schedule for deliveries and disseminated it to community gardeners and faith communities with gardens. **COMPLETED YEAR THREE** • Updated the listing of pantries accepting produce and distributed it to gardeners and faith communities.

Healthy Eating

- **Goal 1**: Increase the accessibility and affordability of healthy food.
  - **Objective 1.3**: Establish new community and school gardens in additional locations.

Priority Issue: Healthy Eating (HE)						
Goal 1	Increase the accessibility and affordability of healthy food.					
Objective 1.3	Establish new community and school gardens in additional locations.					
Key Actions	**Timeframe**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.3.A Examine best practices for community gardening.	10/13	9/15	Leads: Neighborhood and Community Services (NCS) Community Transformation Grant (CTG) staff, Fairfax County Health Department (FCHD) staff HE Priority Issue Team (PIT)	Centers for Disease Control and Prevention (CDC) CTG $500,000 10/13-9/14 Virginia Department of Health (VDH) Healthy Eating and Active Living (HEAL) Grant $67,410 1/14-9/14 Kaiser Foundation (KF) Grant $14,994 8/14-6/15	Identification of best practices for community gardening: Completed # partners who received information: 39 Dissemination of food pantry listing to community gardeners: Completed	**COMPLETED YEAR ONE** • Conducted a Community Gardening Faith Gathering for 39 houses of worship in 9/14 at the First Presbyterian Church in Annandale. • Presented best practices for community gardening among faith communities, including remarks by representatives of houses of worship with established gardens; instruction on how to start a garden; and information about how Master Gardeners can assist houses of worship with their gardening efforts. **COMPLETED YEAR TWO** • Met with LINK, Inc., a nonprofit providing emergency food to people in need, in 1/15 to discuss community gardens and donations to food pantries. • Worked with the Food Providers Network to develop a listing of pantries accepting produce donations from community gardens and distributed it to community gardeners.

Objective 1.3 Continued	Establish new community and school gardens in additional locations.					
Key Actions	**Timeframe**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.3.B Identify potential sites for gardens at schools and in the community.	10/13	9/17	Leads: FCHD, Arcadia Center for Sustainable Food and Agriculture, HE PIT/Fairfax Food Council (FFC) Community Gardens Workgroup Fairfax County Public Schools (FCPS), NCS Community Faith Coordination staff, Virginia Cooperative Extension (VCE), Park Authority	VDH HEAL Grant $67,410 1/14-9/14 KF Grant $14,994 8/14-6/15 Northern Virginia Health Foundation (NVHF) $25,000 10/15-9/16 $75,000 12/16-12/17 Virginia Foundation for Healthy Youth (VFHY) $30,000 per year 7/16-6/18	# new sites for school and community gardens: TBD	**COMPLETED YEAR ONE** • Administered a survey in mid-2014 to the faith community which identified houses of worship with gardens and 39 others interested in starting gardens. • Purchased gardening tools for use by FCPS, a fire station, a senior center, and a faith sector community garden tool share program coordinated by the First Presbyterian Church of Annandale. • Provided support for a Salad Science program in 9/14, which taught 15 FCPS teachers and administrators about the Audubon Naturalist Society Green Kids-Salad Science Program. **COMPLETED YEAR TWO** • Presented to faith community representatives at the United Methodist Church regional meeting and at Herndon/Reston FISH regarding gardening and support for food pantries. • Received a planning grant from the NVHF through Arcadia to increase healthy food access in the Bailey's Crossroads area by supporting school gardens, mobile markets, and nutrition education. **COMPLETED YEAR THREE** • Facilitated collaboration between school gardens and the local community to ensure sustainability, focusing on Bailey's Elementary School, Glen Forest Elementary School, and the Bailey's Community Center. • Conducted outreach to houses of worship to develop gardens on their property to be used as an educational tool for teaching gardening and nutrition to the community, as well as a source of fresh food for local pantries.

Objective 1.3 Continued	Establish new community and school gardens in additional locations.					
Key Actions	**Timeframe**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.3.C Establish partnerships to support additional gardening efforts. *(Revised 3/17)*	10/15	9/17	Leads: FFC Community Gardens Workgroup, VCE	VFHY $30,000 per year 7/16-6/18	Establishment of partnerships to support gardening: TBD	**COMPLETED YEAR THREE** • Enlisted help from the VCE Master Gardener program to provide education and volunteer support for establishing and maintaining community gardens. **PLAN FOR YEAR FOUR** • Solicit funds and training resources to facilitate gardens. • Conduct a bimonthly gardening workshop series in cooperation with VCE focusing on edible community gardens.
1.3.D Establish or expand community gardens, targeting areas with the greatest needs. *(Added 3/17)*	10/16	9/17	Lead: FFC Community Gardens Workgroup	VFHY $30,000 per year 7/16-6/18	# new community gardens established: TBD # community gardens expanded: TBD	**NOT STARTED** **PLAN FOR YEAR FOUR** • Distribute small assistance awards to community organizations for the establishment or expansion of community gardens to increase the availability of healthy and affordable food in one of three targeted communities — Bailey's Crossroads/Culmore area, Herndon/Reston, and Mount Vernon.
1.3.E Develop tools and resources to support local gardening efforts. *(Added 3/17)*	10/15	9/17	Lead: FFC Community Gardens Workgroup	VFHY $30,000 per year 7/16-6/18	Development of gardening resources: Completed	**COMPLETED YEAR THREE** • Compiled a Garden Resource Binder for distribution to community garden groups. **PLAN FOR YEAR FOUR** • Create one-page garden resource guide with web links for distribution and posting on the FFC website. • Develop a spiral herb garden model for replication in faith-based community gardens.

Healthy Eating

- **Goal 1**: Increase the accessibility and affordability of healthy food.
  - **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.

Priority Issue: Healthy Eating (HE)						
Goal 1	Increase the accessibility and affordability of healthy food.					
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.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.4.A Identify geographic locations where access to fresh food is limited.	10/13	9/15	Lead: Fairfax County Health Department (FCHD) HE Priority Issue Team (PIT), George Mason University (GMU)	Virginia Department of Health (VDH) Healthy Eating and Active Living (HEAL) Grant $67,410 1/14-9/14 Kaiser Foundation (KF) Grant $14,994 8/14-6/15	# geographic locations identified: 3	**COMPLETED YEAR ONE** • Identified barriers (i.e., location, hours, payment options) to accessing farmers markets in Reston (population 58,504)—an area with a large population of children receiving free and reduced price lunch, and residents receiving Supplemental Nutrition Assistance Program (SNAP) benefits. **COMPLETED YEAR TWO** • Conducted community food assessments with GMU students in the Bailey's Crossroads, Mt. Vernon, and Reston/Herndon communities to understand existing conditions of the food system and identify gaps and barriers to be addressed. • Finalized the 2015 Community Food Assessment report.

Objective 1.4 Continued	Review gaps and opportunities for improving healthy and affordable food options at farmers markets and all other food retail outlets in low income neighborhoods.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.4.B Increase access to affordable farmers markets for low socioeconomic status communities.	10/13	9/16	Leads: FCHD, Arcadia Center for Sustainable Agriculture and Food Systems, Fairfax Food Council (FFC) Food Access Workgroup Neighborhood and Community Services (NCS), Capital Area Food Bank (CAFB), Southgate Community Center (SCC), Fairfax County Park Authority (FCPA), Inova Health System, Healthy Environment and Active Living Priority Issue Team	VDH HEAL Grant $67,410 1/14-9/14 KF Grant $14,994 8/14-6/15 Northern Virginia Health Foundation (NVHF) $25,000 10/15-9/16 Virginia Foundation for Healthy Youth (VFHY) $30,000 per year 7/16-6/18	# families that access SCC Mobile Marketplace: 400 per month on average	**COMPLETED YEAR ONE** • Collaborated with the CAFB and other local entities to provide access to fresh food at the SCC in Reston through the Mobile Marketplace, beginning in 5/14 and continuing monthly. • Conducted extensive marketing and outreach to increase awareness of and attendance at the market (e.g., newsletter, video, postcards in multiple languages). • Expanded SNAP benefit implementation in the Reston/Lake Anne area with the support of FCPA. **COMPLETED YEAR TWO** • Received a planning grant from the NVHF through Arcadia to increase healthy food access in the Bailey's Crossroads area by supporting school gardens, mobile markets, and nutrition education. **COMPLETED YEAR THREE** • Established a mobile market in the Bailey's Crossroads area. • Developed marketing to SNAP recipients with information about SNAP Matching Dollar programs and their locations. • Implemented a Bailey's Mobile Market Family Day to promote SNAP acceptance and provide nutrition education. **PLAN FOR YEAR FOUR** • Develop a survey to assess barriers to SNAP use at farmers markets. • Conduct a pilot program in the Mt. Vernon area to test innovative ways of promoting SNAP use at farmers markets. • Create a brochure that highlights food resources in areas that have the least SNAP redemption at farmers markets. • Collaborate with Inova on a grant opportunity to develop a prescription-type program that can be applied at farmers markets for low-income families to use towards fruits and vegetables.

