2023 Community Health Needs Assessment

- CHNA Executive Summary
- About our Community
- Key Health Indicators
- Community Input
- Prioritized Health Needs

VHC Health™ 2023 CHNA

VHC Health™ is a 453-bed not-for-profit teaching facility and designated as a Magnet® hospital by the American Nurses Credentialing Center and a proud member of the Mayo Clinic Care Network – a national network of independent healthcare organizations. The Hospital was recognized as a 2021 Top Teaching Hospital by The Leapfrog Group and in 2022 was selected for an 11th consecutive Healthgrades Outstanding Patient Experience Award™ and a 21st consecutive 'A' grade from The Leapfrog Group. VHC Health is committed to being both the best health system and the best workplace in the Washington, DC metro area.

We've grown, along with Arlington and the surrounding neighborhoods, to become the region's community health system, with locations throughout the Washington, DC metro area. We are embracing the new neighborhoods we serve by bringing community-centered, top-quality medical care closer to where our patients and families live. While our name has changed, what has not changed is our promise and commitment to always provide personalized, high-quality care. For you. For life.

VHC Health desires to continue providing clinical programs and services to meet community needs, while also pursuing continuous improvement in existing and future programs to improve the overall health of the communities it serves. As such, VHC Health has conducted a Community Health Needs Assessment (CHNA), using primary and secondary data, to ensure community benefit programs and resources are focused on significant health needs as perceived by the community at large, as well as alignment with VHC Health's mission, services and strategic priorities.

VHC Health has defined its "community" to include 70 zip codes within the counties and cities included on the map to the right. These counties and cities represent VHC Health's primary and secondary service areas. Defining the CHNA community similarly to its primary and secondary service areas will allow VHC Health to more effectively focus its resources to address identified significant health needs, targeting areas of greatest need and health disparities.

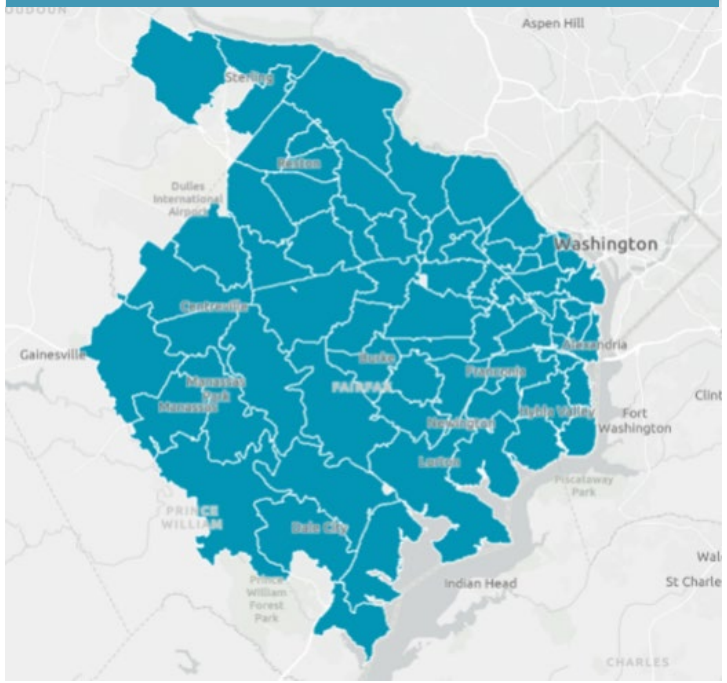
VHC Health obtained input from community leaders representing fifty-six organizations including public health, public schools, local government officials, social services, neighborhood groups and various non-profit organizations through a combination of focus groups and key stakeholder surveys. VHC Health took into account input from individuals and groups representing medically underserved, low income, and minority populations

Secondary data was assessed including:

- Demographics (population, age, sex, race)
- Socioeconomic indicators (household income, poverty, unemployment, educational attainment)
- Key health indicators

Information gathered in the above steps was reviewed and analyzed to identify health issues in the community.

VHC Health™ CHNA Community



VHC Health™ 2023 CHNA

The process identified the following health issues which are listed in alphabetical order:

- Access to Health Services/Navigating Healthcare Services
- Alcohol Abuse
- Chronic Health Conditions
- Food Insecurity
- Isolation for Seniors
- Health Equity/Culturally Competent Care
- Lack of Affordable Housing
- Lack of Mental Health Providers
- Lack of Prenatal Care
- Lack of Substance Abuse Providers
- Mental Distress/Behavioral Health
- Obesity
- Poor Air Quality
- Poverty/High Cost of Living/Homelessness
- Shortage of facilities and services for persons aged 55+
- Substance Abuse/Youth Substance Abuse

Health needs were prioritized with input from a broad base of members of the VHC Health's Leadership Team.

A review of existing community benefit and outreach programs was also conducted as part of this process and opportunities for increased community collaboration were explored.

Building on previous Community Health Needs Assessments and considering information gathered through this Community Health Needs Assessment, VHC Health chose the needs below to address over the next three years. Opportunities for health improvement exist in each area and VHC Health will work to identify areas where it can most effectively focus its resources to have significant impact and develop an implementation strategy for fiscal years ending 2023-2025.

