All appendices referenced in the CHNA report are described below and are also available online at inova.org.

Appendix A: Community Engagement
Summary of community outreach and engagement efforts

Appendix B: Mount Vernon Community Description
Detailed maps and charts exploring resident demographics and characteristics

Appendix C: Forces of Change Assessment Discussion and Responses
Complete responses for the Forces of Change discussion

Appendix D: Community Themes and Strengths Assessment
Communitywide survey results broken down by demographics

Appendix E: Community Health Status Assessment Results
Chart of health indicators used to identify disparities, trends and progress towards state and national benchmarks

Appendix F: Identifying Top Health Issues Methodology
Description of process and outcomes

Appendix G: Actions Taken Since the Previous CHNA
Appendix A: Community Engagement

This Mount Vernon Community Health Needs Assessment (CHNA) gathered community input through two main methods – Forces of Change Assessment (FOCA) discussions and the Community Themes and Strengths Assessment (CTSA) survey.

Forces of Change discussions bring together individuals working in and with the community, who represent a broad diversity of stakeholders. Participants included individuals with special knowledge or expertise in public health; local public health departments; agencies with current data or information about the health and social needs of the community; representatives of social service organizations; business leaders and representatives, leaders and members of medically underserved, low-income and minority populations. Inova team members conducted Forces of Change sessions with representatives of the Mount Vernon Health Equity Community Action Committee, the Partnership for a Healthier Fairfax Steering Committee, the local FQHC, the Board of Supervisors, the Fairfax Health Care Advisory Board and a group of Faith Leaders from around the region.

Inova promoted the CTSA survey to partners and residents alike. The survey was available in print or online in nine languages: Amharic, Arabic, Chinese (Mandarin), English, Farsi, Korean, Spanish, Vietnamese and Urdu. Printed copies were provided to partners and local clinics, as well as health department facilities. Community Health Workers assisted in the collection of print and electronic survey responses in their local communities.

Figure A1. Mount Vernon Health Equity Community Action Committee Organizations

<table>
<thead>
<tr>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem HealthKeepers</td>
</tr>
<tr>
<td>Audubon Estates Community</td>
</tr>
<tr>
<td>CareFirst BCBS</td>
</tr>
<tr>
<td>ENDependence Center of Northern Virginia</td>
</tr>
<tr>
<td>Growth and Healing Hub</td>
</tr>
<tr>
<td>Fairfax County</td>
</tr>
<tr>
<td>Fairfax County Neighborhood and Community Services</td>
</tr>
<tr>
<td>Fairfax County Health Department</td>
</tr>
<tr>
<td>Fairfax County Board of Supervisors</td>
</tr>
<tr>
<td>Fairfax County Public Schools</td>
</tr>
<tr>
<td>Inova</td>
</tr>
<tr>
<td>Inova Mount Vernon Hospital</td>
</tr>
<tr>
<td>Inova Community Health</td>
</tr>
<tr>
<td>Inova Saville Cancer Screening and Prevention Center</td>
</tr>
<tr>
<td>Inova Heart and Vascular Institute</td>
</tr>
<tr>
<td>Inova Behavioral Health</td>
</tr>
<tr>
<td>iTHRIV</td>
</tr>
<tr>
<td>Melwood</td>
</tr>
<tr>
<td>Neighborhood Health</td>
</tr>
<tr>
<td>Sentara</td>
</tr>
<tr>
<td>Mount Olive Baptist Church, Health Ministry</td>
</tr>
<tr>
<td>Southeast Fairfax Development Corporation (SFDC)</td>
</tr>
<tr>
<td>United Community/Community+</td>
</tr>
<tr>
<td>WishKnish</td>
</tr>
</tbody>
</table>
Appendix B: Community Description

This section identifies and describes the community that was assessed by IMVH and IASC. The community was defined by considering the geographic origins of the hospital’s inpatient discharges and emergency department visits.

The Inova Mount Vernon community is comprised of 18 ZIP codes, including parts of Fairfax County and the Alexandria City.

In 2021, the ZIP codes that comprise the community accounted for 68% of the discharges and 74% of the emergency department visits. This defined community reflects a smaller proportion of patients than may normally be assessed due to the hospital’s role as a regional referral center for rehabilitation care. Patients from across Northern Virginia and the Washington D.C. metropolitan area receive rehabilitation services at Inova Mount Vernon Hospital.

**TOTAL POPULATION**

Figure B1. Inova Mount Vernon Community

<table>
<thead>
<tr>
<th>City or County</th>
<th>Percent of Discharges</th>
<th>Percent of Emergency Department Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexandria City, VA</td>
<td>7.0%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Fairfax County, VA</td>
<td>60.9%</td>
<td>70.5%</td>
</tr>
<tr>
<td>Community Total</td>
<td>67.9%</td>
<td>74.2%</td>
</tr>
<tr>
<td>Other areas</td>
<td>32.1%</td>
<td>25.8%</td>
</tr>
<tr>
<td>Total Discharges and ED Visits</td>
<td>7,127</td>
<td>46,156</td>
</tr>
</tbody>
</table>

Source: Inova Health System, 2022

Figure B2. Percent Change in Community Population by Subregion, Mount Vernon Community (2020-2030)

<table>
<thead>
<tr>
<th>Community</th>
<th>Total Population</th>
<th>Percent Change</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2020</td>
<td>2025</td>
<td>2030</td>
<td>2020-2025</td>
</tr>
<tr>
<td>Alexandria City</td>
<td>88,408</td>
<td>96,139</td>
<td>101,646</td>
<td>8.74%</td>
</tr>
<tr>
<td>Alexandria/Old Town</td>
<td>88,408</td>
<td>96,139</td>
<td>101,646</td>
<td>8.74%</td>
</tr>
<tr>
<td>Fairfax County</td>
<td>211,888</td>
<td>215,348</td>
<td>224,205</td>
<td>1.63%</td>
</tr>
<tr>
<td>Franconia/Kingstowne</td>
<td>58,238</td>
<td>58,999</td>
<td>60,405</td>
<td>1.31%</td>
</tr>
<tr>
<td>Lorton/Newington</td>
<td>36,344</td>
<td>37,133</td>
<td>38,446</td>
<td>2.17%</td>
</tr>
<tr>
<td>Mt. Vernon North</td>
<td>27,296</td>
<td>28,045</td>
<td>30,491</td>
<td>2.75%</td>
</tr>
<tr>
<td>Mt. Vernon South/Ft. Belvoir</td>
<td>90,010</td>
<td>91,171</td>
<td>94,862</td>
<td>1.29%</td>
</tr>
<tr>
<td>Community Total</td>
<td>300,296</td>
<td>311,487</td>
<td>325,850</td>
<td>3.73%</td>
</tr>
</tbody>
</table>

Source: Metropolitan Washington Council of Governments, 2021
Appendix B: Community Description

AGE

Population characteristics and changes directly influence community health needs. The total population of the Mount Vernon Community is expected to grow by 6% from 2020-2030. In that same time frame, the population 65+ is expected to increase by 32%. The growth of older populations is likely to lead to a growing need for health services, since on an overall per-capita basis, older individuals typically need and use more services than younger persons.

Figure B3. Percent Change in Population by Age, Mount Vernon Community (2020-2030)

<table>
<thead>
<tr>
<th>Age Cohort</th>
<th>Total Population</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-17</td>
<td>99,700</td>
<td>-0.86%</td>
</tr>
<tr>
<td>18-44</td>
<td>174,314</td>
<td>2.79%</td>
</tr>
<tr>
<td>45-64</td>
<td>120,511</td>
<td>-2.34%</td>
</tr>
<tr>
<td>65+</td>
<td>63,613</td>
<td>17.12%</td>
</tr>
<tr>
<td>Total</td>
<td>458,138</td>
<td>2.64%</td>
</tr>
</tbody>
</table>

Source: Metropolitan Washington Council of Governments, 2021

Figure B4. Age Distribution by Sex, Fairfax County

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates
Appendix B: Community Description

Figure B5. Median Age, Mount Vernon Community

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates

Figure B6. Percent of Population Aged 65+, Mount Vernon Community

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates
RACE AND ETHNICITY

In Fairfax County in 2020 Asians, Hispanics and African Americans represented 19.8%, 16.2% and 9.8% of the county’s population, respectively. Nearly one-quarter of the state’s Hispanic population resides in Fairfax County (U.S. Census Bureau). Racial and ethnic diversity is increasing, as these groups are growing and the percent of the population that is White/Caucasian (excluding Hispanics and Latinos) is decreasing. Additionally, there are portions of the community with high percentages of residents who are foreign-born as well as households with limited English proficiency.

Figure B7a. Race by Location

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates
Appendix B: Community Description

Figure B7b. Ethnicity by Location

<table>
<thead>
<tr>
<th>Location</th>
<th>Not Hispanic or Latino</th>
<th>Hispanic or Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexandria City</td>
<td>83.56%</td>
<td>16.44%</td>
</tr>
<tr>
<td>Fairfax County</td>
<td>83.76%</td>
<td>16.24%</td>
</tr>
<tr>
<td>Virginia</td>
<td>90.47%</td>
<td>9.53%</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates

Figure B8. Percent of Population Black, Mount Vernon Community

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates
Appendix B: Community Description

Figure B9. Percent of Population Hispanic or Latino, Mount Vernon Community

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates

Figure B10. Percent of Population Asian, Mount Vernon Community

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates
Appendix B: Community Description

Figure B11. Percent of Population Foreign-Born, Mount Vernon Community

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates

Figure B12. Percent of Limited English Speaking Households, Mount Vernon Community

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates
**EDUCATION**

Overall the Mount Vernon Community is highly educated. In Fairfax County and the City of Alexandria, 62-65% of residents hold a Bachelor’s degree or higher, with about one third of residents holding a graduate or professional degree. However, there are noticeable discrepancies within the County.

**Figure B13. Educational Attainment by Location**

![Educational Attainment by Location](image)

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates

**Figure B14. Percent of Residents Age 25+ with Bachelor’s Degree or Higher, Mount Vernon Community**

![Percent of Residents Age 25+ with Bachelor’s Degree or Higher](image)

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates
HEALTH INSURANCE

Prior to 2019 in Virginia, Medicaid was primarily available to children in low-income families, pregnant women, low-income elderly persons, individuals with disabilities and parents who met specific income thresholds. Adults without children or disabilities were ineligible.

In January 2019 Virginia expanded Medicaid eligibility to make healthcare more accessible for these populations. It was estimated at the time that over 400,000 Virginians would potentially gain coverage if Medicaid were expanded. According to the Department of Medical Assistance Services as of May 2022, over 650,000 adults in Virginia newly enrolled in Medicaid.

Figure B15. Health Insurance Types, by Location

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates
Appendix B: Community Description

Figure B16. Percent of Residents without Health Insurance Coverage, Mount Vernon Community

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates

Figure B17. Percent of the Population without Health Insurance, by Location (2020)

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates
**SOCIOECONOMIC**

Many health needs have been associated with poverty, unemployment and other socioeconomic factors. While most socioeconomic indicators in the Mount Vernon Community are favorable compared to Virginia overall, there are disparities by race/ethnicity, county/city and even census tract.