Objective 1.4 Continued	Review gaps and opportunities for improving healthy and affordable food options at farmers markets and all other food retail outlets in low income neighborhoods.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.4.C Study programs in other jurisdictions that have successfully introduced fresh food products to underserved areas.	10/14	9/17	Leads: FCHD, Arcadia Center for Sustainable Agriculture and Food Systems, HE PIT/FFC Food Access Workgroup	Northern Virginia Health Foundation (NVHF) $25,000 10/15-9/16 Virginia Foundation for Healthy Youth (VFHY) $30,000 per year 7/16-6/18	Review of model programs: Completed	**COMPLETED YEAR TWO** • Reviewed numerous model programs, including programs cited by the Robert Wood Johnson Foundation, Feeding America, and the Chesapeake Food Network. **COMPLETED YEAR THREE** • Attended a regional Council of Governments meeting and met staff from other local food councils. • Planned for the first FFC Summit to showcase innovative projects from across the country to increase access to healthy foods. • Contacted Dr. Nimali Fernando, founder of the Dr. Yum Project, and Rodney Taylor, Director of the Food and Nutrition Services for Fairfax County Public Schools, to discuss their groundbreaking work related to food equity and health at the FFC Summit. **PLAN FOR YEAR FOUR** • Hold the FFC Summit in 10/16 featuring a screening of the film "Food Frontiers" produced by Leo Horrigan of the Johns Hopkins Center for a Livable Future. • Attend Metropolitan Council of Government (COG) meetings to network with other local food councils and explore opportunities for growth and development. • Hold a spring FFC meeting in 5/17 focused on the Farm Bill and its effect on food assistance programs.
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.	10/16	9/17	Lead: FFC Food Access Workgroup	None identified	# of chambers of commerce reached: 0	**NOT STARTED** **PLAN FOR YEAR FOUR** • Present to the Asian Chamber of Commerce to garner support and discuss healthy food promotion in native languages and ethnic communities.

Objective 1.4 Continued	Review gaps and opportunities for improving healthy and affordable food options at farmers markets and all other food retail outlets in low income neighborhoods.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.4.E Work with ethnic and international grocery stores to accept SNAP benefits. *(Added 1/16)*	10/16	9/17	Leads: FCHD, FFC Food Access Workgroup	VFHY $30,000 per year 7/16-6/18	# stores newly accepting SNAP benefits: TBD	**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.

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Priority Issue: Healthy Eating (HE)						
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 Schools' Food and Nutrition Services setting.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
2.1.A Review and revise school wellness policies and procedures for activities during the instructional day.	10/16	9/18	Lead: Fairfax Food Council (FFC)	None identified	# school policies revised: TBD	**NOT STARTED**
2.1.B Establish a community taskforce to examine nutrition in schools outside of school meals provided by Food and Nutrition Services.	10/16	9/18	Lead: FFC Food for Others, Britepaths, Fairfax County Public Schools (FCPS)	None identified	Establishment of community taskforce to examine nutrition in schools: TBD	**NOT STARTED** **PLAN FOR YEAR FOUR** • Convene a meeting of nonprofits in partnership with FCPS regarding weekend provision of supplemental food assistance. • Develop a taskforce to examine school nonprofit food assistance programs for areas lacking coverage and opportunities for collaboration.
2.1.C Establish, communicate, and implement guidelines and recommendations.	10/16	9/18	Lead: FFC Food for Others, Britepaths, FCPS	None identified	Revision of supplemental food guidelines: TBD	**NOT STARTED** **PLAN FOR YEAR FOUR** • Review and revise best practices on weekend provision of supplemental food assistance with nonprofits and faith-based organizations.

Healthy Eating

- **Goal 2:** Increase the number of environments that promote healthy food choices and educational resources.
  - **Objective: 2.2**: Increase the number of faith communities that adopt healthy eating guidelines.

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Priority Issue: Healthy Eating (HE)						
Goal 2	Increase the number of environments that promote healthy food choices and educational resources.					
Objective 2.2	Increase the number of faith communities that adopt healthy eating guidelines.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
2.2.A Develop guidelines and identify best practices for healthy eating at faith community events and programs.	10/13	9/14	Leads: Neighborhood and Community Services (NCS) Community Transformation Grant (CTG) staff, Fairfax County Health Department (FCHD) staff HE Priority Issue Team (PIT)	Centers for Disease Control and Prevention (CDC) CTG $500,000 10/13-9/14 Virginia Department of Health (VDH) Healthy Eating and Active Living (HEAL) Grant $67,410 1/14-9/14	Identification of best practices for healthy eating at faith community events: Completed	**COMPLETED YEAR ONE** • Identified resources for faith communities that provide guidance on healthy eating and active living programs, practices, and policies that have been established by faith communities in the U.S.; and recipes for healthy food for large groups.
2.2.B Develop culturally and linguistically appropriate educational materials.	10/13	9/14	Leads: NCS CTG staff, FCHD staff HE PIT	CDC CTG $500,000 10/13-9/14 VDH HEAL Grant $67,410 1/14-9/14	Identification of culturally and linguistically appropriate educational materials: Completed	**COMPLETED YEAR ONE** • Identified culturally and linguistically appropriate resources for faith communities, such culturally diverse recipes and Body & Soul – a wellness program designed for African-American churches.

Objective 2.2 Continued	Increase the number of faith communities that adopt healthy eating guidelines.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
2.2.C Provide and promote the use of healthy eating resources to faith communities.	10/13	9/14	Leads: NCS CTG staff, FCHD staff HE PIT	CDC CTG $500,000 10/13-9/14 VDH HEAL Grant $67,410 1/14-9/14	Creation of an online resource for faith communities: Completed	**COMPLETED YEAR ONE** • Created a "Healthy Eating & Faith Communities" web page providing guidance on healthy eating and active living programs, practices, and policies that have been established by faith communities in the U.S.; and recipes for healthy food for large groups. • Presented best practices for community gardening among faith communities, including remarks by representatives of houses of worship with established gardens; instruction on how to start a garden; and information about how Master Gardeners can assist houses of worship with their gardening efforts.

Healthy Eating

- **Goal 2:** Increase the number of environments that promote healthy food choices and educational resources.
  - **Objective 2.3**: Increase the number of family child care providers and child care centers participating in the Child and Adult Care Food Program.

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Priority Issue: Healthy Eating (HE)						
Goal 2	Increase the number of environments that promote healthy food choices and educational resources.					
Objective 2.3	Increase the number of family child care providers and child care centers participating in the Child and Adult Care Food Program.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
2.3.A Develop culturally and linguistically appropriate materials to promote joining the Child and Adult Care Food Program.	10/13	9/14	Leads: Neighborhood and Community Services (NCS) Community Transformation Grant (CTG) staff, Department of Family Services (DFS) Office for Children (OFC) staff	Centers for Disease Control and Prevention (CDC) CTG $500,000 10/13-9/14	Development of culturally and linguistically appropriate materials to promote joining the Child and Adult Care Food Program (CACFP): Completed	**COMPLETED YEAR ONE** • Developed educational materials to help providers understand the process and requirements for obtaining a provider permit. • Developed print materials in English and Spanish (i.e., posters, factsheets, brochures) educating families about the value of choosing a child care provider with a permit and the benefits that providers receive when enrolling in the CACFP. • Developed the *Eat and Run* handbook, which was used as an incentive for permitted or licensed childcare providers that enrolled in the CACFP.
2.3.B Educate providers and families about the benefits of the Child and Adult Care Food Program.	10/13	9/15	Leads: NCS CTG staff, DFS OFC staff	CDC CTG $500,000 10/13-9/14	# workshops held: 12 # providers reached: 411 # providers in CACFP: Increased from 706 to 802	**COMPLETED YEAR ONE** • Held workshops focused on recruitment and retention of family childcare providers enrolled in CACFP. • Distributed educational materials at DFS regional offices; Skill Source Centers; Health Department sites; Women, Infants, and Children program offices; and public libraries. **COMPLETED YEAR TWO** • Conducted additional workshops.