Health Equity & Culturally Competent Care

Mental Illness & Behavioral Health

Childhood & Adult Obesity

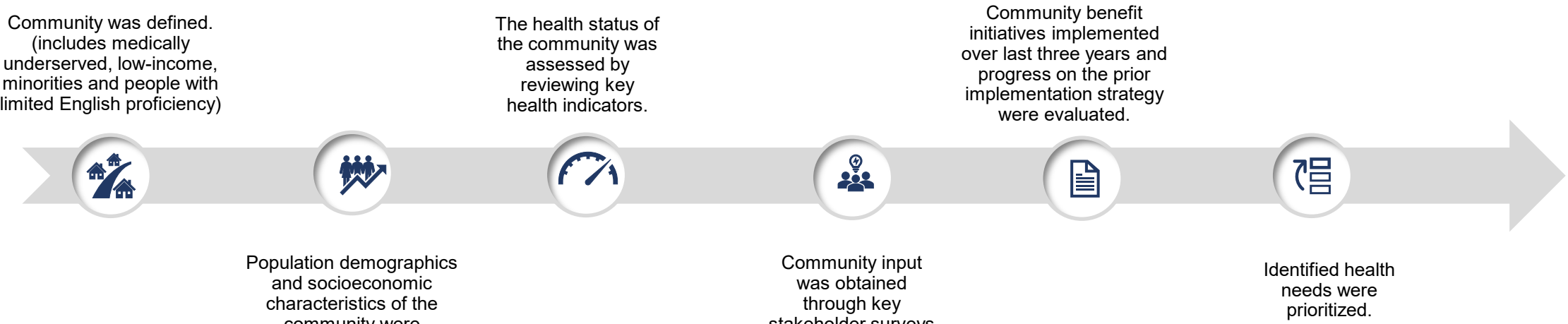
Aging Services

How the Assessment was Conducted

VHC Health conducted a community health needs assessment (CHNA) to support its mission responding to the needs in the community it serves, to fulfill the requirements established by the Patient Protection and Affordable Care Act of 2010, and to comply with federal tax-exemption requirements. The goals were to:

- ✓ Identify and prioritize health issues in VHC Health's service area, particularly for vulnerable and under-represented populations.
- ✓ Ensure that programs and services closely match the priorities and needs of the community.
- ✓ Strategically address those needs to improve the health of the communities served by VHC Health.

Based on current literature and other guidance from the U.S. Department of the Treasury, the following steps were conducted as part of VHC Health's CHNA:



Limitations and Information Gaps

Acknowledgements

The CHNA for VHC Health supports the organization's mission *"To Be the Best Health System"* and vision:

- To provide the highest quality clinical care.
- To achieve the highest levels of patient satisfaction.
- To provide state-of-the-art facilities and equipment.
- To innovate in the use of information technology.
- To invest in the professional growth and development of our people.
- To manage our resources prudently.
- To serve the healthcare needs of our community.

This CHNA was made possible because of the commitment toward addressing the health needs in the community. Many individuals across the organization devoted time and resources to the completion of this assessment. VHC Health would like thank steering committee members who assisted and facilitated the 2023 CHNA.

- Michelle Altman, Patient Care Director, Outpatient Clinic & Pediatric Center
- Sandy Campbell, Director,
- Kate Chutuape, Manager, Senior Health
- Delicia Claure, Clinical Director, Pediatric Center
- Grace Greenan, AVP, People & Experience
- James Meenan, AVP, Population Health
- Adrian Stanton, Vice President, Real Estate
- Erin Swiatocha, Director, Business Intelligence & Integration
- Cathy Turner, Director, Health Promotions

This CHNA has been facilitated by Crowe LLP ("Crowe"). Crowe is one of the largest public accounting, consulting, and technology firms in the U.S. Crowe has significant healthcare experience including providing services to hundreds of large healthcare organizations across the country. For more information about Crowe's healthcare expertise visit www.crowe.com/industries/healthcare.

Written comments regarding the health needs that have been identified in the current CHNA should be directed to:

Adrian Stanton
V.P., Real Estate Acquisition & Development
astanton@vhchealth.org

General Description of VHC Health

VHC Health provides exceptional medical services as our region's community health system. VHC Health was recently designated a 2021 Top Teaching Hospital by The Leapfrog Group. In 2022, the Hospital was selected for an 11th consecutive Healthgrades Outstanding Patient Experience Award™ and a 20th consecutive 'A' grade from The Leapfrog Group. VHC Health is a 453-bed not-for-profit teaching facility and designated as a Magnet® hospital by the American Nurses Credentialing Center. VHC Health is a proud member of the Mayo Clinic Care Network – a national network of independent healthcare organizations.

VHC Health is committed to healthcare superiority and the sophistication of our medical and surgical services. VHC Health takes pride in self-designated Centers of Excellence which include:

- Cardiology & Cardiovascular Surgery
- Emergency
- Neuroscience
- Oncology
- Urology
- Women & Infant Health

Each offers comprehensive care and is staffed by a team of skilled physicians, nurses and other healthcare practitioners who have all undergone specialty training in their medical and/or surgical area of expertise, and continue to do so on an ongoing basis.

Additional services include:

- Bariatric Surgery
- The Reinsch Pierce Family Center for Breast Health
- The Hitt Family Center for Radiation Oncology
- Orthopedics (Total Joint Replacement Services)
- Palliative Care
- Advanced Inpatient Diabetes Program
- Inpatient Rehabilitation
- Wound Healing & Hyperbaric Medicine
- Urology

Community Overview

Demographic Data

To understand the profile of VHC Health's CHNA community, the demographic and health indicator data were analyzed for the population within the defined service area. Data was analyzed for the VHC Health's CHNA Community as a whole as well the primary and secondary service areas. Information was also analyzed at the county and city levels.