**Figure B18. Median Household Income, Mount Vernon Community**

![Median Household Income Map]

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates

**Figure B19. Poverty Distribution, by Location**

<table>
<thead>
<tr>
<th>Location</th>
<th>Poverty Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexandria City</td>
<td>9.40%</td>
</tr>
<tr>
<td>Fairfax County</td>
<td>5.90%</td>
</tr>
<tr>
<td>Virginia</td>
<td>10.00%</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates
Appendix B: Community Description

Figure B20. Poverty Distribution, Mount Vernon Community

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates

Figure B21. Poverty Rates by Race and Ethnicity, by Location

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates
Figure B22. Unemployment Rates over Time, by Location (2021)

Source: U.S. Bureau of Labor Statistics

Figure B23. Other Socioeconomic Factors by Location

<table>
<thead>
<tr>
<th>Measure</th>
<th>Alexandria City</th>
<th>Fairfax County</th>
<th>Virginia</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population 25+ without High School Diploma</td>
<td>6.9%</td>
<td>7.3%</td>
<td>9.7%</td>
<td>11.5%</td>
</tr>
<tr>
<td>Population with a Disability</td>
<td>7.5%</td>
<td>7.2%</td>
<td>11.8%</td>
<td>12.7%</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates
Appendix B: Community Description

Figure B24. Percent of Residents with a Disability, Mount Vernon Community

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates

Figure B25. Food Deserts in Northern Virginia

Food deserts are defined as low-income areas more than one mile from a supermarket in urban areas or more than 10 miles from a supermarket in rural areas. Areas shaded in green are designated food deserts.

Source: U.S. Department of Agriculture, Accessed 5/17/2022
MEDICALLY UNDERSERVED AREAS AND POPULATIONS

Medically Underserved Areas and Populations (MUA/Ps) are designated by the Health Resources and Services Administration (HRSA) based on an “Index of Medical Underservice.” The index includes the following variables: ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level and percentage of the population age 65 or over. Areas with a score of 62 or less are considered “medically underserved.” Populations receiving MUP designation include groups within a geographic area with economic, cultural or linguistic barriers to health care. There are multiple census tracts within the region that have been designated as areas where Medically Underserved Populations are present. In this Mount Vernon Community, this area falls primarily along the Richmond Highway corridor.

Figure B26. Medically Underserved Areas and Populations, Northern Virginia (2022)
RESOURCES
Federally Qualified Health Centers (FQHCs) are established to promote access to ambulatory care in areas designated as “medically underserved.” These clinics receive enhanced reimbursement for Medicaid and Medicare services and most also receive federal grant funds under Section 330 of the Public Health Service Act. There currently are three FQHC organizations operating multiple sites in Northern Virginia.

In addition to the FQHCs, there are other clinics in the area that serve lower-income individuals. These include the Arlington Free Clinic (Arlington, VA), the Culmore Clinic (Falls Church, VA) and multiple sites throughout the region of the George Mason University’s Mason and Partners Clinics (MAP).

In addition to these resources, Inova operates several Inova Cares Clinic sites across Northern Virginia. The Fairfax County Health Department also provides an array of services at locations throughout their jurisdiction and the Alexandria Health Department at locations in the City of Alexandria.
<table>
<thead>
<tr>
<th>Facility</th>
<th>Facility Type</th>
<th>City</th>
<th>ZIP Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dominion Hospital</td>
<td>Psychiatric</td>
<td>Falls Church</td>
<td>22044</td>
</tr>
<tr>
<td>Fairfax Surgical Center</td>
<td>Ambulatory Surgical</td>
<td>Fairfax</td>
<td>22030</td>
</tr>
<tr>
<td>Haymarket Surgery Center</td>
<td>Ambulatory Surgical</td>
<td>Haymarket</td>
<td>20169</td>
</tr>
<tr>
<td>HealthSouth Rehab Hospital of Northern Virginia</td>
<td>Rehabilitation</td>
<td>Aldie</td>
<td>20105</td>
</tr>
<tr>
<td>HealthQare Services ASC, LLC</td>
<td>Ambulatory Surgical</td>
<td>Arlington</td>
<td>22201</td>
</tr>
<tr>
<td>Inova Alexandria Hospital</td>
<td>Acute</td>
<td>Alexandria</td>
<td>22304</td>
</tr>
<tr>
<td>Inova Ambulatory Surgery Center at Lorton</td>
<td>Ambulatory Surgical</td>
<td>Lorton</td>
<td>22079</td>
</tr>
<tr>
<td>Inova Fair Oaks Hospital</td>
<td>Acute</td>
<td>Fairfax</td>
<td>22033</td>
</tr>
<tr>
<td>Inova Fairfax Medical Campus</td>
<td>Acute</td>
<td>Falls Church</td>
<td>22042</td>
</tr>
<tr>
<td>Inova Loudoun Ambulatory Surgery Center</td>
<td>Ambulatory Surgical</td>
<td>Leesburg</td>
<td>20176</td>
</tr>
<tr>
<td>Inova Loudoun Hospital</td>
<td>Acute</td>
<td>Leesburg</td>
<td>20176</td>
</tr>
<tr>
<td>Inova Mount Vernon Hospital</td>
<td>Acute</td>
<td>Alexandria</td>
<td>22306</td>
</tr>
<tr>
<td>Inova Surgery Center at Franconia-Springfield</td>
<td>Ambulatory Surgical</td>
<td>Alexandria</td>
<td>22310</td>
</tr>
<tr>
<td>Kaiser Permanente Tysons Corner Surgery Center</td>
<td>Ambulatory Surgical</td>
<td>McLean</td>
<td>22102</td>
</tr>
<tr>
<td>Lake Ridge Ambulatory Surgical Center</td>
<td>Ambulatory Surgical</td>
<td>Woodbridge</td>
<td>22192</td>
</tr>
<tr>
<td>McLean Ambulatory Surgery, LLC</td>
<td>Ambulatory Surgical</td>
<td>McLean</td>
<td>22102</td>
</tr>
<tr>
<td>North Spring Behavioral Healthcare</td>
<td>Psychiatric</td>
<td>Leesburg</td>
<td>20176</td>
</tr>
<tr>
<td>Northern Virginia Eye Surgery Center, LLC</td>
<td>Ambulatory Surgical</td>
<td>Fairfax</td>
<td>22031</td>
</tr>
<tr>
<td>Northern Virginia Surgery Center</td>
<td>Ambulatory Surgical</td>
<td>Fairfax</td>
<td>22033</td>
</tr>
<tr>
<td>Novant Health UVA Health System</td>
<td>Acute</td>
<td>Haymarket</td>
<td>20169</td>
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<tr>
<td>Novant Health UVA Health System Prince William Medical Center</td>
<td>Acute</td>
<td>Manassas</td>
<td>20110</td>
</tr>
<tr>
<td>Pediatric Specialists of Virginia Ambulatory Surgery Center</td>
<td>Ambulatory Surgical</td>
<td>Fairfax</td>
<td>22031</td>
</tr>
<tr>
<td>Prince William Ambulatory Surgery Center</td>
<td>Ambulatory Surgical</td>
<td>Manassas</td>
<td>20110</td>
</tr>
<tr>
<td>Reston Hospital Center</td>
<td>Acute</td>
<td>Reston</td>
<td>20190</td>
</tr>
<tr>
<td>Reston Surgery Center</td>
<td>Ambulatory Surgical</td>
<td>Reston</td>
<td>20190</td>
</tr>
<tr>
<td>Sentara Northern Virginia Medical Center</td>
<td>Acute</td>
<td>Woodbridge</td>
<td>22191</td>
</tr>
<tr>
<td>Stone Springs Hospital Center</td>
<td>Acute</td>
<td>Dulles</td>
<td>20166</td>
</tr>
<tr>
<td>Virginia Hospital Center</td>
<td>Acute</td>
<td>Arlington</td>
<td>22205</td>
</tr>
</tbody>
</table>

Source: Virginia Health Information
Other Community Resources:
There is a wide range of agencies, coalitions and organizations that serve the Fairfax region. Several organizations maintain large databases to help refer individuals in need to health and human services and resources to address social determinants of health. Resources available include:

<table>
<thead>
<tr>
<th>Housing and utilities</th>
<th>Tax preparation assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food, clothing and household items</td>
<td>Legal, consumer and financial management services</td>
</tr>
<tr>
<td>Food programs</td>
<td>Transportation</td>
</tr>
<tr>
<td>Health care and disability services</td>
<td>Employment and income support</td>
</tr>
<tr>
<td>Health insurance and expense assistance</td>
<td>Family support and parenting</td>
</tr>
<tr>
<td>Mental health and counseling</td>
<td>Disaster services</td>
</tr>
<tr>
<td>Substance abuse and other addictions resources</td>
<td>Government and community services</td>
</tr>
<tr>
<td>Support groups</td>
<td>Education, recreation and the arts</td>
</tr>
</tbody>
</table>
Appendix C: Forces of Change Assessment (FOCA)

The Mount Vernon Health Equity Community Action Committee, along with several other individuals, representatives and groups, participated in Forces of Change Assessments. Figures C1 through C7 are a summary of their responses, categorized into overarching themes.

1. Forces: What are the trends, factors and events that are affecting health in the community
   a. Trends, i.e. patterns over time
   b. Factors, i.e. specific things about the community
   c. Events, i.e. policy changes or natural disasters

2. Categories: What Health Issues are impacted by each force

3. Threats: What are the challenges posed by each force

4. Opportunities: What are the opportunities presented by each force
### Figure C1: Mount Vernon Health Equity Community Action Committee

<table>
<thead>
<tr>
<th>Forces</th>
<th>Category</th>
<th>Threats Posed</th>
<th>Opportunities Created</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Increase in Mental Health Needs and Substance Abuse in Child/Youth Population</em></td>
<td>Chronic Conditions</td>
<td>• Lack of afterschool options for children&lt;br&gt;• Increase in mental health needs and services&lt;br&gt;• Increase in acuity and diagnosis&lt;br&gt;• No education to recognize the signs/symptoms of potential drug use or addiction&lt;br&gt;• Intersection of multiple identities which has made it harder to become aware of those in crisis or those in need&lt;br&gt;• No available facilities to send children for addiction&lt;br&gt;• No safe space to disclose needs in the community or to get family help&lt;br&gt;• Language barriers - people feel what is happening to their child is never explained&lt;br&gt;• Needs for resources, guides and increased literacy for community&lt;br&gt;• Need more family support groups for childhood substance use and abuse&lt;br&gt;• Drug problems are not common in their home countries so they do not know how to handle their kids using substances when they come to the United States&lt;br&gt;• Past events and history have played a major role in these services not being present today</td>
<td>• Increased access for community collaboration and support&lt;br&gt;• Increase communication of information or social mobilization amongst communities&lt;br&gt;• Increase digital literacy amongst all age groups&lt;br&gt;• Allows for increase expression which may aid mental health&lt;br&gt;• Parent support groups have developed between adults and families to reduce stigma in community&lt;br&gt;• Advocating that substance abuse is a mental health problem too&lt;br&gt;• Increase awareness of needs and resources within the community&lt;br&gt;• Increased advocacy to champion schools to develop anti-drugs programs&lt;br&gt;• Topic is brought up more in PTA meetings to bring more community awareness&lt;br&gt;• Programs focused on paying kids to be advocates and developing skills would greatly benefit communities&lt;br&gt;• Addressing grief and trauma that may be linked to substance</td>
</tr>
<tr>
<td>Topic</td>
<td>Issues and Solutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>---------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linked to increased suicide rates</td>
<td>Supporting and building community leaders that could receive stipends to be community support leaders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Afraid to put children in rehab</td>
<td>Creation of more programs and communication that highlight popularity of non-drug use instead of highlighting substance use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The system of human services and mental health need more culturally competent providers and services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need more peer to peer support services and elevated community leaders that can be trusted messengers to combat substance use</td>
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<tr>
<td>Need for rehab facilities that are not county or government run</td>
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<tr>
<td>Fear of deportation or threatening citizenship status</td>
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<tr>
<td>Poses a serious problem for children who don’t have documentation</td>
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<tr>
<td>Rehab hospitalization goes on your permanent record</td>
<td></td>
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<tr>
<td>Legalization of marijuana caused increase in child/youth population using, which may contribute to lack of behavioral health support</td>
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<tr>
<td>Adults in the home using can influence child substance abuse</td>
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<tr>
<td>Social distancing influenced child/youth staying in homes and spaces that promoted unhealthy behaviors</td>
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<tr>
<td>Vaping has significantly increased amongst the child/youth community</td>
<td></td>
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<tr>
<td>Transportation Disparity in Mount Vernon Community</td>
<td>Economic Stability Healthcare access</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of transportation in Mount Vernon influences children being recruited to gangs</td>
<td>Enhanced and accessible transportation improves health and welfare of children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children and adults miss out on</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injury and Violence Neighborhood, Community and Environment Obesity, Nutrition and Physical Activity</td>
<td>opportunities to enhance quality of life • Barrier to access • Enhances food insecurity issues in community • Creates wealth disparities and financial instability if people cannot get to work • Challenges access to healthcare and prescriptions • Increased utilizations of ED and Urgent Cares for healthcare needs • Created gaps and inequities in vaccine access amongst community members • Organizations need to be able to better pivot resources in emergency response • Will mobilization continue when COVID is over</td>
<td>• Increased community partnership and mobilization within community • Increase in peer support groups and services, carpooling, etc. • Increased presence of resources and needs being brought into the community by community stakeholders • Increase mobile services programs and models to “show up” in communities • Improves access to resources and services</td>
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</tr>
<tr>
<td>COVID Related Increased “Labeling” of Disability in Community</td>
<td>Chronic Conditions Economic Stability Healthcare Access Mental Health Neighborhood, Community and Environment</td>
<td>• Having a disability or “problem” is seen as weak, wrong and avoided • Seen as a pipeline to prison • Labeling yourself is a hard pill to swallow • Race and ethnicity are a disability in community • Need for increased mobilization of peer/community support for need and resources</td>
<td>• Increased mobilization of community support through community partnership and peer affinity groups • Increasing the efficacy that you do have power • Increased intersectionality within disability community • Enhanced awareness that Disability is more than affliction</td>
</tr>
</tbody>
</table>
**Figure C2: Partnership for Healthier Fairfax**