Healthy Eating

- **Goal 2:** Increase the number of environments that promote healthy food choices and educational resources.
  - **Objective 2.4**: Promote healthy eating resources in the business community.

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Priority Issue: Healthy Eating (HE)						
Goal 2	Increase the number of environments that promote healthy food choices and educational resources.					
Objective 2.4	Promote healthy eating resources in the business community.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
2.4.A Examine best practices around healthy eating in the local business community.	10/17	9/18	Lead: Fairfax Food Council (FFC)	None identified	Identification of best practices for healthy eating in the workplace: TBD	**NOT STARTED**
2.4.B Develop guidelines that identify opportunities for businesses to improve nutrition in the work environment.	10/17	9/18	Lead: FFC	None identified	Development of guidelines for healthy eating in the workplace: TBD	**NOT STARTED**
2.4.C Promote and disseminate guidelines to local businesses.	10/17	9/18	Lead: FFC	None identified	# employers reached: TBD	**NOT STARTED**

Healthy Eating

- **Goal 2:** Increase the number of environments that promote healthy food choices and educational resources.
  - **Objective 2.5**: Promote nutrition as a part of standard health care.

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Priority Issue: Healthy Eating (HE)						
Goal 2	Increase the number of environments that promote healthy food choices and educational resources.					
Objective 2.5	Promote nutrition as a part of standard health care.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
2.5.A Examine best practices for nutrition screening and counseling for primary care doctors and compile recommendations.	10/16	9/17	Lead: Department of Family Services Office for Children (DFS OFC) Head Start and Early Head Start Fairfax Food Council (FFC); Fairfax County Health Department (FCHD) Maternal Child Health Services (MCH)	None identified	Identification of best practices for food insecurity screening: Completed	**COMPLETED YEAR THREE** • Hosted a food insecurity panel discussion, which highlighted screening for food insecurity in a medical setting. • Applied for and received award notification for a grant to pilot a project focused on addressing food insecurity in a pediatric clinical setting. • Used *Addressing Food Insecurity: A Toolkit for Pediatricians,* developed by American Academy of Pediatricians (APA) and the Food Research & Action Center, to develop best practice models for the pilot project.
2.5.B Identify community resources and tools that medical practices can use for referral sources.	10/16	9/18	Lead: DFS OFC FFC; FCHD MCH; Burke Pediatrics	University of California, Los Angeles, Johnson & Johnson Community Health Improvement Project Award $1000 12/16 – 12/17	Development of community resources and tools for medical practices: TBD	**NOT STARTED** **PLAN FOR YEAR FOUR** • Create a food insecurity assessment tool to be piloted in a pediatric practice. • Produce a nutrition resources parent education pamphlet to be used by pediatric offices with clients. • Develop a food insecurity assessment tool to be used by FCHD MCH nurses. • Make a food access guide to be used by MCH nurses with clients identified as food insecure. • Pilot the assessment tools and resources.

Objective 2.5 Continued	Promote nutrition as a part of standard health care.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
2.5.C Promote awareness of recommendations, tools, and resources.	10/17	9/18	Lead: DFS OFC FFC; FCHD MCH	University of California, Los Angeles, Johnson & Johnson Community Health Improvement Project Award $1000 12/16 – 12/17	Distribution of assessment tools and resources: TBD	**NOT STARTED** **PLAN FOR YEAR FIVE** • Analyze data from the pilot program and make recommendations for improvement and replication. • Share recommendations, assessment tools and materials with other medical practices in Fairfax County.

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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.

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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.

Priority Issue: Tobacco-Free Living (TFL)						
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.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.1.A Contact neighboring jurisdictions to determine best practices for a smoke-free campaign for public parks.	10/13	9/14	Lead: Sara Baldwin, Fairfax County Park Authority (FCPA) TFL Priority Issue Team (PIT)	Centers for Disease Control and Prevention (CDC) Community Transformation Grant (CTG) $15,000 10/13-9/14	Identification of best practices: Completed	**COMPLETED YEAR ONE** • Conducted extensive research related to implementation of smoke-free park best practices from other jurisdictions.
1.1.B Educate policymakers and decision makers on the benefits of tobacco-free living environments.	10/13	9/14	Lead: Sara Baldwin, FCPA TFL PIT	CDC CTG $15,000 10/13-9/14	Presentation on the benefits of tobacco-free living environments: Completed	**COMPLETED YEAR ONE** • Presented a policy proposal for "Tobacco-Free Play Zones" to the Park Friends, Fairfax County Athletic Council, and Park Authority Board in 3/14.

Objective 1.1 Continued	Increase access to smoke-free parks and outdoor recreational environments.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
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."	10/13	9/14	Lead: Sara Baldwin, FCPA Sandy Evans, Fairfax County Public Schools (FCPS) School Board; Chris Leonard, Neighborhood and Community Services (NCS); TFL PIT	CDC CTG $15,000 10/13-9/14	Adoption of policy to implement tobacco-free play zones by Park Authority Board: Completed # locations where signs were posted at playgrounds, athletic fields, and skate parks: 485	**COMPLETED YEAR ONE** • Received unanimous approval of the "Tobacco-Free Play Zones" policy proposal by the Park Authority Board in 4/14. • Unveiled the tobacco-free signage in a joint ceremony in 9/14, which included the installation of "Tobacco-Free Play Zone" signs in areas of parks frequented by children such as playgrounds, athletic fields, and skate parks.
1.1.D Expand posting of signs for all other public park amenities, such as picnic shelters, marinas, golf courses, and trails.	10/13	9/17	Lead: Sara Pappa, Regional Tobacco Control Coordinator, Fairfax County Health Department (FCHD) Sara Baldwin, FCPA; Sandy Evans, FCPS School Board; Chris Leonard, NCS; TFL PIT	CDC CTG $15,000 10/13-9/14 Virginia Department of Health (VDH) Tobacco Use Control Project (TUCP) $88,000 4/15-3/18	# locations where signs were posted at other public park amenities: 22 NCS athletic fields/courts and playgrounds, and 825 FCPS athletic fields and playgrounds # signs posted at other public park amenities: 255	**COMPLETED YEAR ONE** • Implemented a complementary "Tobacco-Free Play Zone" policy for NCS playgrounds and athletic fields in 9/14. • The FCPS Board adopted the "Tobacco-Free Play Zone" policy in 9/14 for all school properties as recommended by the School Health Advisory Committee. **COMPLETED YEAR TWO** • Expanded tobacco-free signage to tennis courts, basketball courts, volleyball courts, amphitheaters, and marinas. **COMPLETED YEAR THREE** • Expanded tobacco-free signage to other public park amenities, such as golf courses, trails, Frisbee golf courses, picnic shelters, amusements (trains, carousels), and outdoor fitness areas. • Reached out to the Northern Virginia Regional Park Authority to discuss using the tobacco-free signage in their parks. **PLAN FOR YEAR FOUR** • Promote tobacco-free policies and signage at farmers markets, universities, and community centers.