VHC Health's CHNA community has a total population of 2,116,097 according to the U.S. Census Bureau American Community Survey 2017-2021 5-year estimates. The percentage of population by combined race and ethnicity is made up of 48.2% Non-Hispanic White, 19.2% Hispanic or Latino, 15.5% Non-Hispanic Asian, 12.3% Non-Hispanic Black and 4.8% Non-Hispanic some other race. The demographic makeup of VHC Health's CHNA community is as follows:

$184,445

Average Family Income

60%

People 25+ with a Bachelor's Degree or Higher

6.5%

of people are living in poverty (135,128 persons)

9.3%

Adults age 18-64 without Health Insurance Coverage (143,163 persons)

72%

Population 16+ in Civilian Labor Force

6%

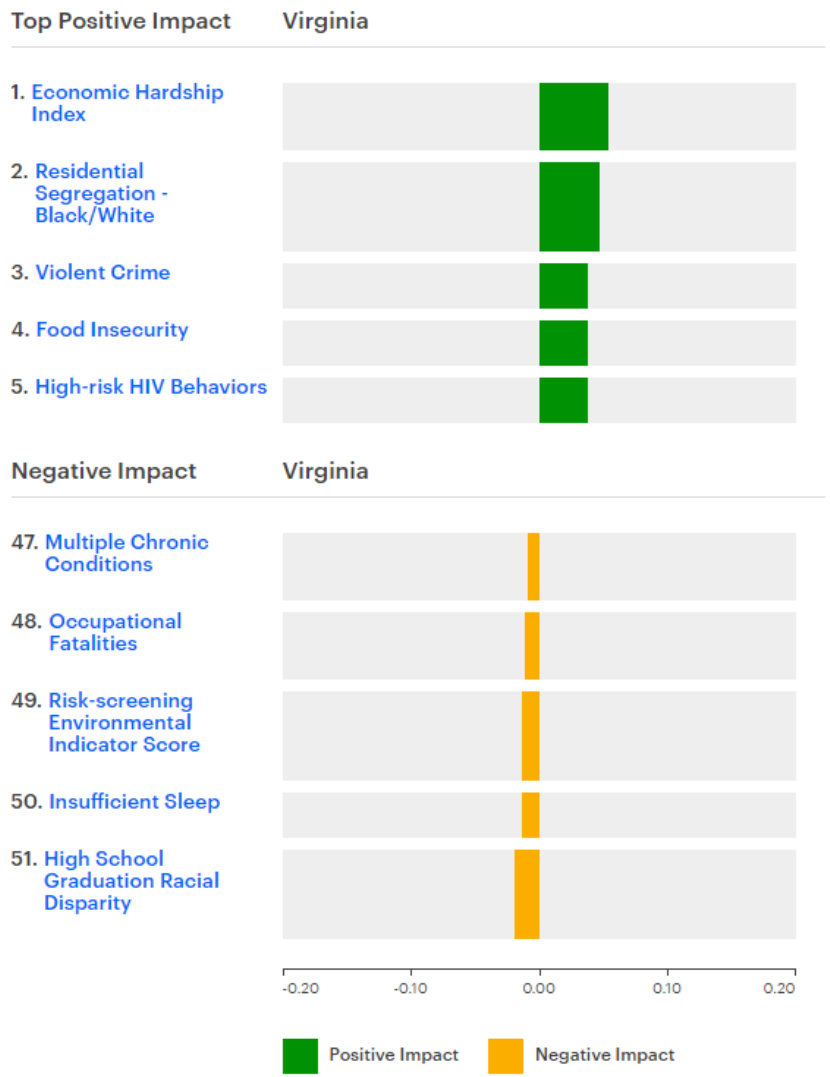
122,425 persons living in Limited English speaking households

America's Health Rankings - Virginia

America's Health Rankings evaluates a comprehensive set of health, environmental and socioeconomic data to illuminate both health challenges and successes; determine national and state health benchmarks; and enable stakeholders to take action to improve health. Annually, state-by-state analysis of 51 measures are prepared. Among the 50 states, Virginia ranks 18th for health behaviors and 22nd for health outcomes. Virginia's overall ranking is 14th among the 50 states as it is positively impacted by social and economic factors as well as its physical environment. The chart to the right reports which of the 51 measures have the most impact on Virginia's ranking. The positive measures reported have the highest healthier score and the negative measures have the lowest less healthy scores.

Strengths:
- Low economic hardship index score
- Low percentage of household food insecurity
- High adult flu vaccination rate

Challenges:
- High Income inequality
- High occupational fatality rate
- Low supply of mental health providers



Below are highlights from Virginia's 2022 report.

47%
Frequent mental distress

Frequent mental distress increased 47% from 10.0% to 14.7% of adults between 2014 and 2021.

14%
Uninsured

Uninsured decreased 14% from 7.9% to 6.8% of the population between 2019 and 2021.

13%
Obesity

Obesity increased 13% from 30.3% to 34.2% of adults between 2018 and 2021.