<table>
<thead>
<tr>
<th>Forces</th>
<th>Category</th>
<th>Threats Posed</th>
<th>Opportunities Created</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in Mental Health Needs and Resources/Social Isolation</td>
<td>Chronic Conditions, Economic Stability, Health Literacy, Injury and Violence, Maternal, Infant, Child and Youth Health, Mental Health, Neighborhood, Community and Environment, Obesity, Nutrition and Physical Activity</td>
<td>• Disproportionately affected BIPOC community&lt;br&gt;• Social Media&lt;br&gt;  o Has been an insidious force for some in our society/adverse impact on adolescent mental health&lt;br&gt;  o Brutal for young girls&lt;br&gt;  o Increase dissemination of misinformation across multiple platforms&lt;br&gt;  o Allows for multiple identities which has made it harder to become aware of those in crisis or those in need&lt;br&gt;  o Influence on society/algorithms&lt;br&gt;• Workforce challenges reinforce mental health stress and anxiety&lt;br&gt;• Limited/lack of providers for mental health regardless of public or private insurance&lt;br&gt;• Limited capacity in the community to handle community members in crisis&lt;br&gt;• Decreased access to mental health services and support&lt;br&gt;• Reduction of people around you&lt;br&gt;• Social isolation can lead to alienation which leads to breakdowns in community fabric (humanity, culture) which is such an important ingredient for communities to function&lt;br&gt;</td>
<td>• Social Media&lt;br&gt;  o Increased access for community collaboration and support&lt;br&gt;  o Increase communication of information or social mobilization amongst communities&lt;br&gt;  o Increase digital literacy amongst all age groups&lt;br&gt;  o Allows for increase expression which may aid mental health&lt;br&gt;• Increase in acuity and diagnosis&lt;br&gt;• Increase in suicide prevention services and resources for kids and LGBTQ+ community (especially in schools)&lt;br&gt;• Increased development of online intervention strategies to build support networks/social media&lt;br&gt;• Increased awareness of need for more support services for community members&lt;br&gt;• Medicaid expansion increased access to services&lt;br&gt;• Increase in mental health awareness and issues with LGBTQ+ community</td>
</tr>
</tbody>
</table>
### Increased and Sustained Workforce Challenges

| Economic Stability | Healthcare workforce is strained  
| Inclusion and Violence | 1 in 5 healthcare workers have left their jobs in the last two years  
| Mental Health | Staffing shortages  
| Neighborhood, Community and Environment | Increased violence and threats to healthcare workers  
| | Impacts ability for organizations to provide core support to the community  
| | Student population is declining because of burnout  
| | COVID sickness or family-member becoming sick is very impactful to home environment  
| | Put a serious strain on other family members to cover needs  
| | Extended family running daycare’s now for community  
| | Decreased financial stability  
| | Not about bad versus good people  

### Function
- Increased sedentary behavior which has increased morbidity and mortality  
- Transition periods (especially for kids) have become challenging and have impacted children and young adults  
- Increased drop-out rates  

### Youth/Young Adult Population
- Social isolation increased enrollment for local colleges  
- Increased communication with individuals and families beyond their homes, communities and even countries  
- Increased behavioral health need  
- Increase in creativity around how to exercise, enjoy nature and parks  
- Increased and Sustained Workforce Challenges

### Economic Stability
- Perception of unemployment  
- Increased visibility of essential workers/roles in workforce  
- Increased benefits offered at most organizations to attract people to the workforce  
- Less carbon footprint due to decrease of transportation
<table>
<thead>
<tr>
<th>Category</th>
<th>Chronic Conditions</th>
<th>Substance abuse has increased/opioid deaths have increased</th>
<th>Other forms of addiction have increased due to stress/anxiety</th>
<th>BIPOC community was already disproportionately affected prior to COVID</th>
<th>Highest risk for getting sick or impacted by family members getting sick</th>
<th>Inability to isolate due to increased number of people living in the home</th>
<th>Workforce challenges</th>
<th>Face-to-face interactions to assist people have declined due to COVID restrictions</th>
<th>Increased mobilization of community support through community partnership</th>
<th>Increased awareness of the vulnerability of these populations</th>
<th>Increased community voice and organizations seeking community voice and input</th>
<th>Increase in community and neighborhood ambassadors as trusted messengers</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID/Disproportionate</td>
<td>Economic Stability</td>
<td>Income/wealth disparities</td>
<td>Increased the number of family members/families in one house</td>
<td>Increased vulnerable population</td>
<td>Increased violence and proximity to danger being in shelters</td>
<td>Increase in hypothermia cases due to individuals not wanting to congregate and get sick from COVID</td>
<td>Increased risk and incidence of homelessness</td>
<td>Impacted family stability and neighborhood livability</td>
<td>Law enforcement response to homelessness has evolved during the pandemic for the better</td>
<td>Increased awareness for services and resources from community partners/shelters</td>
<td>Encampments in community areas</td>
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<tr>
<td>Impact to BIPOC Community</td>
<td>Healthcare Access</td>
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<td>Mental Health</td>
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<td>Neighborhood, Community and Environment</td>
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<td></td>
<td>Tobacco and Substance Abuse</td>
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<tr>
<td>Increase of Homeless</td>
<td>Economic Stability</td>
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<tr>
<td>Population</td>
<td>Healthcare Access</td>
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<td>Injury and Violence</td>
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<td>Neighborhood, Community and Environment</td>
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### Appendix C: FOCA

#### Figure C3: Fairfax County Health Department

<table>
<thead>
<tr>
<th>Forces</th>
<th>Category</th>
<th>Threats Posed</th>
<th>Opportunities Created</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Increasing Mental Health Issues</strong></td>
<td><strong>Chronic Conditions</strong></td>
<td>- Pandemic-related issues – compounding of life issues&lt;br&gt;  o Isolation and loneliness, inability to connect, loss and grief – reduction in home services&lt;br&gt;  o Kids not able to be in school affects development and socialization&lt;br&gt;  o Fear, anxiety and stress related to health and economic issues&lt;br&gt;  o Chronic conditions and obesity affect mental health&lt;br&gt;  o Rise in domestic violence behind closed doors&lt;br&gt; - Can be hard to struggle in an environment like NoVA that emphasizes and prioritizes success – increase in stress due to “keeping up appearances”&lt;br&gt; - Political divisiveness causing dissension and escalation between family and community members, creates unsafe and volatile environments – taboos around acknowledging another viewpoint if it is seen as “other” by one’s group</td>
<td>- There is a more compassionate view of mental health struggles which could lead to a more nurturing environment&lt;br&gt;  o Increased awareness of underlying factors and influences&lt;br&gt; - Increase in engagement in mindfulness exercises&lt;br&gt; - Opportunity to create free (equitable, community directed) emotional/physical outlets (e.g. outdoor gyms) that could provide relief and connection</td>
</tr>
<tr>
<td></td>
<td><strong>Mental Health</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Pandemic Affecting Social Determinants of Health</strong></td>
<td><strong>Chronic Conditions</strong></td>
<td>- Those with lack of transportation, forward facing work and crowded home conditions are at increased risk of exposure to COVID-19 and exposing loved ones&lt;br&gt; - Those most impacted were also often the</td>
<td>- Global shift in awareness of the tremendous impact that SDOH has on health outcomes&lt;br&gt; - Increased awareness of the needs facing the most vulnerable</td>
</tr>
<tr>
<td></td>
<td><strong>Healthcare Access</strong></td>
<td></td>
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<tr>
<td></td>
<td><strong>Obesity, Nutrition and Physical Health</strong></td>
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</tbody>
</table>
most susceptible to poor outcomes due to chronic diseases – elderly, marginalized ethnic/racial groups
- Increase in obesity rates due to increase in sedentary lifestyle during social isolation
- Do not yet know what the long-haul impact of the pandemic will be on these populations and their effect on generational poor health

• Increased upstream preventative actions by community leaders and partners
• Increased policy focused on SDOH

### Diversity/Immigration

<table>
<thead>
<tr>
<th>Healthcare Access</th>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Virginia may not be the most supportive place for immigrants/refugees because of perception and visibility - increase in stress and mental health conditions/issues due to inequities</td>
<td></td>
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<tr>
<td>Generational gaps between older immigrant family members and younger native-born family members can create challenges like isolation</td>
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</tbody>
</table>

• We have the data we need to support our communities – need to understand the underlying stories to create sustainable solutions
• Diversity of our region is part of strategic planning, knowing that one-size-fits-all interventions will not work
• Increasingly recognize that communities must be involved in efforts that affect them
• While inequities and disparities brought to light by COVID-19 may have surprised the non-health sectors, healthcare system has been lending efforts/resources to community efforts to make change and address conditions that make treatment difficult

### Climate Crisis

<table>
<thead>
<tr>
<th>Chronic Conditions</th>
<th>Immunizations and Infectious Diseases</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who will be hardest hit by environmental changes will be the same vulnerable communities that have been impacted by COVID – people of color,</td>
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</table>

• Increased awareness of environmental health and root causes and increased community collaboration to address concerns –
Neighborhood, Community and Built Environment  
Obesity, Nutrition and Physical Activity  

<table>
<thead>
<tr>
<th>Threats Posed</th>
<th>Opportunities Created</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly and low income</td>
<td>Increase in diverse, strategic conversations with communities/stakeholders to find sustainable solutions</td>
</tr>
<tr>
<td>Radical temperature changes have resulted in excessive rain/flooding and an increase in insect vectors and disease</td>
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<tr>
<td>Exacerbation of breathing conditions or passing infectious diseases – not being able to cool homes properly can be a particular problem for those who are immobile</td>
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<tr>
<td>Young people experiencing health conditions usually seen in older age</td>
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<tr>
<td>People are living in conditions that do not allow them to follow the medical care plans received from healthcare providers</td>
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</table>