Objective 1.1 Continued	Increase access to smoke-free parks and outdoor recreational environments.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.1.E Form a coalition of Northern Virginia jurisdictions to develop a consensus for consistent tobacco-free living efforts across the region.	4/15	3/18	Lead: Sara Pappa, Regional Tobacco Control Coordinator, FCHD TFL PIT	VDH TUCP $88,000 4/15-3/18	Establishment of a Northern Virginia Tobacco-Free Coalition: TBD	**COMPLETED YEAR TWO** • Awarded VDH TUCP grant for a dedicated staff position at the FCHD to support tobacco control efforts for the Northern Virginia Health Region, and hired the Regional Tobacco Control Coordinator in 9/15. **COMPLETED YEAR THREE** • Presented on tobacco-free play zone initiatives at the Virginia Foundation for Healthy Youth conference. • Worked with the Community Health Care Network to increase the use of the Quit Line fax referral form. • Convened stakeholders to discuss tobacco-free areas and cessation programs, and to explore how the Medical Reserve Corps (MRC) could assist with efforts. **PLAN FOR YEAR FOUR** • Collaborate with the American Heart Association to work on tobacco-use prevention and cessation activities. • Provide giveaways and educational items to county community centers for countywide Kick Butts Day events for teens. • Work with the Virginia Department of Health to promote the Quit Line fax referral form at regional addiction treatment trainings for behavioral health care providers. • Convene a Northern Virginia Regional Tobacco Use Control and Prevention meeting in 5/17 to establish a regional coalition to work on multi-sector strategies for the reduction of secondhand smoke exposure and tobacco use. • Partner with the Truth Initiative Campaign on youth tobacco-use prevention and cessation activities. • Provide programmatic support and technical assistance with tobacco control and prevention activities and events, such as cessation services; VA Quit Line training and resources; and tobacco-free policies at local schools, colleges and universities, worksites, places of worship, parks and recreational facilities, healthcare facilities, and multi-unit housing complexes. • Collaborate with the Community Services Board on the delivery of evidence-based cessation services. • Leverage MRC volunteers for tobacco-free living activities.

Objective 1.1 Continued	Increase access to smoke-free parks and outdoor recreational environments.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.1.E (Continued) Form a coalition of Northern Virginia jurisdictions to develop a consensus for consistent tobacco-free living efforts across the region.	4/15	3/18	Lead: Sara Pappa, Regional Tobacco Control Coordinator, FCHD TFL PIT	VDH TUCP $88,000 4/15-3/18	Establishment of a Northern Virginia Tobacco-Free Coalition: TBD	**PLAN FOR YEAR FOUR (Continued)** • Coordinate with VDH and other regional tobacco control coordinators across the state. • Promote the Virginia Quit Line and enroll clinics and other healthcare providers in the Quit Line fax referral program. • Participate in activities related to Kick Butts Day, Quit Day, and the Great American Smoke-out.

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 1.2**: Increase the number of smoke-free policies that are voluntarily implemented by multi-unit housing neighborhoods.

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Priority Issue: Tobacco-Free Living (TFL)						
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 1.2	Increase the number of smoke-free policies that are voluntarily implemented by multi-unit housing neighborhoods.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.2.A Invite property management, housing, and insurance stakeholders to discuss smoke-free housing.	4/15	3/18	Lead: Sara Pappa, Regional Tobacco Control Coordinator, Fairfax County Health Department (FCHD) Toni Clemons-Porter, Associate Director, Senior Housing and Assisted Living, Housing and Community Development (HCD); TFL Priority Issue Team (PIT)	Virginia Department of Health (VDH) Tobacco Use Control Project (TUCP) $88,000 4/15-3/18	Discussions on smoke-free housing: TBD	**COMPLETED YEAR TWO** • Conducted initial research and discussion with HCD regarding smoke-free policies for senior housing residences. • Awarded VDH TUCP grant for a dedicated staff position at the FCHD to support tobacco control efforts for the Northern Virginia Health Region, and hired the Regional Tobacco Control Coordinator in 9/15. **COMPLETED YEAR THREE** • Provided technical assistance and support to HCD for expanded smoke-free housing initiatives. **PLAN FOR YEAR FOUR** • Establish a regional tobacco-free coalition to work on multi-sector strategies for the reduction of secondhand smoke exposure and tobacco use in multi-unit housing and at worksites, and the support of the Quit Now Virginia quit line service. • Monitor the status of proposed and passed U.S. Department of Housing and Urban Development smoke-free housing regulations.

Objective 1.2 Continued	Increase the number of smoke-free policies that are voluntarily implemented by multi-unit housing neighborhoods.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.2.B Identify smoke-free housing champions and provide education on its benefits.	10/15	9/16	Lead: Sara Pappa, Regional Tobacco Control Coordinator, FCHD Toni Clemons-Porter, Associate Director, Senior Housing and Assisted Living, HCD; TFL PIT	VDH TUCP $88,000 4/15-3/18	# champions identified: 1 Education on benefits of smoke-free housing: Completed	**COMPLETED YEAR TWO** • Created an educational toolkit for residents of multi-unit housing regarding the hazards of smoking, secondhand smoke, and the importance of smoke-free policies. **COMPLETED YEAR THREE** • Engaged residents in the creation of smoke-free policies by conducting surveys and gathering input. • Selected champions to encourage the acceptance and implementation of the new smoke-free policies among residents. • Initiated private-sector smoke-free housing coalition building. • Provided information to local housing groups to support implementation of smoke-free housing throughout HCD communities.
1.2.C Conduct an initial survey of residents in multiple housing communities to identify smoking prevalence and support for smoke-free initiatives.	1/15	9/17	Lead: Sara Pappa, Regional Tobacco Control Coordinator, FCHD Toni Clemons-Porter, Associate Director, Senior Housing and Assisted Living, HCD; TFL PIT	VDH TUCP $88,000 4/15-3/18	Administration of resident surveys: Completed	**COMPLETED YEAR TWO** • Conducted initial research via survey in four HCD communities planned to participate in the smoke-free policy pilot program. **COMPLETED YEAR THREE** • Analyzed survey data taking into consideration health risk factor data and chronic disease rates. • Identified vulnerable populations at risk for poor health outcomes in order to create targeted messaging. **PLAN FOR YEAR FOUR** • Provide support and technical assistance to public and private housing groups, including cessation resources.

Objective 1.2 Continued	Increase the number of smoke-free policies that are voluntarily implemented by multi-unit housing neighborhoods.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.2.D Conduct residential community forums to discuss smoke-free initiatives and implementation considerations needed for success.	1/15	9/17	Lead: Sara Pappa, Regional Tobacco Control Coordinator, FCHD Toni Clemons-Porter, Associate Director, Senior Housing and Assisted Living, HCD; TFL PIT	VDH TUCP $88,000 4/15-3/18	# residential community forums conducted to discuss smoke-free initiatives: TBD	**COMPLETED YEAR TWO** • Conducted forums in the HCD pilot program sites. **COMPLETED YEAR THREE** • Support private-sector initiatives to conduct residential community forums on smoke-free housing. **PLAN FOR YEAR FOUR** • Conduct forums in other HCD communities to ascertain resident concerns about the new smoke-free policy that may impact compliance and address concerns. • Support private-sector initiatives to conduct residential community forums on smoke-free housing.
1.2.E Create a community pilot program for a model “clean air” apartment or condominium agreement.	10/14	9/17	Lead: Sara Pappa, Regional Tobacco Control Coordinator, FCHD Toni Clemons-Porter, Associate Director, Senior Housing and Assisted Living, HCD; TFL PIT	VDH TUCP $88,000 4/15-3/18	Creation of a pilot smoke-free policy: TBD	**COMPLETED YEAR TWO** • 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. **COMPLETED YEAR THREE** • Provided technical assistance and support to HCD for the expansion of the smoke-free housing program to all HCD communities. • Identified model lease addendum language for various communities to fit property management needs. **PLAN FOR YEAR FOUR** • Partner with the Fairfax County Housing Authority to support tobacco-free multi-unit public and private housing.

Objective 1.2 Continued	Increase the number of smoke-free policies that are voluntarily implemented by multi-unit housing neighborhoods.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.2.F Design a "no tobacco use" education campaign for multi-family housing providers to include posters and signage in multiple languages.	1/15	9/17	Lead: Sara Pappa, Regional Tobacco Control Coordinator, FCHD Toni Clemons-Porter, Associate Director, Senior Housing and Assisted Living, HCD; TFL PIT	VDH TUCP $88,000 4/15-3/18	Development of a "No Tobacco Use" education campaign: TBD	**COMPLETED YEAR TWO** • Hung smoke-free policy signs in the HCD pilot residential areas. • Created an educational toolkit for residents in HCD pilot communities regarding the hazards of smoking, secondhand smoke, and the importance of smoke-free policies. **COMPLETED YEAR THREE** • Began work on a tailored toolkit for residents based on survey results in preparation for the expansion of the smoke-free policy, and translated it into multiple languages. **PLAN FOR YEAR FOUR** • Finalize a tailored toolkit for residents based on survey results in preparation for the expansion of the smoke-free policy and translate it into multiple languages. • Partner with the Fairfax County Housing Authority to support tobacco-free multi-unit public and private housing.