Access to Services

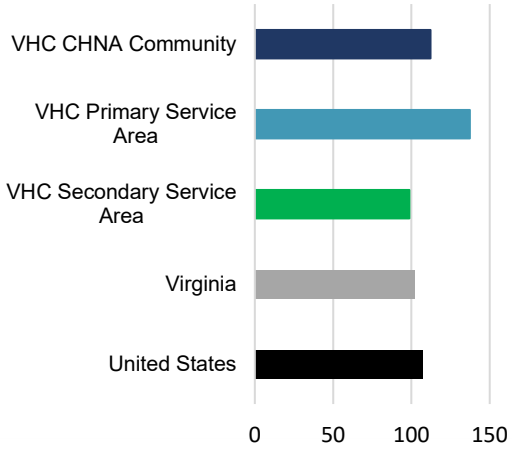
Limited access to care presents barriers to good health. The supply and accessibility of facilities and physicians affect access. **As shown below, the rate of healthcare providers within VHC Health's CHNA community is higher than state and national rates for primary care and dental health. The rate of mental health providers is comparable to the state average, but significantly lower than the national rate. Over 75% of the adult population have a dedicated healthcare provider.**

Data Tables

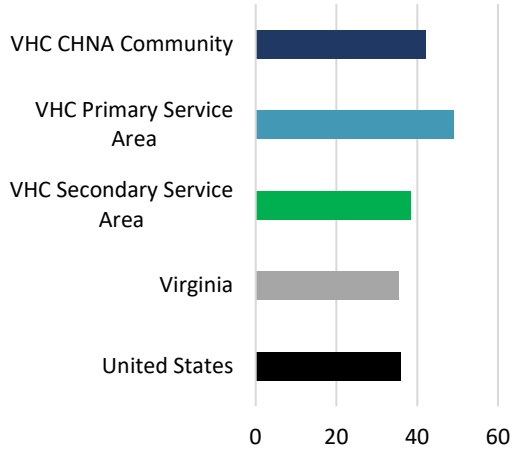
76.2%

of adults over age 18 have a dedicated healthcare provider in Virginia according to America's Health Rankings.

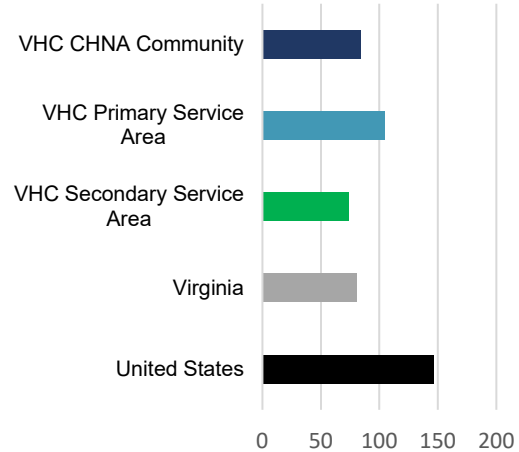
2,285
Primary Care Providers
Rate per 100,000 Population



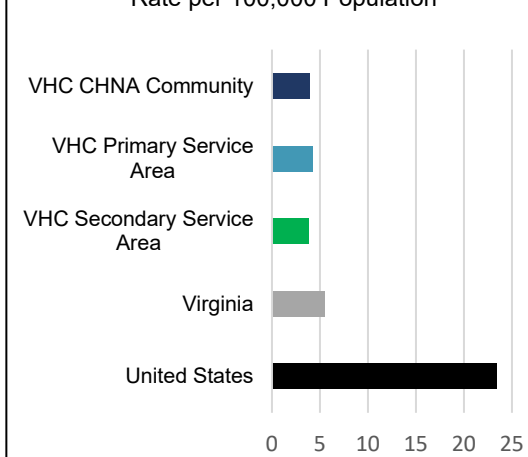
897
Dental Health Providers
Rate per 100,000 Population