Figure C4: Neighborhood Health, Federally Qualified Health Center

<table>
<thead>
<tr>
<th>Forces</th>
<th>Category</th>
<th>Threats Posed</th>
<th>Opportunities Created</th>
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</thead>
</table>
| Medicaid Expansion | Healthcare Access | Not overall positive – lacking coverage is still a barrier for the community  
Cost-sharing is not equitable (sliding scale fees, etc.)  
Specialty care access is even more of a barrier | Dropping of 40-quarters of work history helped in Virginia for immigrants to receive benefits  
Increase in dental benefit and service access  
Better collaboration between safety-net clinics |
| Insufficient Mental Health Services/Resources | Healthcare Access  
Injury and Violence | Demand has increased  
Providers decreased because of COVID regulations, etc.  
Pandemic related social isolation  
Lack of insurance coverage, especially private insurance payors | Increase in providers for Medicaid plans  
Imbedding mental health services broadly across unique organizations/entities |
### Appendix C: FOCA

| Insufficient Dental/Oral Health Services/Resources | Healthcare Access Oral Health | Demand has increased  
Providers decreased because of COVID regulations, etc.  
No increase in dental providers with the expansion of Medicaid  
Additional coverage costs/supplemental programs are too expensive  
Capacity in community needs to increase  
Transportation | Medicaid expansion of dental services helps more people  
Also created an opportunity for more providers to help population |
|---|---|---|
Mistrust/perception in community keeps population from access care and services  
Structural impacts affect resources  
Immigration status  
Workforce | Increases diversity of community  
Workforce  
Better targeted messaging and outreach during COVID pandemic  
Trusted community members aided health communication and messaging from organizations |
| Income/Wealth Disparities | Economic Stability Healthcare Access  
Mental Health Neighborhood, Community and Environment Oral Health | Affects transportation  
Quality of life  
Life expectancy  
Access to care/services/resources  
Greatly affects those that do not qualify for benefits  
Essential workers/sick leave | Became the greatest driver or marker during COVID to determine need and creating more access  
Created better pathways for vaccination efforts for high-risk groups |
### Appendix C: FOCA

#### Access to Specialty Care

<table>
<thead>
<tr>
<th>Access to Specialty Care</th>
<th>Chronic Conditions</th>
<th>Healthcare Access</th>
<th>Mental Health</th>
<th>Oral Health</th>
<th>Threats Posed</th>
<th>Opportunities Created</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Declined and became a huge barrier during COVID pandemic</td>
<td>Send a lot of patients to UVA/VCU (has decreased over the years)</td>
<td>Having to go through a different FAP (barrier)</td>
<td>Transportation</td>
<td>Medicaid expansion increased services pathways</td>
<td>Increased collaboration between FQHCs and healthcare institutions</td>
</tr>
</tbody>
</table>

### Figure C5: Fairfax County Health Care Advisory Board

<table>
<thead>
<tr>
<th>Forces</th>
<th>Category</th>
<th>Threats Posed</th>
<th>Opportunities Created</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health Resources and Planning During COVID-19</td>
<td>Healthcare Access</td>
<td>Focus on COVID-19 has de-emphasized other important chronic diseases and conditions</td>
<td>Focused attention and concern on public health resources which historically are taken for granted and under-funded when not in crisis</td>
</tr>
<tr>
<td>Exposure of Gaps/Disparities</td>
<td>Chronic Conditions Healthcare Access</td>
<td>COVID-19 revealed existing health inequities to the public at a time when while chronic disease increased and worsened during a period of isolation and social distancing</td>
<td>Opportunities to improve communication strategies in order to meet under-resourced communities where they are</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health communication and messaging developed by those in charge may be</td>
<td>Impact may have been significant enough to change the way people think about public health</td>
</tr>
</tbody>
</table>
Based on assumptions and not reach those in need (language, culture, technology access, geographic location)

- Public health guidance for pandemic safety was not an option for many who needed to work front-line roles and lived in multigenerational homes that put them at risk (often the same communities at higher risk due to historic health inequities)

- More focus on health issues outside of “who is your healthcare provider” and “how often do you go to the doctor”

- Future preparation will require government departments (not just the health department) working together with the private sector to avoid “gear up” time and maintain partnerships

<table>
<thead>
<tr>
<th>Lack of Faith in Government Entities</th>
<th>Education Health Literacy</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>COVID-19 intensified and made more obvious the extent of distrust of our communities</td>
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<td></td>
<td>Historical distrust and hesitance affected vaccine uptake</td>
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<td></td>
<td>Significant misinformation and mixed messages spread that further hurt the credibility of experts – social media “respected voices” communicated messages that further amplified misinformation</td>
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<tr>
<td></td>
<td>Exposed lack of medical understanding and health literacy in our communities</td>
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<td></td>
<td>Efforts to address vaccine hesitancy has increased knowledge and awareness of agencies of the need</td>
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<td></td>
<td>Countries that appear to have managed the pandemic best also had a high degree of trust among their people – how can this success be replicated</td>
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<td></td>
<td>Potential to enhance education in schools regarding understanding statistics and science</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Environmental Health Concerns</th>
<th>Neighborhood, Community and Environment</th>
<th>Clear that the environment is linked to health and health outcomes</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td>Need better communication to our communities about its importance</td>
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<tr>
<td></td>
<td></td>
<td>Increase political awareness of environmental concerns</td>
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<td></td>
<td></td>
<td>Many opportunities for environmental health to be included in community health</td>
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<td>Social media has really expanded this conversation during the pandemic and created platforms for</td>
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<tr>
<td>Forces</td>
<td>Category</td>
<td>Threats Posed</td>
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<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Violence (Domestic and Interpersonal)</td>
<td>Healthcare Access</td>
<td>• Increased during COVID</td>
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<tr>
<td></td>
<td>Injury and Violence</td>
<td>• Tied to a lack of mental health and substance abuse resources</td>
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<tr>
<td></td>
<td>Mental Health</td>
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<td></td>
<td>Tobacco and Substance Use</td>
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<tr>
<td>Insufficient Mental Health Services/Resources</td>
<td>Healthcare Access</td>
<td>• Demand has increased</td>
</tr>
<tr>
<td></td>
<td>Injury and Violence</td>
<td>• Poor management of behavioral health systems</td>
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<tr>
<td></td>
<td>Mental Health</td>
<td>• Increased hospitalizations</td>
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<td></td>
<td>Tobacco and Substance Use</td>
<td>• Increase in violence</td>
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<td></td>
<td></td>
<td>• Kids/adults stuck at home with abusers</td>
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<td>• Providers decreased because of COVID regulations, etc.</td>
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<td>• Pandemic related social isolation – major behavioral issues in schools</td>
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<td></td>
<td>• Lack of insurance coverage, especially private insurance payors</td>
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<td>• Needs for more mental health support services in schools</td>
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<td>• Law enforcement</td>
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<td></td>
<td>• Transportation</td>
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<td></td>
<td></td>
<td>• Workforce challenges</td>
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## Substance Abuse

<table>
<thead>
<tr>
<th>Healthcare Access</th>
<th>Mental Health</th>
<th>Tobacco and Substance Use</th>
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</thead>
<tbody>
<tr>
<td>Opioid crisis has dramatically increased because of pandemic</td>
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<tr>
<td>Mental health and substance abuse are connected</td>
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<tr>
<td>Demand has increased for services</td>
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<tr>
<td>Providers decreased because of COVID regulations, etc.</td>
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<td>No increase in providers to match the expansion of medical care plans</td>
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</tr>
<tr>
<td>Additional coverage cost/Supplemental programs are too expensive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capacity in community needs to increase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need more data and understanding in this area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce challenges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language barriers present challenges to care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Immigration/Immigrant Population

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Healthcare Access</th>
<th>Neighborhood, Community and Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population most-at-risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mistrust/perception in community keeps population from access care and services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Structural impacts affect resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immigration status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce challenges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not equitably providing this population with services or resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language barriers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income/wealth challenges – they are the lowest earners in the community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited or no access to healthcare despite working multiple jobs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Medicaid expansion of services helps more people
- Also created an opportunity for more providers to help population
- Increased/enhanced community partnership to meet needs where possible
- Increases diversity of community
- Better targeted messaging and outreach during COVID pandemic
- Trusted community members aided health communication and messaging from organizations
### Appendix C: FOCA

#### Income/Wealth Disparities

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Healthcare Access</th>
<th>Mental Health</th>
<th>Neighborhood, Community and Environment</th>
</tr>
</thead>
</table>

- Limited or no access to transportation (impacted during COVID so this impacted their ability to get to work)

#### Access to Care

<table>
<thead>
<tr>
<th>Chronic Conditions</th>
<th>Healthcare Access</th>
<th>Mental Health</th>
</tr>
</thead>
</table>

- Declined and became a huge barrier during COVID pandemic
- Having to go through a different FAP (barrier)
- Transportation
- Workforce challenges

#### Figure C7. Faith Based Leaders, All Regions

<table>
<thead>
<tr>
<th>Forces</th>
<th>Category</th>
<th>Threats Posed</th>
<th>Opportunities Created</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in Mental Health Impact on Community</td>
<td>Chronic Conditions Healthcare Access Health Literacy Mental Health</td>
<td>• Need more providers trained in intersectionality to help address multiple identities in the space of behavioral/mental health&lt;br&gt;• Need more providers for long-term intervention&lt;br&gt;• Faith leaders can only provide short-term</td>
<td>• Church counseling ministries have increased to address awareness for behavioral health and mental health support&lt;br&gt;• Awareness for services and programs has increased&lt;br&gt;• Would like to expand services and</td>
</tr>
</tbody>
</table>
### Appendix C: FOCA

<table>
<thead>
<tr>
<th>Neighbors, Community and Environment</th>
<th>Interventions for faith-based counseling</th>
<th>Make them more well-known to all of community – reducing stigma</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Even pastors/faith leaders can only provide short-term intervention. What next? This really is a barrier to care when someone is in a mental health crisis.</td>
<td>- Public providers are overwhelmed.</td>
<td></td>
</tr>
<tr>
<td>- Stigma is still a huge problem regarding mental health in religious/faith communities.</td>
<td>- Many people do not know they are depressed.</td>
<td></td>
</tr>
<tr>
<td>- Depends on word of mouth for referrals for counseling.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Increase in Immigrant/Refugee Population</th>
<th>Economic Stability, Healthcare Access, Health Literacy, Mental Health, Neighborhood, Community and Environment</th>
<th>Individuals have trauma and it is not being addressed sufficiently.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Affordable housing not accessible.</td>
<td>- Commonly told that if those who were seeking citizenship were to apply for social services their applications would be denied.</td>
<td></td>
</tr>
<tr>
<td>- Dual trained community members were trained to do pastoral support and programs/services to help address disparities.</td>
<td>- Need to better address trauma when these community members arrive.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Increase in Food Insecurity/Food Pantries</th>
<th>Economic Stability, Maternal, Infant, Child and Youth Health</th>
<th>Certain ethnic and cultural groups were totally loss to systems (i.e. Haitian, Africans, etc.).</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Not everyone was included as a vulnerable group.</td>
<td>- Community had to come to them instead.</td>
<td>- Increase in community partnership and collaboration to address enhanced need.</td>
</tr>
<tr>
<td>- Churches mobilized community-based food pantries to deliver service to community.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neighborhood, Community and Environment</td>
<td>of services coming to them</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td>• Transportation greatly affected community and food accessibility – especially in counties with limited public transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• School unable to provide dual services that helped address this need</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reduced barriers for community members to access more food for their households and other households were limited due to transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Food pantries were not paying attention and were distributing expired foods a lot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Lack of community trust impacted access to food networks, pantries and resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For accessibility, what Loudoun Hunger Relief did to promote vaccination access was to distribute food at a remote location. LHR was the &quot;anchor&quot; and they partnered with Department of Health to distribute vaccines. LHR gave a gift card as a promo to ensure people would vaccinate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Using volunteers of diverse backgrounds enhanced trust and increased community participation in using services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Test community members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Lots of overlapping services which may have been barriers to communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Integrating food distribution between community partners to streamline access</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Championed peer-to-peer/neighbor-to-neighbor support groups that facilitated transportation and distribution to communities limited by transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reduced the emphasis on targeting ethnic and racial groups and open to all</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barrier to Distributing COVID Assistance</td>
<td>Economic Stability Healthcare Access</td>
<td>Healthcare Access Immunizations and Infectious Disease Mental Health Neighborhood, Community and Environment</td>
</tr>
</tbody>
</table>
Appendix D: Community Themes and Strengths Assessment (CTSA)

Data for the Community Themes and Strengths Assessment (CTSA) were collected through a survey (Figure D1) that asked participants details about themselves, such as gender, race, income and zip code and their opinion about three main questions:

- What are the greatest strengths of our community?
- What are the most important health issues for our community?
- What would most improve the quality of life for our community?