Health Workforce

Health Workforce

- **Goal 1**: Have a health care workforce that is responsive to the health care needs of a diverse population.

Health Workforce

- **Goal 1**: Have a health care workforce that is responsive to the health care needs of a diverse population.
  - **Objective 1.1 (New)**: 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.

Priority Issue: Health Workforce (HW)						
Goal 1	Have a health care workforce that is responsive to the health care needs of a diverse population.					
Objective 1.1 (New)	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. *[Replaced Objective 1.1 (Original) 12/13]*					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.1.A Engage key stakeholders to define criteria for and identify specific communities of need that will be targeted.	10/13	9/14	Lead: HW Priority Issue Team (PIT)	Centers for Disease Control and Prevention (CDC) Community Transformation Grant (CTG) $30,000 10/13-9/14	Identification of communities in need: Completed	**COMPLETED YEAR ONE** • Identified communities in greatest need considering race, ethnicity, income and poverty levels, incidence of chronic disease, access to care, and the community needs index.
1.1.B Identify and establish a partnership among organizations in the Fairfax community to coordinate and deliver the Chronic Disease Self-Management Program (CDSMP).	10/13	9/14	Lead: HW PIT	CDC CTG $30,000 10/13-9/14	Identification of key partners: Completed	**COMPLETED YEAR ONE** • Selected, interviewed, and consulted with key stakeholders to identify strengths and needs for the delivery of the CDSMP. • Incorporated partner input and feedback into the model that was developed for CDSMP. • Delivered the CDSMP model to the Fairfax County Health Department (FCHD) Community Health Outreach (CHO) for implementation.

Objective 1.1 (New) Continued	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.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
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.	10/13	9/14	Lead: HW PIT	CDC CTG $30,000 10/13-9/14	Development of CDSMP model: Completed	**COMPLETED YEAR ONE** • Developed a framework for CDSMP which identified the roles and functions necessary to sustain and expand the program.
1.1.D Develop consistent messaging to market the benefit of CDSMP participation to health care providers, community-based organizations, and community members.	10/13	9/14	Lead: HW PIT	CDC CTG $30,000 10/13-9/14	Development of marketing to healthcare providers: Completed	**COMPLETED YEAR ONE** • Prepared a half-hour webinar to educate healthcare providers who treat patients with chronic disease about CDSMP.

Objective 1.1 (New) Continued	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.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.1.E Implement quality assurance efforts in the implementation of the CDSMP.	10/13	9/15	Lead: HW PIT FCHD CHO	CDC CTG $30,000 10/13-9/14	Identification of evidence-based model: Completed Implementation of an evaluation plan: Completed	**COMPLETED YEAR ONE** • Identified the Stanford CDSMP program as the evidence-based program for continued use. • Developed a CDSMP Study Site Evaluation Plan Concept for monitoring the process and measuring outcomes of implementation. **COMPLETED YEAR TWO** • Developed and implemented instruments to conduct a pre-test and post-tests immediately following and at periodic intervals after the training 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.F Educate the public and policymakers about the importance of institutionalizing or embedding the CDSMP program into their existing initiatives.	1/14	9/14	Lead: HW PIT	CDC CTG $30,000 10/13-9/14	Development of CDSMP model: Completed	**COMPLETED YEAR ONE** • Developed a framework for CDSMP which identified the roles and functions necessary to sustain and expand the program.
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.	4/14	9/14	Lead: HW PIT	CDC CTG $30,000 10/13-9/14	Development of marketing to healthcare providers: Completed	**COMPLETED YEAR ONE** • Developed a framework for CDSMP which identified the roles and functions necessary to sustain and expand the program. • Prepared a half-hour webinar to educate healthcare providers who treat patients with chronic disease about the value of CDSMP.

Health Workforce

- **Goal 1**: Have a health care workforce that is responsive to the health care needs of a diverse population.
  - **Objective 1.1 (Original)**: Increase the number of trained chronic disease self-management facilitators in community-based organizations who employ best practices for chronic disease prevention and self-management.

Priority Issue: Health Workforce (HW)						
Goal 1	Have a health care workforce that is responsive to the health care needs of a diverse population.					
Objective 1.1 (Original)	Increase the number of trained chronic disease self-management facilitators in community-based organizations who employ best practices for chronic disease prevention and self-management. *[Replaced with Objective 1.1 (New) 12/13]*					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.1.A Identify and train master trainers to facilitate train-the-trainer sessions for chronic disease self-management programs (CDSMP) in communities of need throughout the Fairfax community.	10/13	9/15	Lead: Neighborhood and Community Services HW Priority Issue Team (PIT), Department of Family Services (DFS) Area Agency on Aging (AAA), Fairfax County Health Department (FCHD) Community Health Outreach (CHO)	Centers for Disease Control and Prevention (CDC) Community Transformation Grant (CTG) $30,000 10/13-9/14 Virginia Department of Health (VDH) funding to AAA	# CDSMP leaders trained by master trainers: 215	**COMPLETED YEAR ONE** • Identified the necessary system-level changes to support the long-term sustainability of CDSMP. • Developed a model that identified the roles and functions necessary to expand the program to successfully reach high-risk populations in the Fairfax community. **COMPLETED YEAR TWO** • Expanded the availability of CDSMP for targeted communities. DFS AAA continues to provide CDSMP to seniors and adults with disabilities, while FCHD CHO is targeting specific ethnic or minority communities.

Objective 1.1 (Original) Continued	Increase the number of trained chronic disease self-management facilitators in community-based organizations who employ best practices for chronic disease prevention and self-management.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.1.B Identify organizations and community health workers working with communities of need willing to offer chronic disease self-management programs.	10/13	9/15	Lead: HW PIT DFS AAA, FCHD CHO	VDH funding to AAA	# individuals completing CDSMP: 523 (over a 4-year period) # CDSMP workshops: 53 (over a 4-year period)	**COMPLETED YEAR ONE** • Identified communities in greatest need considering race, ethnicity, income and poverty levels, incidence of chronic disease, access to care, and the community needs index. **COMPLETED YEAR TWO** • Identified organizations and community health workers working with communities of need willing to offer CDSMP.
1.1.C Develop a structure for providing, tracking, and evaluating outcomes of chronic disease self-management trainings.	10/13	9/15	Lead: HW PIT DFS AAA, FCHD CHO	None identified	Development of structure for providing, tracking, and evaluating outcomes of CDSMP: Completed	**COMPLETED YEAR ONE** • Developed a CDSMP Study Site Evaluation Plan Concept for monitoring the process and measuring outcomes of a workshop series at a local clinic. **COMPLETED YEAR TWO** • Developed and implemented instruments to conduct a pre-test and post-tests immediately following and at periodic intervals after the training to learn if behavioral changes were initiated and maintained.
1.1.D Analyze outcomes on an ongoing basis and add to the evidence base on CDSMP.	10/13	9/15	Lead: HW PIT DFS AAA, FCHD CHO	None identified	Analysis of CDSMP performance measures: Completed	**COMPLETED YEAR TWO** • Developed a Results-Based Accountability plan for FCHD CHO that includes annual analysis of performance measures for CDSMP.

Health Workforce

- **Goal 1**: Have a health care workforce that is responsive to the health care needs of a diverse population.
  - **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.

Priority Issue: Health Workforce (HW)						
Goal 1	Have a health care workforce that is responsive to the health care needs of a diverse population.					
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.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.2.A Identify key partners and leverage national, state, and local resources to develop the survey.	10/13	9/14	Lead: HW Priority Issue Team (PIT)	Anonymous donor $7,500 1/14-6/14 Diversity and Research in Action Consortium (DRAC) at George Mason University (GMU) $5,500 8/14	# of key partners identified: 6	**COMPLETED YEAR ONE** • Developed, pilot-tested, and revised the survey instrument to examine health care organization awareness and implementation of the CLAS standards 3, 4, and 7 that address workforce composition, cultural competency, and language access.
1.2.B Administer the survey to health care employers.	7/14	12/14	Lead: HW PIT	Anonymous donor $7,500 1/14-6/14 DRAC at GMU $5,500 8/14	# of surveys completed: 67	**COMPLETED YEAR TWO** • Administered the CLAS survey to health care providers and employers.