1,795
Mental Health Providers
Rate per 100,000 Population



84
Addiction/Substance Abuse Providers
Rate per 100,000 Population

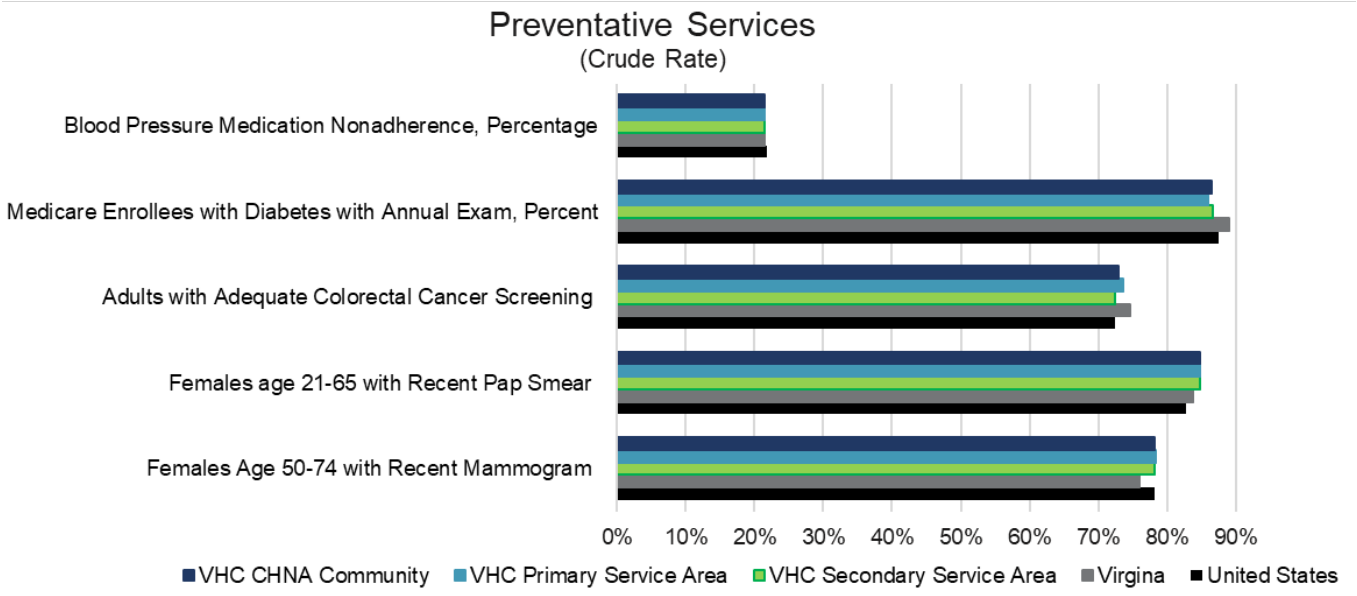


Clinical Preventive Services

Rates of morbidity, mortality, and emergency hospitalizations can be reduced if community residents access services such as health screenings, routine tests, and vaccinations. Prevention indicators can call attention to a lack of access or knowledge regarding one or more health issues and can inform program interventions.

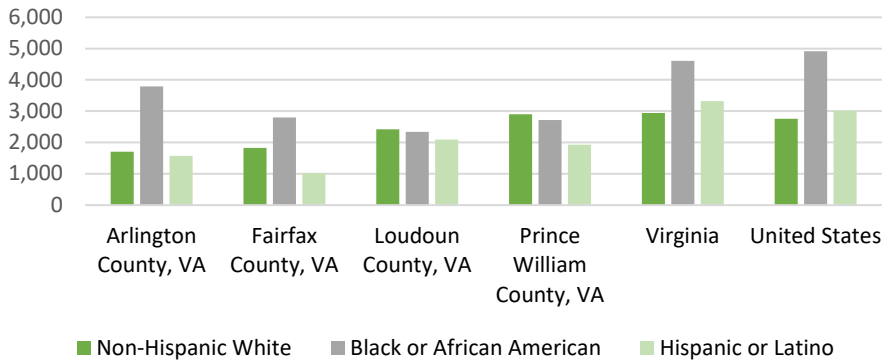
41.9% of women 65+ in the community are up-to-date with core preventative services compared to the national benchmark of 37.9%.

50.0% of men 65+ in the community are up-to-date with core preventative services compared to the national benchmark of 43.7%.



Preventable Hospitalization Rate by Race and Ethnicity

(Per 100,000 Medicare Beneficiaries)



Preventable hospitalizations include hospital admissions among Medicare beneficiaries for one or more of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection.

- **The rate for preventable hospitalizations in VHC Health's CHNA Community is favorable to state and national rates. And has significantly improved since 2016.**
- Preventable hospitalizations for VHC Health's CHNA Community are generally higher for Black or African American populations. **The highest rate of preventable hospitalizations is for the Black or African American population in Arlington County which is more than double the rate for the Non-Hispanic White population in the county.**