Survey participants could select up to three choices for each question and leave open feedback in a freeform field. The survey was made available online and in paper format and was in the field from January through the first week of April 2022. Surveys were available in Arabic, Amharic, Chinese (Mandarin), English, Farsi, Korean, Spanish, Urdu and Vietnamese. This survey utilized a convenience sampling method; therefore, results from this survey are not generalizable to the entire community.

Themes were identified in the survey in two ways. First, the overall results were considered and a survey response is considered a theme if it is in the top 5 of all responses (as shown in the CHNA Report). Second, the results were analyzed by respondent demographics in order to identify disparities and different perspectives. In this case, a survey response was considered a theme if it fell in the top five for that group.
Appendix D: CTSA

Figure D1. CTSA Survey

Survey Introduction:
Inova is conducting a short, anonymous survey to learn about what is important to people in Northern Virginia. The results will be used to inform ongoing efforts to make this a healthier community. We also ask a few questions about you so we can understand more about who took this survey. If you need more information, please visit https://www.inova.org/about-inova/inova-your-community/community-health-needs-assessments or contact us at CHNA@inova.org or call 703-698-2575. Thank you for participating in this anonymous survey.

We know that COVID-19 has affected health in many ways. Please keep that in mind when answering these questions.

1. In your opinion, what are the greatest strengths of our community?
   Please select up to THREE (3) boxes below:
   - Opportunities to be involved in the community
   - Diversity of the community (social, cultural, faith, economic)
   - Access to healthy food (fresh fruits and vegetables)
   - Housing that is affordable
   - Services that support basic needs (food, clothing, temporary cash assistance)
   - Access to health care
   - Educational opportunities (schools, libraries, vocational programs, universities)
   - A good place for children to live
   - A good place for older adults to live
   - Jobs and a healthy economy
   - Transportation options
   - Mental health and substance abuse services
   - Police, fire and rescue services
   - Safe place to live
   - Parks and recreation
   - Walkable, bikeable community
   - Clean and healthy environment
   - Arts and cultural events
   - Other (please specify):

2. In your opinion, what are the most important health issues for our community?
   Please select up to THREE (3) boxes below:
   - Dental problems
   - Teen pregnancy
   - Maternal, infant and child health
   - Violence and abuse
   - Preventable injuries (car or bicycle crashes, falls)
   - Aging-related health concerns
   - Tobacco use (cigarettes, vaping, e-cigarettes, snuff, chewing tobacco)
   - Alcohol, drug, and/or opiate abuse
   - Mental health problems (depression, anxiety, stress, suicide)
   - Obesity
   - Other chronic health conditions (asthma, cancers, diabetes, heart disease, stroke)
   - Illnesses spread by insects and/or animals (Lyme disease, Zika, rabies)
   - Sexually transmitted diseases
   - HIV
   - Other illnesses that spread from person to person (flu, TB)
   - Vaccine preventable diseases (whooping cough, measles, tetanus)
   - Food safety
   - Intellectual disabilities (autism, developmental disabilities)
   - Sensory disabilities (hearing, vision)
   - Physical disabilities
   - Differences in life expectancy and health outcomes based on race, ethnicity, and economic well-being
   - Other (please specify):
3. In your opinion, what would most improve the quality of life for our community?

Please select up to THREE (3) boxes below:

- Opportunities to be involved in the community
- Welcoming of diversity (social, cultural, faith, economic)
- Access to healthy food (fresh fruits and vegetables)
- Housing that is affordable
- Services that support basic needs (food, clothing, temporary cash assistance)
- Access to health care for all
- Educational opportunities (schools, libraries, vocational programs, universities)
- Jobs and a healthier economy
- Transportation options
- Mental health and substance abuse services
- Improved public safety (law enforcement, fire, EMS)
- Improved public health
- Access to parks and recreation
- A walk-able, bike-able community
- Clean and healthy environment
- Arts and cultural events
- Working to end homelessness
- Other (please specify):

Please answer the following questions about yourself. We ask these questions to better understand your answers.

D1. Your HOME ZIP CODE: ____________

D2. Your AGE Mark (X) only ONE (1) box:
   - Under 18 years
   - 18 - 24 years
   - 25 - 29 years
   - 30 - 39 years
   - 40 - 49 years
   - 50 - 64 years
   - 65 - 79 years
   - 80+ years

D3. Your HIGHEST LEVEL OF EDUCATION
   Mark (X) only ONE (1) box:
   - Less than high school diploma
   - High school diploma / GED
   - Some college
   - Associates / Technical degree
   - Bachelor’s degree
   - Graduate degree or higher

D4. ARE YOU HISPANIC OR LATINO?
   Mark (X) only ONE (1) box:
   - Yes
   - No

D5. Your RACE - Which one or more of the following race categories do you identify with? Select ALL THAT APPLY:
   - American Indian or Alaska Native
   - Asian
   - Black or African American
   - Native Hawaiian or Other Pacific Islander
   - White or Caucasian

D6. Do you live in a home with HOUSEHOLD MEMBERS THAT ARE YOUNGER THAN 18 YEARS OLD? Mark (X) only ONE (1) box:
   - Yes
   - No

D7. Where do you USUALLY GO FOR HEALTHCARE? Mark (X) only ONE (1) box:
   - Hospital / emergency room
   - Private doctor’s office / HMO
   - Urgent care center
   - Free or reduced-fee clinic
   - I don’t get healthcare

D8. Your ASSIGNED SEX AT BIRTH
   Mark (X) only ONE (1) box:
   - Female
   - Male

D9. Your ANNUAL HOUSEHOLD INCOME
   Mark (X) only ONE (1) box:
   - Less than $10,000
   - $10,000 - $49,999
   - $50,000 - $99,999
   - $100,000 - $149,999
   - $150,000+

https://www.surveymonkey.com/r/NoVAHealthAssessment-English
<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number of Respondents</th>
<th>Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Responses</strong></td>
<td>809</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>167</td>
<td>21%</td>
</tr>
<tr>
<td>Not Hispanic/Latino</td>
<td>631</td>
<td>78%</td>
</tr>
<tr>
<td>No response</td>
<td>11</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>20</td>
<td>2%</td>
</tr>
<tr>
<td>Asian</td>
<td>88</td>
<td>11%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>128</td>
<td>16%</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander</td>
<td>6</td>
<td>1%</td>
</tr>
<tr>
<td>White or Caucasian</td>
<td>523</td>
<td>65%</td>
</tr>
<tr>
<td>No response</td>
<td>76</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Language</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amharic</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Arabic</td>
<td>2</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Chinese</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>English</td>
<td>709</td>
<td>88%</td>
</tr>
<tr>
<td>Farsi</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Spanish</td>
<td>74</td>
<td>9%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>12</td>
<td>1%</td>
</tr>
<tr>
<td>Urdu</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Korean</td>
<td>10</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Lives with child (&lt;18 years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>372</td>
<td>46%</td>
</tr>
<tr>
<td>No</td>
<td>424</td>
<td>52%</td>
</tr>
<tr>
<td>No response</td>
<td>13</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>599</td>
<td>74%</td>
</tr>
<tr>
<td>Male</td>
<td>191</td>
<td>24%</td>
</tr>
<tr>
<td>No response</td>
<td>19</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Annual Household Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than $10,000</td>
<td>36</td>
<td>4%</td>
</tr>
<tr>
<td>$10,000 to $49,000</td>
<td>144</td>
<td>18%</td>
</tr>
<tr>
<td>$50,000 to $99,999</td>
<td>161</td>
<td>20%</td>
</tr>
<tr>
<td>$100,000 to $149,000</td>
<td>176</td>
<td>22%</td>
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<tr>
<td>Greater than $150,000</td>
<td>246</td>
<td>30%</td>
</tr>
<tr>
<td>No response</td>
<td>46</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Age Category</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 18 years</td>
<td>26</td>
<td>3%</td>
</tr>
<tr>
<td>18-24 years</td>
<td>32</td>
<td>4%</td>
</tr>
<tr>
<td>25-29 years</td>
<td>36</td>
<td>4%</td>
</tr>
<tr>
<td>30-39 years</td>
<td>157</td>
<td>19%</td>
</tr>
</tbody>
</table>
### Education

<table>
<thead>
<tr>
<th></th>
<th>Number of People Who Selected Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than High School Diploma</td>
<td>73</td>
<td>9%</td>
</tr>
<tr>
<td>High School Diploma or GED</td>
<td>73</td>
<td>9%</td>
</tr>
<tr>
<td>Some College</td>
<td>55</td>
<td>7%</td>
</tr>
<tr>
<td>Associates or Technical Degree</td>
<td>30</td>
<td>4%</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>235</td>
<td>29%</td>
</tr>
<tr>
<td>Graduate Degree or Higher</td>
<td>334</td>
<td>41%</td>
</tr>
<tr>
<td>No response</td>
<td>9</td>
<td>1%</td>
</tr>
</tbody>
</table>

### Regular Source of Healthcare

<table>
<thead>
<tr>
<th></th>
<th>Number of People Who Selected Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital or Emergency Room</td>
<td>56</td>
<td>7%</td>
</tr>
<tr>
<td>Private Doctor’s Office or HMO</td>
<td>621</td>
<td>77%</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>39</td>
<td>5%</td>
</tr>
<tr>
<td>Free or Reduced Fee Clinic</td>
<td>48</td>
<td>6%</td>
</tr>
<tr>
<td>I don’t get healthcare</td>
<td>31</td>
<td>4%</td>
</tr>
<tr>
<td>No response</td>
<td>14</td>
<td>2%</td>
</tr>
</tbody>
</table>

**Top Five Answers to “What are the top health issues facing our community?” by Select Demographic Groups**

### Figure D3. Low Income Respondents (Household Income <$50,000/year)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Response</th>
<th>Number of People Who Selected Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mental health problems (depression, anxiety, stress, suicide)</td>
<td>90</td>
</tr>
<tr>
<td>2</td>
<td>Dental problems</td>
<td>56</td>
</tr>
<tr>
<td>3</td>
<td>Alcohol, drug and/or opiate abuse</td>
<td>49</td>
</tr>
<tr>
<td>4</td>
<td>Other chronic health conditions (asthma, cancers, diabetes, heart disease, stroke)</td>
<td>41</td>
</tr>
<tr>
<td>5</td>
<td>Violence and abuse</td>
<td>35</td>
</tr>
</tbody>
</table>

### Figure D4. Respondents with Less than a High School Diploma or GED (25+ years of age)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Response</th>
<th>Number of People Who Selected Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Dental problems</td>
<td>26</td>
</tr>
<tr>
<td>2</td>
<td>Other chronic health conditions (asthma, cancers, diabetes, heart disease, stroke)</td>
<td>22</td>
</tr>
<tr>
<td>3</td>
<td>Mental health problems (depression, anxiety, stress, suicide)</td>
<td>18</td>
</tr>
<tr>
<td>4</td>
<td>Alcohol, drug and/or opiate abuse</td>
<td>8</td>
</tr>
<tr>
<td>5</td>
<td>Maternal, infant and child health</td>
<td>6</td>
</tr>
</tbody>
</table>
## Appendix D: CTSA