Objective 1.2 Continued	Conduct a baseline survey for health care employers to determine awareness and implementation of the CLAS Standards that address workforce composition, cultural competency, and language access.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.2.C Analyze and disseminate the survey results.	12/14	9/16	Lead: HW PIT	Anonymous donor $7,500 1/14-6/14 DRAC at GMU $5,500 8/14	Analysis of the CLAS survey results: Completed Dissemination of survey results: Completed	**COMPLETED YEAR TWO** • Analyzed survey results and completed the final report in 3/15. • Used the findings to recruit additional HW PIT members and engage key audiences in advancing the work. **COMPLETED YEAR THREE** • Shared and discussed the CLAS survey findings at Partnership for a Healthier Fairfax community coalition meetings. • Utilized the findings of the survey to inform Story Sharing project development.

Health Workforce

- **Goal 1**: Have a health care workforce that is responsive to the health care needs of a diverse population.
  - **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.

Priority Issue: Health Workforce Goal (HW)						
Goal 1	Have a health care workforce that is responsive to the health care needs of a diverse population.					
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.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.3.A Key actions will focus on collaboration and coordination to be determined based on survey results.	1/15	9/15	Lead: HW Priority Issue Team (PIT)	None identified	Development of work plan: Completed	**COMPLETED YEAR TWO** • Developed a plan with new key actions based on the results of the CLAS survey, which identified a lack of awareness of: (1) the impact of failing to provide culturally and linguistically appropriate services, (2) the need to engage all parties in the discussion of ways to provide such services, (3) the need to empower all parties, and (4) the need to better support workforce development. • Targeted key actions based on an assessment of the team's capacity as a volunteer community group.
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. *(Added 1/15)*	1/15	9/15	Lead: HW PIT	None identified	Development of framework: Completed	**COMPLETED YEAR TWO** • Identified four key audiences: patients/community, providers/project managers, educators, and policymakers. • Identified four key issues: health equity, language access, cultural competency education, and health workforce composition.

Objective 1.3 Continued	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.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.3.C Identify champions across sectors, disciplines, and organizations to identify and recruit story sharers from a range of populations represented in Fairfax County. *(Added 1/15; Revised 3/17)*	1/15	9/17	Lead: HW PIT Patricia Garcia, Fairfax County Health Department (FCHD) Community Health Outreach (CHO) Manager	None identified	Number of patient story sharers recruited: 12 Number of provider story sharers recruited: TBD	**COMPLETED YEAR TWO** • Recruited new members with a particular emphasis on those with an interest in the story sharing initiative. **COMPLETED YEAR THREE** • Presented an overview of the story sharing project to the Multicultural Advisory Council in 2/16. • Assembled a brainstorming session in 8/16 with community leaders to develop recruitment strategies targeting patient and provider communities, educators, and professional organizations. • Began recruitment of story sharers using outreach and engagement specialists, and community-based partners and organizations. **PLAN FOR YEAR FOUR** • Recruit patients and providers for the Story Sharing Project.
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. *(Added 1/15)*	1/15	9/17	Lead: HW PIT; Sara Pappa, Partnership Manager Patricia Garcia, FCHD CHO Manager; Center for Digital Storytelling	Virginia Adult Learning Resource Center Kaiser Foundation $3,100 1/17-3/17 Literacy Council of Northern Virginia $1,500 1/17-3/17 FCHD Community Health Development and Preparedness	Number of digital stories produced: TBD	**COMPLETED YEAR TWO** • Identified story sharing groups, focus areas, key audiences, and desired outcomes. • Researched story sharing models and potential vendors. **COMPLETED YEAR THREE** • Conducted a Digital Story Sharing Workshop with the Virginia Adult Learning Resource Center in 1/16. • Developed a project proposal, selected a vendor, and contracted with them for the story sharing initiative. • Conducted a training webinar with the team to engage stakeholders and community leaders, and recruit participants in 8/16. **PLAN FOR YEAR FOUR** • Apply for grants to develop and implement the digital Story Sharing Project. • Implement a story sharing workshop to collect 8 stories from diverse patient/community members about accessing health care. • Conduct a second story sharing workshop to collect stories from providers about their experiences serving diverse patients.

Objective 1.3 Continued	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.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.3.E Develop an online, interactive portal for outreach, education, advocacy and resource sharing regarding adherence to CLAS Standards 3, 4, and 7. *(Added 1/15)*	1/15	9/17	Lead: HW PIT	None	Launch of an online interactive portal: TBD	**COMPLETED YEAR TWO** • Submitted a letter of intent to apply for funding of an online resource clearinghouse to the Northern Virginia Health Foundation (not awarded). **PLAN FOR YEAR FOUR** • Create an online portal for story sharing to increase need awareness and the impact of providing CLAS, and put human faces to the legal requirements and policy mandates facing our health workforce. • Launch the online portal, including stories, educational resources, and links.
1.3.F Create an awareness campaign, leveraging partners to disseminate information about the survey results and activities, to address areas for improvement. *(Added 1/15)*	10/15	9/18	Lead: HW PIT	None	Creation of an awareness campaign: TBD	**COMPLETED YEAR THREE** • Shared and discussed the CLAS survey findings at Partnership for a Healthier Fairfax community coalition meetings. • Added a description of the Story Sharing Project to the Live Healthy Fairfax Health Workforce webpage. **PLAN FOR YEAR FOUR** • Post the digital stories on the Live Healthy Fairfax Health Workforce website with links to available resources. • Plan an additional story sharing workshop for healthcare providers.

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.

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.

Priority Issue: Access to Health Services (Access)						
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.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
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.	10/13	9/14	Lead: Northern Virginia Marketplace Consortium Jesse Ellis, Neighborhood and Community Services (NCS); Access Priority Issue Team (PIT)	Northern Virginia Family Service (NVFS), Northern Virginia Health Foundation (NVHF), Consumer Health Foundation (CHF), Virginia Consumer Voices for Healthcare (VCVH), Cafritz Foundation (CF), Meyer Foundation (MF), US Centers for Medicare and Medicaid Services (CMMS)	# public outreach events: 88 # individuals educated: 2,000+	**COMPLETED YEAR ONE** • NVFS 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 efforts. • Coordinated 88 public outreach events, educating over 2,000 individuals about health insurance coverage.

Objective 1.1 Continued	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.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
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.	10/13	9/14	Lead: Northern Virginia Marketplace Consortium Jesse Ellis, NCS; Access PIT	NVFS, NVHF, CHF, VCVH, CF, MF, CMMS	# households enrolled in health insurance through the Marketplace: 2,045	**COMPLETED YEAR ONE** • 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.
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.	10/14	9/15	Lead: Enroll Virginia Jesse Ellis, NCS; Access PIT	NVFS, NVHF, CHF, VCVH, CF, MF, CMMS	Provision of education, assistance, and support to community members: Completed	**COMPLETED YEAR TWO** • 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 regarding accessing and appropriately using health care services, especially among diverse populations and the first-time insured.

Objective 1.1 Continued	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.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.1.D Increase community awareness of chronic disease and risk factors to empower individuals to take control of their health.	10/13	9/18	Lead: Jesse Ellis, NCS Access PIT; Fairfax County Health and Human Services Healthy People Workgroup (HHS HPW)	Funding needed to support an educational campaign	Documentation of increased community awareness of chronic disease and risk factors: TBD	**COMPLETED YEAR ONE** • Fairfax County Health Department (FCHD) applied in 3/14 for the National Prevention Partnerships Award Grant, which would have provided funding to conduct a chronic disease educational campaign in faith communities of target populations (not awarded). • FCHD applied in 7/14 for the Partnerships to Improve Community Health Grant, which would have provided funding to conduct a community-wide chronic disease educational campaign (not awarded). **COMPLETED YEAR THREE** • Included increasing community awareness of chronic disease and risk factors in the HHS action steps for the Healthy People results area. **PLAN FOR YEAR FOUR** • Build community capacity to deliver health promotion and prevention services around chronic disease through the implementation of the HHS HPW strategies.

Access to Health Services

- **Goal 1**: Improve access to primary and specialty care, including oral and behavioral care.
  - **Objective 1.2**: Increase access to health services through policy and system improvements among providers.