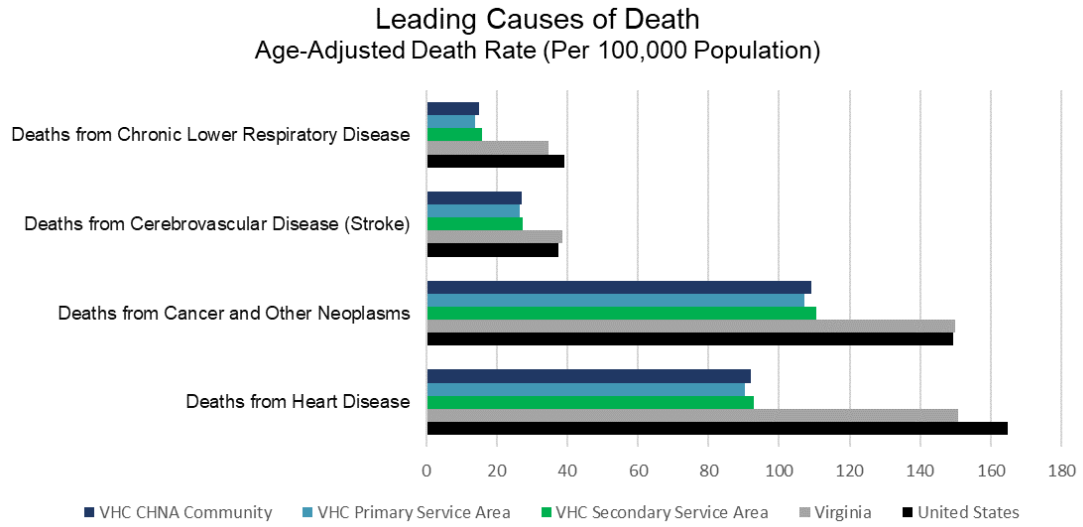
Data Tables

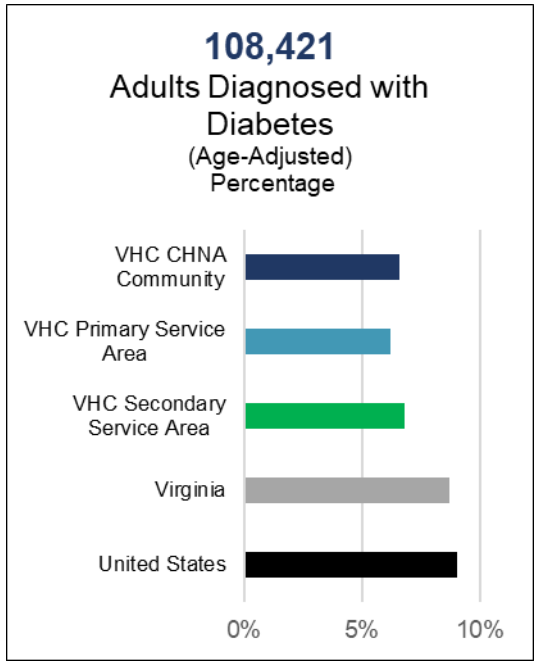
Health Outcomes & Mortality

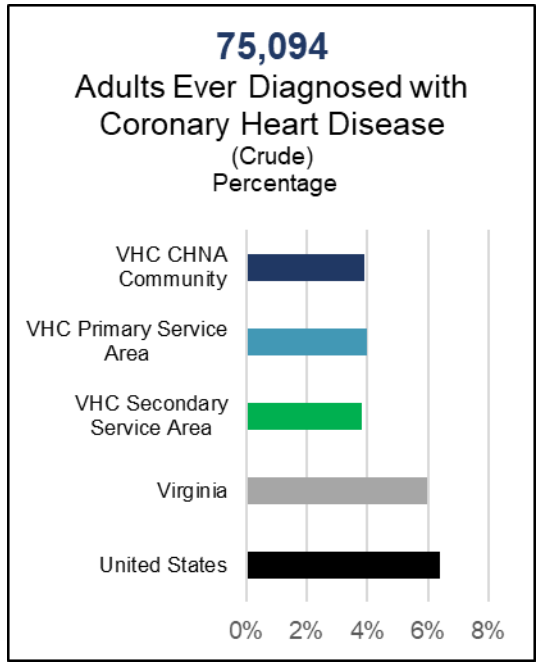
VHC Health's CHNA community has a significant number of adults who have been diagnosed with chronic illnesses. **The prevalence of chronic diseases in the VHC Health community is favorable to state and national percentages.** ***Over 26% of the population, 510,252 adults, have high blood pressure.***

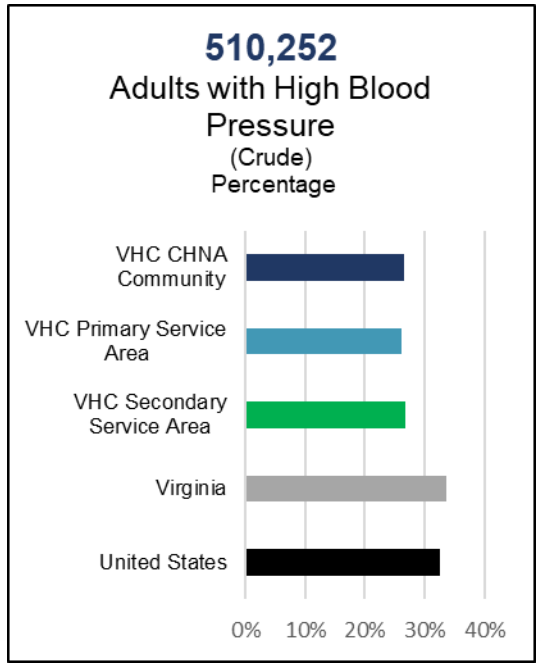
Coronary heart disease, cancer, lung disease and stroke are leading causes of death in the United States. Adjusted death rates for the community are favorable to state and national rates with deaths from neurological disorders decreasing significantly while state and national rates have increased.