### Figure D5. Younger Respondents (<25 years of age)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Response</th>
<th>Number of People Who Selected Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mental health problems (depression, anxiety, stress, suicide)</td>
<td>36</td>
</tr>
<tr>
<td>2</td>
<td>Alcohol, drug and/or opiate abuse</td>
<td>22</td>
</tr>
<tr>
<td>3</td>
<td>Tobacco use (cigarettes, vaping, e-cigarettes, snuff, chewing tobacco)</td>
<td>16</td>
</tr>
<tr>
<td>4</td>
<td>Violence and abuse</td>
<td>15</td>
</tr>
<tr>
<td>5</td>
<td>Differences in life expectancy and health outcomes based on race, ethnicity and economic well-being</td>
<td>12</td>
</tr>
</tbody>
</table>

### Figure D6. Older Respondents (50 years of age or older)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Response</th>
<th>Number of People Who Selected Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mental health problems (depression, anxiety, stress, suicide)</td>
<td>193</td>
</tr>
<tr>
<td>2</td>
<td>Differences in life expectancy and health outcomes based on race, ethnicity and economic well-being</td>
<td>118</td>
</tr>
<tr>
<td>3</td>
<td>Aging-related health concerns</td>
<td>100</td>
</tr>
<tr>
<td>4</td>
<td>Other chronic health conditions (asthma, cancers, diabetes, heart disease, stroke)</td>
<td>82</td>
</tr>
<tr>
<td>5</td>
<td>Alcohol, drug and/or opiate abuse</td>
<td>80</td>
</tr>
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</table>

### Figure D7. Spanish Speaking Respondents (Survey Language in Spanish)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Response</th>
<th>Number of People Who Selected Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Dental problems</td>
<td>35</td>
</tr>
<tr>
<td>2</td>
<td>Other chronic health conditions (asthma, cancers, diabetes, heart disease, stroke)</td>
<td>26</td>
</tr>
<tr>
<td>3</td>
<td>Mental health problems (depression, anxiety, stress, suicide)</td>
<td>24</td>
</tr>
<tr>
<td>4</td>
<td>Alcohol, drug and/or opiate abuse</td>
<td>18</td>
</tr>
<tr>
<td>5</td>
<td>Tobacco use (cigarettes, vaping, e-cigarettes, snuff, chewing tobacco)</td>
<td>14</td>
</tr>
</tbody>
</table>

### Figure D8. Survey Completed in a Language other than English or Spanish

<table>
<thead>
<tr>
<th>Rank</th>
<th>Response</th>
<th>Number of People Who Selected Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mental health problems (depression, anxiety, stress, suicide)</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>Tobacco use (cigarettes, vaping, e-cigarettes, snuff, chewing tobacco)</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>Obesity</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Food safety</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>Alcohol, drug and/or opiate abuse</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Other chronic health conditions (asthma, cancers, diabetes, heart disease, stroke)</td>
<td>5</td>
</tr>
</tbody>
</table>
### Figure D9. Respondents of Color (All respondents except white, non-Hispanic or without race/ethnicity info)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Response</th>
<th>Number of People Who Selected Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mental health problems (depression, anxiety, stress, suicide)</td>
<td>197</td>
</tr>
<tr>
<td>2</td>
<td>Other chronic health conditions (asthma, cancers, diabetes, heart disease, stroke)</td>
<td>99</td>
</tr>
<tr>
<td>3</td>
<td>Alcohol, drug and/or opiate abuse</td>
<td>94</td>
</tr>
<tr>
<td>4</td>
<td>Differences in life expectancy and health outcomes based on race, ethnicity and economic well-being</td>
<td>83</td>
</tr>
<tr>
<td>5</td>
<td>Dental problems</td>
<td>78</td>
</tr>
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</table>

### Figure D10. Respondents of Hispanic or Latino Ethnicity (regardless of race)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Response</th>
<th>Number of People Who Selected Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mental health problems (depression, anxiety, stress, suicide)</td>
<td>80</td>
</tr>
<tr>
<td>2</td>
<td>Dental problems</td>
<td>58</td>
</tr>
<tr>
<td>3</td>
<td>Other chronic health conditions (asthma, cancers, diabetes, heart disease, stroke)</td>
<td>47</td>
</tr>
<tr>
<td>4</td>
<td>Alcohol, drug and/or opiate abuse</td>
<td>40</td>
</tr>
<tr>
<td>5</td>
<td>Violence and abuse</td>
<td>32</td>
</tr>
</tbody>
</table>

### Figure D11. Female Respondents

<table>
<thead>
<tr>
<th>Rank</th>
<th>Response</th>
<th>Number of People Who Selected Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mental health problems (depression, anxiety, stress, suicide)</td>
<td>815</td>
</tr>
<tr>
<td>2</td>
<td>Differences in life expectancy and health outcomes based on race, ethnicity and economic well-being</td>
<td>357</td>
</tr>
<tr>
<td>3</td>
<td>Other chronic health conditions (asthma, cancers, diabetes, heart disease, stroke)</td>
<td>355</td>
</tr>
<tr>
<td>4</td>
<td>Alcohol, drug and/or opiate abuse</td>
<td>320</td>
</tr>
<tr>
<td>5</td>
<td>Violence and abuse</td>
<td>287</td>
</tr>
</tbody>
</table>
Appendix E: Community Health Status Assessment (CHSA)

The health indicators that comprised the Community Health Status Assessment (CHSA) were selected based on best practices, availability and local knowledge of emerging health issues. The data include rates and percentages of mortality, morbidity, incidence and prevalence (death, chronic illness and new and existing disease). Data were compiled from published secondary sources and surveys in June 2022. County-level data, as well as breakdowns by population characteristics, was not consistently available, which means the amount of information within certain health topics may be limited. Specific indicators were selected and compiled to support a broad picture of health in the Mount Vernon Community and may not encompass all data available.

Figure E1 lists the data sources for Figure E2, which provides an overview of much but not all of the data considered. Please contact Inova for more information.