Priority Issue: Access to Health Services (Access)						
Goal 1	Improve access to primary and specialty care, including oral and behavioral care.					
Objective 1.2	Increase access to health services through policy and system improvements among providers.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.2.A Integrate primary health care with behavioral health, oral health, social services, specialty care, and public health.	10/13	9/18	Lead: Fairfax County Health and Human Services System (HHS) Access Priority Issue Team (PIT)	None identified	Evidence of integration of primary health care, behavioral health, oral health, social services, specialty care, and public health: Completed	**COMPLETED YEAR ONE** • Identified potential strategies to integrate primary care, behavioral health, social services, and public health services across the safety net through the HHS. **COMPLETED YEAR TWO** • Appointed a Director of System Transformation of the County Executive's Office. • Initiated work to identify information technology solutions to support HHS service integration. • Implemented integrated and co-located services for several county-operated primary care and behavioral health clinics. **COMPLETED YEAR THREE** • Formed an advisory committee to work on a plan for the Children's Behavioral Health System of Care. • Gained approval for the Children's Behavioral Health System of Care Blueprint, which includes multiple strategies to integrate primary and behavioral health care of children. • Coordinated multiple workgroups through the Fairfax County System of Care Office to assist with implementation of the Children's Behavioral Health System of Care Blueprint. **PLAN FOR YEAR FOUR** • Develop tools to support the integration of youth behavioral health and primary care services.

Objective 1.2 Continued	Increase access to health services through policy and system improvements among providers.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
1.2.B Improve collaboration among community support networks and safety net providers through changes such as streamlined eligibility systems.	10/16	9/18	Lead: Fairfax County Health and Human Services Information Technology Governance Board (FCHHS ITGB)	None identified	Evidence of improved collaboration between community support networks and safety net providers: TBD	**COMPLETED YEAR THREE** • Engaged a national consultant to facilitate the development of the Health and Human Services Information Technology (IT) Five-Year Plan, and a more detailed Integrative System IT Roadmap. • Collaborated with government safety net providers to streamline eligibility and intake processes. **PLAN FOR YEAR FOUR** • Continue implementation of the Integrative System IT Roadmap.
1.2.C Improve the availability and accessibility of alternatives to long-term institutional care, including home- and community-based services.	4/16	4/18	Lead: Neighborhood and Community Services (NCS) Access PIT	Metropolitan Washington Council of Governments $472,000 4/16 – 4/18	Evidence of enhanced accessibility or availability of alternatives to long-term institutional care: TBD	**COMPLETED YEAR THREE** • Received funding for the Northern Virginia Mobility Access Project to improve transportation options for seniors and individuals with disabilities, a key factor in allowing people to age in place, with a focus on low-income and underserved areas.

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.

Priority Issue: Access to Health Services (Access)						
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.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
2.1.A Bring together critical stakeholders to create and implement a community-wide comprehensive suicide prevention agenda.	10/13	9/17	Lead: Jesse Ellis, Prevention Manager, Neighborhood and Community Services (NCS) Suicide Prevention Alliance of Northern Virginia (SPAN), Promoting Mental Health Subgroup of the Access Priority Issue Team (PMH)	Virginia Department of Behavioral Health and Developmental Services (BHDS) funding $165,000 7/14-6/15 $125,000 7/15-6/16	Development of a community-wide comprehensive suicide prevention plan: Completed	**COMPLETED YEAR ONE** • Fairfax-Falls Church Community Services Board received a regional grant from BHDS. • Developed a regional suicide prevention plan based on the National Strategy for Suicide Prevention in 8/14. **COMPLETED YEAR TWO** • Formed the 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, all working together to raise awareness and share resources to prevent suicide. • 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. **COMPLETED YEAR THREE** • Released the first annual report of findings and recommendations on behavioral health initiatives from the Youth Suicide Review Team. **PLAN FOR YEAR FOUR** • Disseminate population-specific suicide prevention resources and messaging through SPAN. • Increase communications and marketing to promote SPAN and its activities and resources.

Objective 2.1 Continued	Improve the capacity of the community to deliver services that promote social and emotional wellness.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
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.	10/14	9/18	Lead: Jesse Ellis, Prevention Manager, NCS PMH, System of Care Office	None identified	Expansion of existing mental health activities: Completed	**COMPLETED YEAR TWO** • Developed an inventory of resiliency activities to identify gaps and expand on existing efforts. • Developed strategies in response to a Centers for Disease Control and Prevention Epi-Aid Report on Youth Suicide in Fairfax County released in 6/15. • Convened a committee to promote the use of resiliency programming and practices among schools and community-based service providers. • Formed a new cross-sector committee to advise on funding and programming for the Fairfax County System of Care Office and the broader youth behavioral health system of care. **COMPLETED YEAR THREE** • Created a document of resources and best practices for post-suicide services and support (postvention). **PLAN FOR YEAR FOUR** • Expand guidance and resources for community-based organizations on responding to suicide, including a protocol on how organizations could support schools and work together after a suicide occurs. • Develop and implement strategies to promote resiliency among youth participating in community-based activities and organizations.

Objective 2.1 Continued	Improve the capacity of the community to deliver services that promote social and emotional wellness.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
2.1.C Implement evidence-based behavioral health screenings and make appropriate referrals in health care provider offices, schools, and other settings.	10/14	9/17	Lead: Jesse Ellis, Prevention Manager, NCS PMH, Fairfax County Health Department (FCHD), Fairfax County System of Care Office	None identified	# new settings where behavioral health screenings have been implemented: 1	**COMPLETED YEAR TWO** • Conducted pilot training for primary care providers to implement intimate partner violence screenings for women in FCHD clinics. **COMPLETED YEAR THREE** • Worked with George Mason University to validate the intimate partner violence screening tool. **PLAN FOR YEAR FOUR** • Train additional healthcare providers on the implementation of intimate partner violence screenings. • Deliver trainings for primary care, behavioral health, and other providers on implementing evidence-based behavioral health screenings and making referrals.
2.1.D Offer high-quality, community-based prevention programs designed to increase social and emotional wellness and behavioral health among individuals and families.	10/14	9/17	Lead: NCS Prevention Unit	Fairfax County Partners in Prevention Fund (PIPF)	# community-based organizations implementing high quality prevention programs designed to increase social and emotional wellness and behavioral health: 18 # community-based prevention programs implemented: FY 16 – 11	**COMPLETED YEAR TWO** • Implemented the Lifelines, Signs of Suicide, Safe Dates, Parents Raising Safe Kids, and Strengthening Families prevention programs through the PIPF. • Identified additional programs to be included by the PIPF Advisory Team. **COMPLETED YEAR THREE** • Issued a request for proposals to fund additional organizations to implement programs. **PLAN FOR YEAR FOUR** • Award contracts, train providers, and begIn implementing Lifelines, Signs of Suicide, Safe Dates, Parents Raising Safe Kids, Life Skills Training, and Strengthening Families prevention programs through the PIPF.

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 2.2**: Improve awareness of mental illness and how to promote mental health among the public and community-based organizations.

Priority Issue: Access to Health Services (Access)						
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 2.2	Improve awareness of mental illness and how to promote mental health among the public and community-based organizations.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
2.2.A Train community-based organizations to recognize signs of mental illness and depression and make appropriate referrals.	10/14	9/15	Lead: Jody Tompros, Cornerstones Neighborhood and Community Services (NCS) Prevention Unit, Access Priority Issue Team (PIT), Systems of Care Office	Fairfax County Partners in Prevention Fund (PIPF) Fairfax-Falls Church Community Services Board Virginia Department of Behavioral Health and Developmental Services (BHDS) $165,000 7/14-6/15 $125,000 7/15-6/16	# individuals completing Kognito trainings: 10,000+ # individuals completing Mental Health First Aid trainings: 1,800+	**COMPLETED YEAR TWO** • Increased offerings of Mental Health First Aid Trainings to the public, school communities, and youth-serving organizations. • Purchased a suite of online suicide prevention training products developed by Kognito that is available free for two years to anyone in Fairfax County and required for Fairfax County Public Schools middle and high school teachers, and NCS youth-serving staff. • Added a Kognito training for working with elementary school-aged youth and required it for elementary school teachers. Added a Kognito training for high school students (Friend 2 Friend) and included it in the 10th grade health curriculum.