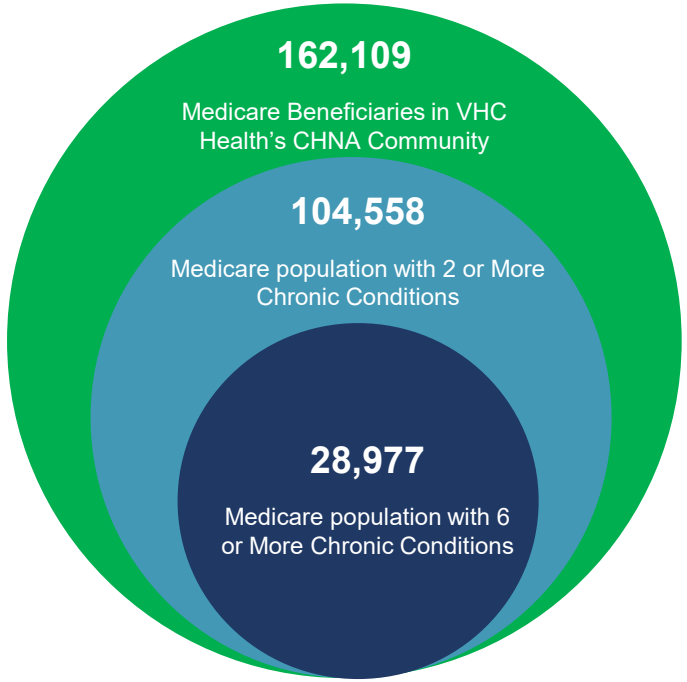
Data Tables









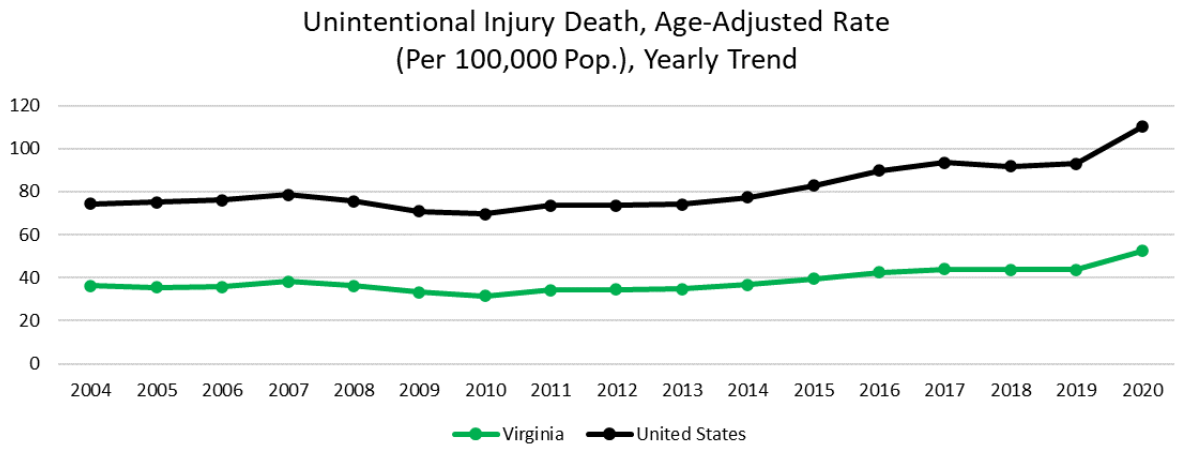


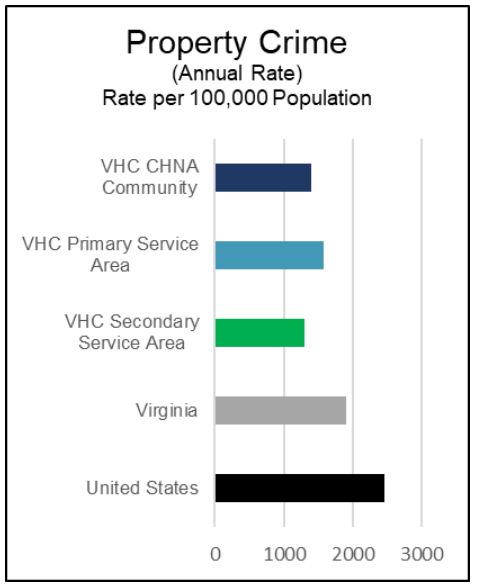
Injury and Violence

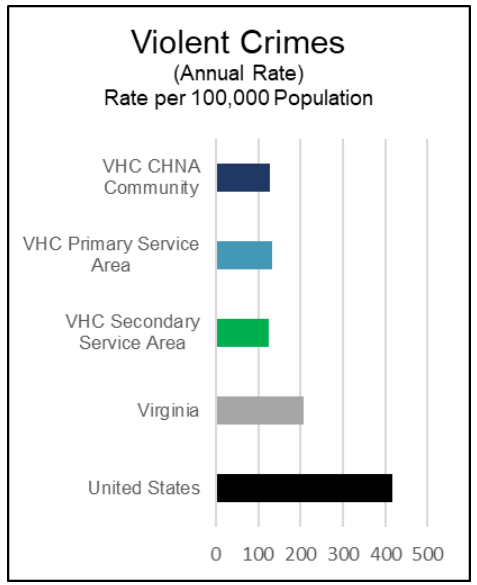
Crime rates, including violent crimes and property crimes, in the VHC Health's CHNA community are favorable compared to state and national rates.

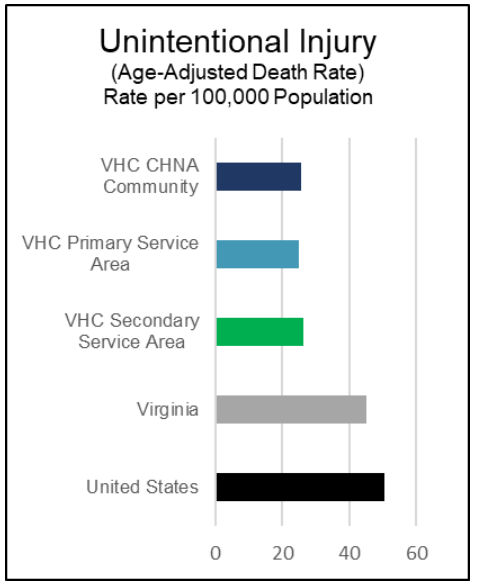
The yearly trend of death due to unintentional injury (accident) for Virginia is lower than the national average rate, with the rate in VHC Health's CHNA community falling even further below the state rate. This indicator is relevant because accidents are a leading cause of death in the United States.