Figure E1. CHSA Data Sources

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Community Survey</td>
<td>ACS</td>
</tr>
<tr>
<td>Centers for Disease Control and Prevention</td>
<td>CDC</td>
</tr>
<tr>
<td>Centers for Medicare and Medicaid Services</td>
<td>CMS</td>
</tr>
<tr>
<td>County Health Rankings</td>
<td>CHR</td>
</tr>
<tr>
<td>Feeding America</td>
<td>FA</td>
</tr>
<tr>
<td>National Cancer Institute, State Cancer Profiles</td>
<td>NCI-SEER</td>
</tr>
<tr>
<td>National Center for Health Statistics</td>
<td>NCHS</td>
</tr>
<tr>
<td>Small Area Health Insurance Estimates, Census</td>
<td>SAHIE</td>
</tr>
<tr>
<td>US Bureau of Labor Statistics</td>
<td>BLS</td>
</tr>
<tr>
<td>Virginia Behavioral Risk Factor Surveillance System</td>
<td>VA BRFSS</td>
</tr>
<tr>
<td>Virginia Department for Aging and Rehabilitative Services</td>
<td>VA DARS</td>
</tr>
<tr>
<td>Virginia Department of Education</td>
<td>VDE</td>
</tr>
<tr>
<td>Virginia Department of Health</td>
<td>VDH</td>
</tr>
<tr>
<td>Virginia Health Information</td>
<td>VHI</td>
</tr>
<tr>
<td>Virginia Online Injury Reporting System</td>
<td>VOIRS</td>
</tr>
<tr>
<td>Category</td>
<td>Data Point</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>Chronic Conditions</td>
<td>Persons with a disability</td>
</tr>
<tr>
<td></td>
<td>Age-adjusted death rate due to cancer</td>
</tr>
<tr>
<td></td>
<td>Age-adjusted death rate due to diabetes</td>
</tr>
<tr>
<td></td>
<td>Age-adjusted death rate due to heart disease</td>
</tr>
<tr>
<td></td>
<td>Age-adjusted death rate due to stroke</td>
</tr>
<tr>
<td></td>
<td>Age-adjusted hospitalization due to diabetes</td>
</tr>
<tr>
<td></td>
<td>Age-adjusted hospitalization due to pediatric asthma</td>
</tr>
<tr>
<td></td>
<td>Age-adjusted hospitalization rate due to adult asthma</td>
</tr>
<tr>
<td></td>
<td>Age-adjusted hospitalization rate due to heart failure</td>
</tr>
<tr>
<td></td>
<td>Age-adjusted hospitalization rate due to hypertension</td>
</tr>
<tr>
<td></td>
<td>All cancer incidence rate</td>
</tr>
<tr>
<td></td>
<td>Medicare beneficiaries with Alzheimer’s Disease or Dementia</td>
</tr>
<tr>
<td></td>
<td>Age Adjusted COPD hospitalization</td>
</tr>
<tr>
<td></td>
<td>Persons with a disability who live in poverty</td>
</tr>
<tr>
<td>Economic Stability</td>
<td>Median Household Income</td>
</tr>
<tr>
<td></td>
<td>Children living below poverty level</td>
</tr>
<tr>
<td></td>
<td>People 65+ living below poverty level</td>
</tr>
<tr>
<td></td>
<td>People living below poverty level</td>
</tr>
<tr>
<td></td>
<td>Child food insecurity rate</td>
</tr>
<tr>
<td></td>
<td>Food insecurity rate</td>
</tr>
<tr>
<td></td>
<td>Social and Economic Factors Ranking</td>
</tr>
<tr>
<td></td>
<td>Students Eligible for the Free Lunch Program</td>
</tr>
<tr>
<td></td>
<td>Income Inequality</td>
</tr>
<tr>
<td>Category</td>
<td>Data Point</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annual Unemployment Rate</td>
</tr>
<tr>
<td></td>
<td>People 25+ with a Bachelor's degree or higher</td>
</tr>
<tr>
<td></td>
<td>High school graduation</td>
</tr>
<tr>
<td></td>
<td>Proportion of students receiving advanced studies diploma</td>
</tr>
<tr>
<td></td>
<td>Enrolled in any post-secondary</td>
</tr>
<tr>
<td></td>
<td>Adults with Health Insurance</td>
</tr>
<tr>
<td></td>
<td>Children with Health Insurance</td>
</tr>
<tr>
<td></td>
<td>Clinical Care Ranking</td>
</tr>
<tr>
<td></td>
<td>Colon Cancer Screening</td>
</tr>
<tr>
<td></td>
<td>Mammogram in Past 2 Years: 50-74</td>
</tr>
<tr>
<td></td>
<td>Pap test in past three years</td>
</tr>
<tr>
<td></td>
<td>Preventable Hospital Stays - Medicare Population</td>
</tr>
<tr>
<td></td>
<td>Below 138% FPL uninsured</td>
</tr>
<tr>
<td>Immunizations and Infectious Disease</td>
<td>Adults 65+ with pneumonia vaccination</td>
</tr>
<tr>
<td></td>
<td>Lyme Disease Incidence</td>
</tr>
<tr>
<td></td>
<td>Tuberculosis incidence</td>
</tr>
<tr>
<td></td>
<td>Varicella (Chickenpox) incidence</td>
</tr>
<tr>
<td></td>
<td>Hepatitis B, chronic</td>
</tr>
<tr>
<td></td>
<td>Hepatitis C, chronic</td>
</tr>
<tr>
<td>Maternal, Infant and Child Health</td>
<td>Babies with low birth weight</td>
</tr>
<tr>
<td></td>
<td>Infant mortality rate</td>
</tr>
<tr>
<td></td>
<td>Mothers who received early prenatal care</td>
</tr>
<tr>
<td>Category</td>
<td>Data Point</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Appendix E: CHSA</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>Teen birth rate 15-17</td>
</tr>
<tr>
<td></td>
<td>Teen birth rate &lt;19</td>
</tr>
<tr>
<td></td>
<td>Infants born preterm</td>
</tr>
<tr>
<td></td>
<td>Age-adjusted death rate due to suicide</td>
</tr>
<tr>
<td></td>
<td>Frequent mental distress (14+ days)</td>
</tr>
<tr>
<td></td>
<td>Mental health provider rate</td>
</tr>
<tr>
<td></td>
<td>Poor mental health: 5+ days</td>
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<tr>
<td></td>
<td>Adults ever diagnosed with a depressive disorder</td>
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<tr>
<td></td>
<td>Depression: Medicare population</td>
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<tr>
<td><strong>Neighborhood, Community and Environment</strong></td>
<td>Severe housing problems</td>
</tr>
<tr>
<td></td>
<td>Renters spending 30% or more on household income on rent (30.0-34.9)</td>
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<tr>
<td></td>
<td>Renters spending 30% or more on household income on rent (35.0 or more)</td>
</tr>
<tr>
<td></td>
<td>Mean travel time to work</td>
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<tr>
<td></td>
<td>Workers commuting by public transportation</td>
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<td></td>
<td>Workers who walk to work</td>
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<tr>
<td></td>
<td>Food Environment Index</td>
</tr>
<tr>
<td></td>
<td>Residential segregation non-white/white index</td>
</tr>
<tr>
<td></td>
<td>Residential segregation black/white index</td>
</tr>
<tr>
<td><strong>Obesity, Nutrition</strong></td>
<td>Access to exercise opportunities</td>
</tr>
<tr>
<td>Category and Physical Activity</td>
<td>Data Point</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Adults engaging in physical activity</td>
<td>Alexandria City</td>
</tr>
<tr>
<td>Adults who are overweight or obese</td>
<td>Alexandria City</td>
</tr>
<tr>
<td>Adults who are sedentary</td>
<td>Alexandria City</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Oral Health</th>
<th>Data Point</th>
<th>Value</th>
<th>Unit of measure</th>
<th>Year of Data</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist rate</td>
<td>Alexandria City</td>
<td>85.00</td>
<td>Fairfax County</td>
<td>108.00</td>
<td>2019</td>
</tr>
<tr>
<td>Visited dentist in past year</td>
<td>Alexandria City</td>
<td>76.30</td>
<td>Fairfax County</td>
<td>77.50</td>
<td>2018</td>
</tr>
<tr>
<td>Teeth Extractions- 65+</td>
<td>Alexandria City</td>
<td>8.10</td>
<td>Fairfax County</td>
<td>6.70</td>
<td>2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual and Reproductive Health</th>
<th>Data Point</th>
<th>Value</th>
<th>Unit of measure</th>
<th>Year of Data</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia incidence rate</td>
<td>Alexandria City</td>
<td>414.00</td>
<td>Fairfax County</td>
<td>249.20</td>
<td>2020</td>
</tr>
<tr>
<td>Gonorrhea incidence rate</td>
<td>Alexandria City</td>
<td>124.80</td>
<td>Fairfax County</td>
<td>55.30</td>
<td>2020</td>
</tr>
<tr>
<td>HIV/AIDS prevalence rate</td>
<td>Alexandria City</td>
<td>7.60</td>
<td>Fairfax County</td>
<td>5.00</td>
<td>2020</td>
</tr>
<tr>
<td>Teen pregnancy rate</td>
<td>Alexandria City</td>
<td>12.60</td>
<td>Fairfax County</td>
<td>3.50</td>
<td>2020</td>
</tr>
<tr>
<td>HIV Incidence</td>
<td>Alexandria City</td>
<td>5.00</td>
<td>Fairfax County</td>
<td>5.90</td>
<td>2021</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tobacco and Substance Use</th>
<th>Data Point</th>
<th>Value</th>
<th>Unit of measure</th>
<th>Year of Data</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults who drink excessively</td>
<td>Alexandria City</td>
<td>19.00</td>
<td>Fairfax County</td>
<td>15.00</td>
<td>2019</td>
</tr>
<tr>
<td>Adults who smoke</td>
<td>Alexandria City</td>
<td>12.00</td>
<td>Fairfax County</td>
<td>11.00</td>
<td>2019</td>
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<tr>
<td>Death rate due to or heroin overdose</td>
<td>Alexandria City</td>
<td>0.60</td>
<td>Fairfax County</td>
<td>0.40</td>
<td>2020</td>
</tr>
<tr>
<td>Death rate due to opioid overdose</td>
<td>Alexandria City</td>
<td>10.70</td>
<td>Fairfax County</td>
<td>5.70</td>
<td>2020</td>
</tr>
<tr>
<td>Emergency department visit rate due to heroin</td>
<td>Alexandria City</td>
<td>3.20</td>
<td>Fairfax County</td>
<td>2.30</td>
<td>2020</td>
</tr>
<tr>
<td>Emergency department visit rate due to opioids</td>
<td>Alexandria City</td>
<td>30.50</td>
<td>Fairfax County</td>
<td>29.00</td>
<td>2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Violence and Injury</th>
<th>Data Point</th>
<th>Value</th>
<th>Unit of measure</th>
<th>Year of Data</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violent Crime rate</td>
<td>Alexandria City</td>
<td>186.00</td>
<td>Fairfax County</td>
<td>96.00</td>
<td>2014-2016</td>
</tr>
<tr>
<td>Age-Adjusted Hospitalization Rate related to unintentional fall</td>
<td>Alexandria City</td>
<td>11.90</td>
<td>Fairfax County</td>
<td>14.60</td>
<td>2020</td>
</tr>
<tr>
<td>All-cause injury deaths</td>
<td>Alexandria City</td>
<td>30.30</td>
<td>Fairfax County</td>
<td>32.60</td>
<td>2020</td>
</tr>
<tr>
<td>Firearm deaths</td>
<td>Alexandria City</td>
<td>7.60</td>
<td>Fairfax County</td>
<td>5.60</td>
<td>2020</td>
</tr>
<tr>
<td>Motor vehicle deaths</td>
<td>Alexandria City</td>
<td>3.80</td>
<td>Fairfax County</td>
<td>3.20</td>
<td>2020</td>
</tr>
<tr>
<td>All-cause injury hospitalizations</td>
<td>Alexandria City</td>
<td>194.60</td>
<td>Fairfax County</td>
<td>234.50</td>
<td>2020</td>
</tr>
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</table>
Appendix F: Identifying Top Health Issues Methodology

As described throughout this document and the CHNA Report, each of the three assessments identified areas of concern. Community health needs were determined to be “top health issues” if they were identified as problematic in at least two of the three assessments. An Assessment Scoring Matrix was developed in order to visualize these results. Figure F1 shows this matrix for the Mount Vernon Community.

Figure F1: Mount Vernon Community Assessment Scoring Matrix

<table>
<thead>
<tr>
<th>Category</th>
<th>CTSA Theme?</th>
<th>CHSA Theme?</th>
<th>FOCA Theme?</th>
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</thead>
<tbody>
<tr>
<td>Chronic Conditions</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>(stroke, heart disease, diabetes, Alzheimer's/dementia, arthritis, cancer)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic Stability</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(income inequality, poverty, unemployment, housing costs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(school climate, graduation rates, college)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Literacy</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>(misinformation, disparity awareness, community health education)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare Access</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>(insurance coverage, unnecessary hospitalization, healthcare disparities)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations and Infectious Disease</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>(infectious disease incidence, immunization rates)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injury and Violence</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(accidental injury, motor vehicle collision, assault)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal, Infant, Child and Youth health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(infant mortality, maternal mortality, birth rate among adolescents, prenatal care)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(mental distress, depression, anxiety, aggression, suicide)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neighborhood, Community and Environment</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(safety, food access, commuting, green space, climate impacts, diversity, polarization)</td>
<td></td>
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<tr>
<td>Obesity, Nutrition and Physical Activity</td>
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<td>X</td>
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<tr>
<td>(obesity, food insecurity, physical activity)</td>
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<tr>
<td>Oral Health</td>
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<td>X</td>
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<tr>
<td>(tooth loss, received dental services)</td>
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<tr>
<td>Sexual and Reproductive Health</td>
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<tr>
<td>(sexual wellness, HIV and STI incidence and prevalence)</td>
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<tr>
<td>Tobacco and Substance Use</td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td>(tobacco and e-cigarette use, alcohol and drug use)</td>
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Using this framework, the top health issues identified for the Mount Vernon Community are: chronic conditions; economic stability; healthcare access; mental health; neighborhood, community and environment; and tobacco and substance use.
Appendix G: Actions Taken Since Previous CHNA

This appendix discusses community health improvement actions taken by Inova since its last CHNA reports were published in 2019 and based on the subsequently developed Implementation Strategies. The information is included in the 2021 CHNA reports to respond to final IRC 501(r) regulations.

Members of the Community Health Division, Inova leadership, Inova Mount Vernon Hospital, Fairfax County Health Department and community partners have been working diligently on the priority areas set forth in the 2019 CHNA Implementation Strategy.

Through the work and collaboration of diverse stakeholders, much progress has been made. In early 2020, two listening sessions were conducted to gather region wide insights from stakeholders regarding issues presented in the Implementation Strategy. These groups discussed Healthcare Workforce Development and Behavioral Health Gaps. Stakeholders included representation from local colleges and universities, the Area Health Education Center, County Health Departments, Public Schools, Federally Qualified Health Centers, Community Services Boards and behavioral health providers. The insights gathered provide perspective on the scope of gaps and opportunities.

Soon after, COVID-19 lockdowns and shifting priorities put many of the Implementation Strategy approaches on hold. Efforts continued to maintain partnerships and support community work. In collaboration with the Partnership for a Healthier Fairfax, Inova partnered in Community Health Improvement Plan efforts to address community stakeholder post-pandemic recovery and to address social isolation and develop a toolkit of resources to assist individuals experiencing the mental health impact of social isolation for a variety of issues including age, physical health, mental health, sexual orientation and gender identity.

Inova is a partner of the county’s Community Provider Strategy Team (CPST), formerly the Community Provider Coordination Team (CPCT), and participates on numerous subcommittees related to health access, food and communication. During 2020, this group also collaborated to communicate and address COVID-19-related health disparities and connect services to clients in the community.

Due to significant changes to the social and health landscapes, the Implementation Strategy was shifted in mid-2020 to include the lenses of health equity, antiracism and social determinants of health. A structure was implemented whereby a steering committee addresses system-wide approaches to improving CHNA-identified health needs and the Mount Vernon Health Equity Community Action Committee consisting of Inova team members and community partners identifies local needs and opportunities and develops partnerships to address them. The Steering Committee meets monthly to identify needs and opportunities throughout the system. The Action Committee also meets monthly and brings together representatives from multiple Inova departments, faith-based organizations, primary and secondary education institutions, community businesses and organizations, mental health stakeholders, United Community, Neighborhood Health FQHC and county teams including Equity, Community Services Board, Public Schools, Health Department, and Neighborhood and Community Services and community members who reside in the Mt. Vernon neighborhoods.

Inova in the Community (Improving Healthcare Access)
The Action Committee conversations in Mount Vernon as well as those in other regions of Northern Virginia supported Inova’s efforts to have an increased presence in and engagement with its local
Appendix G: Actions Taken

communities to build trust. A tool was developed to collect information from Inova team members with interest in sharing their expertise at community events and activities. Rather than create events, Inova works with local non-profit, faith, clinical, government and neighborhood partners to collaboratively deliver resources at events and activities designed and attended by community members. Inova team members volunteer their time and expertise at a variety of events including health fairs, health education sessions, workforce development opportunities and community celebrations. In Mt. Vernon, this included participating in events such as a Juneteenth celebration at Creekside, Multicultural Community Day at Sequoyah, Multicultural Community Day at Audubon, Woodlawn Apartments Community Day, the Trunk and Treat Halloween Resource Fair at the Sacramento Neighborhood Center and a month of culturally competent holiday season events in December for the Audubon Community.