Objective 2.2 Continued	Improve awareness of mental illness and how to promote mental health among the public and community-based organizations.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
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.	10/14	9/17	Lead: Jesse Ellis, Prevention Manager, NCS Access PIT, Trauma-Informed Community Network	PIPF	# community-based organizations trained to implement trauma-informed practices in non-clinical settings: 10 # individuals trained to implement trauma-informed practices in non-clinical settings: 1,000+	**COMPLETED YEAR TWO** • Developed trainings on trauma-informed practices for non-clinical community-based youth service providers and supervisors. • Published a one-page trauma fact sheet/resource guide. • Established a Fairfax Trauma-Informed Community Network to share resources and best practices and to develop and implement shared training opportunities. **COMPLETED YEAR THREE** • Launched the online Trauma-Informed Community Network Awareness Training. • Conducted a screening of the trauma-related film, “Paper Tigers” that was hosted by the Trauma-Informed Community Network. **PLAN FOR YEAR FOUR** • Expand the work of the Trauma-Informed Community Network by developing and implementing new trainings and networking opportunities. • Conduct trauma-informed training sessions for senior leaders for Health and Human Services and Fairfax County Public Schools in fall 2016 with screenings of the film “Resilience: The Biology of Stress & the Science of Hope.”

Objective 2.2 Continued	Improve awareness of mental illness and how to promote mental health among the public and community-based organizations.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
2.2.C Increase community awareness of mental illness, including how to get help and ways to promote mental health in order to connect people with services and reduce the stigma of mental illness.	10/14	9/17	Lead: Jesse Ellis, Prevention Manager, NCS Access PIT	BHDS $165,000 7/14-6/15 $125,000 7/15-6/16 Fairfax County Health Department funding Partners in Prevention Fund $6,000	# estimated impressions for individuals reached: 3,000 # PSAs published: 1	**COMPLETED YEAR TWO** • Developed three public service announcements (PSAs) to promote access to mental health services and to destigmatize mental illness. • Distributed the PSAs to the public via social media. • Provided mini-grants for six youth-led projects to address stigma around mental illness. **COMPLETED YEAR THREE** • Developed and aired youth suicide prevention PSAs at various locations, including movie theaters, YouTube, social media, and television. • Awarded a second round of mini-grants for youth-led initiatives for mental illness prevention. **PLAN FOR YEAR FOUR** • Award a third round of mini-grants to youth-led initiatives to reduce the stigma surrounding mental illness.

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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.

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.

Priority Issue: 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.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
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.	10/14	5/15	Leads: Fairfax County Health Department (FCHD), Priority Issue Team (PIT) Chairs	None identified	Identification of community health indicators: Completed	**COMPLETED YEAR TWO** • Identified and selected health indicators through an integrated local community health dashboard for each priority issue area of the CHIP.

Objective 1.1 Continued	Establish a set of community health indicators to measure health outcomes that may be influenced by Community Health Improvement Plan programs and initiatives.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
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.	10/13	9/14	Lead: Neighborhood and Community Services (NCS) Community Transformation Grant (CTG) Staff	Centers for Disease Control and Prevention (CDC) CTG $30,000 10/13-9/14	Review of data availability and sources: Completed	**COMPLETED YEAR ONE** • Compiled a list of community health indicators and data sources, classified by national, state, county, local, and private sources. • Met with PITs to discuss data needs related to proposed goals, objectives, and key actions for the CHIP.
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.	1/15	9/15	Lead: FCHD	None identified	Identification of community health indicators that measure health disparities: Completed	**COMPLETED YEAR TWO** • Identified and secured four years of hospitalization data from Virginia Health Information for inclusion on the site with analysis to demonstrate where health disparities exist.

Objective 1.1 Continued	Establish a set of community health indicators to measure health outcomes that may be influenced by Community Health Improvement Plan programs and initiatives.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
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.	10/13	9/14	Lead: NCS CTG Staff	CDC CTG $30,000 10/13-9/14	Documentation of data gaps: Completed	**COMPLETED YEAR ONE** • Documented gaps in data availability in a CTG project report to explain the background and need for an integrated local community health data system.

Data

- **Goal 1**: Develop recommendations for a comprehensive public health data collection, monitoring, analysis, and reporting system to support evaluation of health outcomes.
  - **Objective 1.2**: Integrate the identified community health indicators into a comprehensive public health monitoring, analysis, and reporting system that is accessible to the community.

Priority Issue: Data						
Goal 1	Develop recommendations for a comprehensive public health data collection, monitoring, analysis, and reporting system to support evaluation of health outcomes.					
Objective 1.2	Integrate the identified community health indicators into a comprehensive public health monitoring, analysis, and reporting system that is accessible to the community.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
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.	10/13	9/14	Lead: Neighborhood and Community Services (NCS) Community Transformation Grant (CTG) Staff	Centers for Disease Control and Prevention (CDC) CTG $30,000 10/13-9/14	Identification of project informants: Completed # project participants: 16	**COMPLETED YEAR ONE** • Identified potential project informants (key staff with expertise in data collection and management) from Fairfax County Health Department (FCHD) and NCS to discuss requirements for an integrated local community health data system in Fairfax County.

Objective 1.2 Continued	Integrate the identified community health indicators into a comprehensive public health monitoring, analysis, and reporting system that is accessible to the community.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
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.	10/13	9/14	Lead: NCS CTG Staff	CDC CTG $30,000 10/13-9/14	# tools assessed for potential use as an integrated community health data system: 8 # meetings held: 11	**COMPLETED YEAR ONE** • Held meetings to explore options for a system to help the county monitor and share public health indicators focused on chronic disease, including health outcomes and social determinants of health. • Met with staff to gather more in-depth information in relation to data analysis and dissemination needs. • Coordinated demonstrations of potential tools for the system and gathered feedback on the advantages and disadvantages of each tool.
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.	10/13	9/14	Lead: NCS CTG Staff	CDC CTG $30,000 10/13-9/14	Establishment of an action plan: Discontinued Selection of system tool: Completed	**COMPLETED YEAR ONE** • Completed a requirements analysis of potential platforms for the system, hereafter referred to as the Community Health Dashboard (CHD). • Decided to forgo the development of an action plan due to the early termination of the CTG and proceed with implementation of the CHD to improve data collection, monitoring, analysis, and reporting. • Selected a product for implementation that best met data needs and provided a mechanism to report on community health indicators and performance measures specific to the Community Health Improvement Plan (CHIP). • Established a contract with the Healthy Communities Institute and secured the CHD for implementation.

Objective 1.2 Continued	Integrate the identified community health indicators into a comprehensive public health monitoring, analysis, and reporting system that is accessible to the community.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status**
	Start	**End**				
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.	5/15	9/17	Lead: FCHD	FCHD funds for first-year implementation Sustainability of the CHD will require annual contributions from partners	Reporting of data through implementation of CHD: Launched 5/15	**COMPLETED YEAR TWO** • Worked with the vendor to customize the selected tool for the CHD to meet Fairfax community data needs. • Created a series of web pages within the CHD to communicate progress on the CHIP and report on evaluation metrics for each priority issue area. • Launched the CHD in 5/15 to report health indicators and CHIP progress to the community. • Created postcards to advertise the availability and utility of the CHD. • Provided demonstrations of the CHD to targeted audiences. **COMPLETED YEAR THREE** • 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 vendor. **PLAN FOR YEAR FOUR** • Present the CHD as a community health assessment resource at the Partnership for a Healthier Fairfax meeting in 11/16. • Add Health and Human Services Report Card data to show system-level and population-level indicators for six results areas: Connected Individuals, Economic Self-Sufficiency, Healthy People, Positive Living for Older Adults and Individuals with Disabilities, Successful Children and Youth, and Sustainable Housing. • Create and post video tutorials to teach site users about the functionality of and resources on the CHD. • Add Health Department local indicators to the site. • Explore the addition of indicators related to the *Strategic Plan to Facilitate the Economic Success of Fairfax County*.

Conclusion

- The Community Health Improvement Plan was designed to transform the Fairfax community into a place where all may lead healthier, more productive lives. With the completion of the third year of implementation, much progress has been made in addressing the seven identified priority issues. **Of the 122 key actions outlined in this report, 69% have been completed, 14% are in progress, and 17% are yet to begin.** While this body of work is quite impressive, achieving improved health outcomes takes time, resources, and the dedication of many individuals. Only when diverse community stakeholders and county partners work together can the Partnership achieve its vision of optimal health and well-being for all who live, work , and play in the Fairfax community.

- **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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Community Health Improvement Plan 2013-2018
Annual Evaluation Report – Year Three
October 2015-September 2016

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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/