Inova and partners recognize that to improve healthcare access it is important to improve awareness of existing community resources. Reaching under-resourced communities with messaging about services requires tailored approaches and have included the use of Community Health Workers, trusted messengers and popular opinion leaders, multi-lingual and multi-cultural outreach, targeted social media campaigns and interagency partnerships and cross-promotion.

Inova Community Health Clinics and Programs Respond to Needs
The Inova Cares Clinics and outreach programs have expanded many services. As the COVID-19 pandemic worsened and under-resourced communities suffered disproportionately, Inova moved to make many resources available to improve safety and expand access. Physicians from across the Inova system worked at the community health clinics to ensure sufficient resources for these patients. Pulse oximeters were provided to patients free of charge so they could self-monitor during COVID-19 infection and keep in touch with their providers about their readings. Pregnant patients at Inova Cares Clinic for Women were provided free blood pressure cuffs and scales to reduce the number of in-person visits required while still ensuring appropriate monitoring and care.

Food insecurity was already prevalent in the community, and the pandemic only worsened the situation. Inova Cares Clinics for Women and Children and Care Connections for the Community worked with local grocery stores and other partners to collect food and distribute it, often right to the doors of families without access to healthy meals. As the pandemic and the ongoing issues of food access persisted, food pantries were set up at the Inova Cares Clinics for Families, and planning for pantries in the Inova hospitals is underway.

As schools planned to reopen in the fall of 2021, Inova and its partners recognized the challenges facing parents in preparing their children to return. This included difficulties getting caught up on vaccinations and back to school physicals. In 2021 and 2022, Inova Cares Clinics for Children and Families partnered with local health departments, schools and community partners to make weekend and weekday clinics available for families to prepare for a healthy new school year.

Inova has made great strides in creating safe spaces for the LGBTQ+ community to seek healthcare and support. Inova’s hospitals have been ranked by the Human Rights Campaign Healthcare Equality index, which promotes equitable and inclusive care for all patients and their families. In 2022, the Inova Pride Clinic opened its doors to provide inclusive and judgment-free care, answering questions and supporting long-term health and wellness without barriers. This first-of-its-kind clinic provides primary care and mental health services and addresses LGBTQ-specific healthcare needs.
Creating a Diverse Workforce (Improving Healthcare Access, Supporting Behavioral Health)

Dream Big, Inova's health equity-based workforce development initiative, aims to increase racial and ethnic diversity in the healthcare workforce to better reflect and represent the communities Inova has the privilege to serve. The program was created in 2021 and gives minority youth an up-close look at a variety of healthcare careers and roles. Inova team members of diverse backgrounds and professions – known as the Dream Team – created short videos highlighting their career journeys. Team members visit Title 1 middle and high schools in Northern Virginia to show the videos and share their work-life experiences. The goal is to inspire young people to visualize their own healthcare career success stories. The first Dream Big events were conducted in the Mt. Vernon region in partnership with the local Title I schools.

In addition, Inova Community Health and Inova Talent Acquisition joined forces to develop resources for youth and adults who aspire to a healthcare career. Information includes positions that don't require post-secondary education, career ladders and tuition assistance options at Inova. These materials can help students determine next steps after high school, as well as offer adults opportunities to join the healthcare field. It’s a win-win – providing the community with career opportunities and economic stability and providing Inova with a culturally responsive and representative workforce.

Social Determinants of Health Screening (Improving Healthcare Access, Addressing Chronic Conditions, Supporting Behavioral Health)

In 2021, Inova established a Clinical Effectiveness sprint to implement Social Determinants of Health screenings across the system. The screening tool is made up of validated questions assessing need in a wide array of social determinants. The project brought together a team representing all aspects of the Inova workforce to determine how the tool and resulting “wheel” should be presented, who it should be available to, and what was necessary to begin socializing its use. The tool launched at the end of August following the project and a variety of mechanisms are in place to gather the information, including directly from patients, via the MyChart patient portal. A resource page was created on the Inova intranet to assist in the use of the tool and referrals based on individual responses. The system is in the process of implementing an SDOH referral platform (Unite Us/Unite Virginia) for active referrals to social services and non-profit partners, and the Inova team is encouraging referral partners to join the platform as well. This will close the loop for those using the screening tool and needing easy access to resources for patients.

Community Health Fund/Health Equity Grants (Improving Healthcare Access, Addressing Chronic Conditions, Supporting Behavioral Health)

Every year Inova provides Community Fund grants to non-profit organizations in Northern Virginia providing services aligned with the CHNA. In 2020, the overall award amount was doubled to $120,000. Awarded to: The Women’s Center and The American Foundation for Suicide Prevention.

In 2021, the overall award amount was again doubled to $240,000. Awarded to: United Community and Our Minds Matter (Formerly The Josh Anderson Foundation).

In 2022, the grant program was renamed to the Inova Health Equity Grants and the total award amount was quadrupled to one million dollars. Recipients located in Mount Vernon include Arm & Arm and the Capital Area Food Bank. Several other awardees will be providing services in the region.
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Community Health Workers (Improving Healthcare Access, Addressing Chronic Conditions)
Inova is a member of the Virginia Hospital & Healthcare Association and participated in its HealthBegins cohort to use health disparity data to drive interventions. A charter was developed to identify and address food insecurity and access in the area bordering Fairfax County and the City of Alexandria. This effort led to increased interest in the use of Community Health Workers (CHW) to partner with individuals and communities to promote health and address social determinants of health. In 2020, a CHW was hired for the charter region and another was identified for zip codes in eastern Loudoun County. CHW roles are now present in all Inova Cares Clinic for Families sites located in regions with high rates of health disparities.

Healthcare Worker Education (Improving Healthcare Access)
In September 2020, Inova presented the second annual Healthcare Disparities Conference entitled: “Culture of Health: A Call to Action for Health Equity, Access, and Justice”. This event reached healthcare workers across Northern Virginia and throughout the United States with topics addressing the role sociocultural barriers and challenges play when caring for culturally and ethnically diverse patients. The event included a panel of regional partners who spoke about their work in Northern Virginia and answered questions from the participants. The partnership that coordinated this CME-accredited event included George Mason University, Virginia Area Health Education Center, and the Integrated Translational Health Research Institute of Virginia (iTHRIV CTSA).

In October 2021 Inova and its partnership presented the third annual Healthcare Disparities Conference entitled: “A Call for Transformation: Impactful Strategies for Sustainable Change”. This event addressed strategies for implementing individual, team, community and systemic change to address health disparities and improve the health and wellbeing of culturally and ethnically diverse patients. Speakers shared their experiences with advancing health equity and implementing change in their practice settings and communities. Participants learned how to be a community ally by supporting practice and policy changes that promote health equity. Planning has begun for the fourth annual conference in October 2022 with a focus on health disparities and intersecting identities.

Also in 2021, the Health Equity Grand Rounds series was launched. This virtual series is made available to all team members across the Inova system. The launch session provided an overview of how healthcare systems can focus on health equity by addressing social determinants of health and other upstream approaches to health and wellness.

Inova’s Diversity, Equity and Inclusion efforts have made numerous strides including implementing DEI rounding activities, education programs and publishing an anti-racism statement. In late 2021 Inova’s Inclusion Council launched the first Team Member Resource Groups (TMRGs), which provide a platform for team members with shared characteristics or life experiences to connect across the system. Voluntary, member-led and open to anyone at Inova, TMRGs lead initiatives in recruiting, engagement, education, communication, mentorship, celebrations, community outreach and more. Through these efforts TMRGs amplify the voices of under-represented people and communities and strengthen inclusion and belonging.

COVID-19 Vaccination Efforts in the Community (Improving Healthcare Access)
As the COVID-19 pandemic persisted, Inova collaborated with multiple community partners to get “shots in arms” across the region.

Inova’s first large-scale vaccine distribution center, which opened at the Inova Center for Personalized Health in late 2020, was soon vaccinating up to 4,000 Inova team members per day. In early 2021, Inova served as the primary source of vaccines for public and private school teachers and employees, and vaccinated community members aged 65+ by appointment. To accommodate increasing demand, the site moved to the Inova Stonebridge COVID-19 Vaccination Center in the City of Alexandria and began accepting walk-in appointments from the general public in mid-March. The site also offered drive-through vaccinations to improve access. Members of Volunteer Fairfax, the Fairfax County Community Emergency Response Team and the Virginia National Guard helped with patient movement and flow. The Fairfax County Medical Reserve Corps provided 10 volunteers each day in addition to the 100 Inova team members needed daily to administer vaccines. By the end of 2021 more than 450,000 vaccines had been administered.

For those who couldn’t leave their homes to get a vaccine, the Inova Medical House Calls was one of the first groups to operationalize in-home vaccines in early 2021. Between January and March, the team administered 1,260 doses to 655 homebound older adults and family caregivers without wasting a single dose.

Despite widespread availability as the year progressed, some community members did not have access or were reluctant to get the vaccine. To reach them, Inova Cares Clinic for Families (ICCF) teamed up with local health departments in Fairfax, Loudoun and Prince Williams counties, which linked ICCF with pastors from local African American churches to rally their congregations. Faith leaders became incredibly important in building trusted relationships between healthcare systems and communities they serve to improve access to care for all. The churches helped to coordinate transportation to ICCF locations, and ICCF set aside clinic days and times during non-work hours to meet the needs of this community.

As a result of these joint outreach efforts, more than 4,000 community members were vaccinated at designated ICCF sites. Inova team members administered the shots while church volunteers and health department workers coordinated registration and flow.

To educate the community and encourage people to get the COVID-19 vaccine, Inova created and participated in a number of messaging campaigns, including:

- **Get the Vaccine!** – Inova produced 45 videos to address vaccine hesitancy and reinforce that the vaccine is safe and effective. Inova physicians from a variety of cultural backgrounds and specialties, including general and internal medicine, surgery, OB-GYN and pediatrics, participated. Providers recorded the message in English and their native languages. Inova also used the videos to engage faith, school and business leaders who found them useful in reaching congregations, families and customers.

- **Vax UP FCPS** – In mid-October, Fairfax County Public Schools (FCPS) reached out to request a partnership with Inova’s pediatricians to address the questions and concerns of parents considering vaccinating their soon-to-be eligible 5- to 11-year-olds. Within a few weeks, and in
Appendix G: Actions Taken

time for the official authorization, the joint Inova-FCPS team created videos answering some of the most common questions about the COVID-19 vaccine for kids. These videos were posted to the FCPS page and were made available on the Inova Get the Vaccine! page to maximize their reach in all areas of Northern Virginia.

- **Understanding the COVID-19 Vaccination** – In February, Inova team members held a virtual town hall with Black church leaders to discuss the vaccine, address hesitancy and discuss messaging for congregations. This well-informed and collaborative conversation helped shape Inova’s outreach efforts to our vulnerable and marginalized populations, while supporting faith leaders in their efforts to keep their communities healthy.

Expansion of Community Health Clinics and Programs (Improving Healthcare Access, Addressing Chronic Conditions, Supporting Behavioral Health)

Inova continued to grow its community presence through the expansion of clinics and programs into specific neighborhoods which are open to individuals throughout Northern Virginia. Inova Ewing FACT and Inova Cares Clinic for Women opened new clinics in Alexandria to add to their existing presence in Fairfax and Loudoun Counties. Inova Cares Clinic for Families opened a Herndon location to add to its presence in Alexandria, Annandale, Sterling and Manassas. Inova Medical House Calls continued to grow its service area to include Mt. Vernon. The Inova Healthy Plate Club provided parents and children with virtual health cooking classes with free ingredients available for pickup to reduce barriers during the pandemic. In 2022, Inova’s Community Health Division launched two new programs in the region that address community need – Inova Pride Clinic for LGBTQ+ individuals and Inova Cares for Behavioral Health.