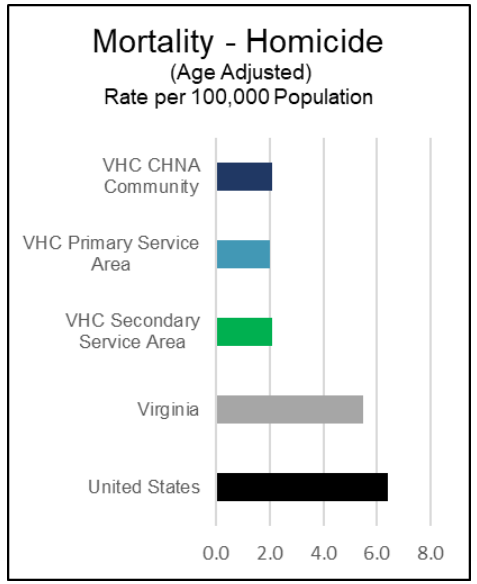
Data Tables











Maternal, Infant and Child Health

Engaging in prenatal care decreases the likelihood of maternal and infant health risks such as low birth weight. **Rates for low birth weight in are favorable to state and national rates.**

In VHC Health's CHNA Community, of the 61,731 total female population age 15-19, **the teen birth rate is 10.5 per 1,000, which is less than the state's teen birth rate of 15.3** according to CDC - National Vital Statistics System. 2014-2020. Source geography: County.

17% of women giving birth in the VHC Health CHNA Community had no prenatal care in the first trimester of pregnancy.

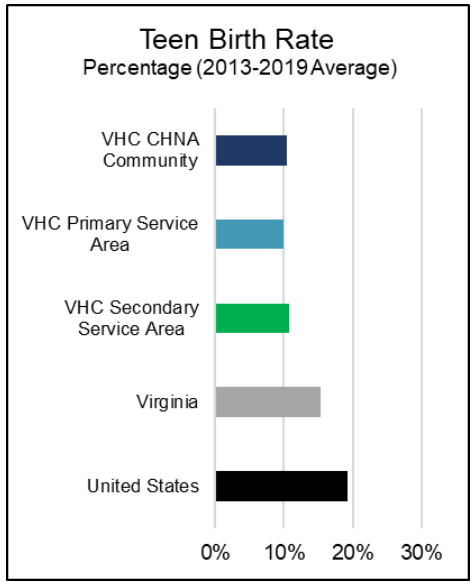
11% of mothers with infants are living in poverty in VHC Health's CHNA Community compared to the U.S. Benchmark of 23%..

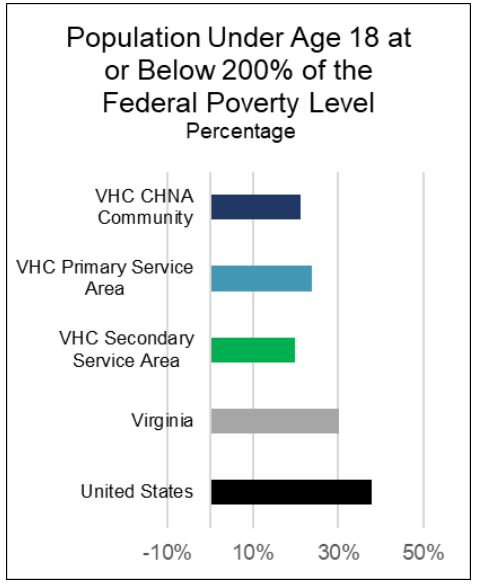
Data Tables

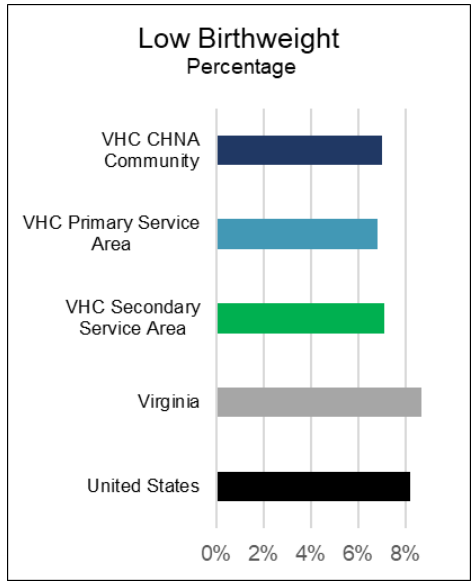
17%

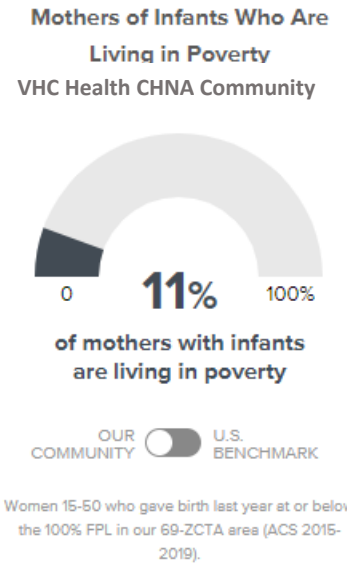
Women giving birth in the VHC Health CHNA Community had no prenatal care in the first trimester.

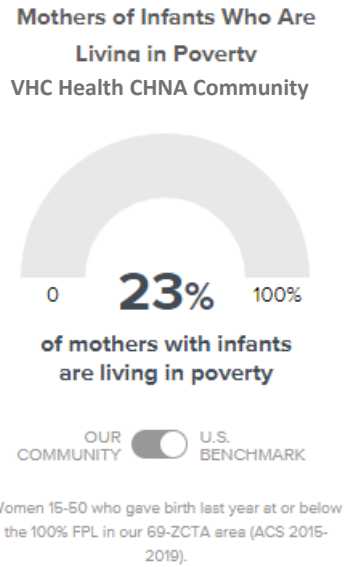
Natality Records 2012-2018 in 9-county area on CDC WONDER Online Database.









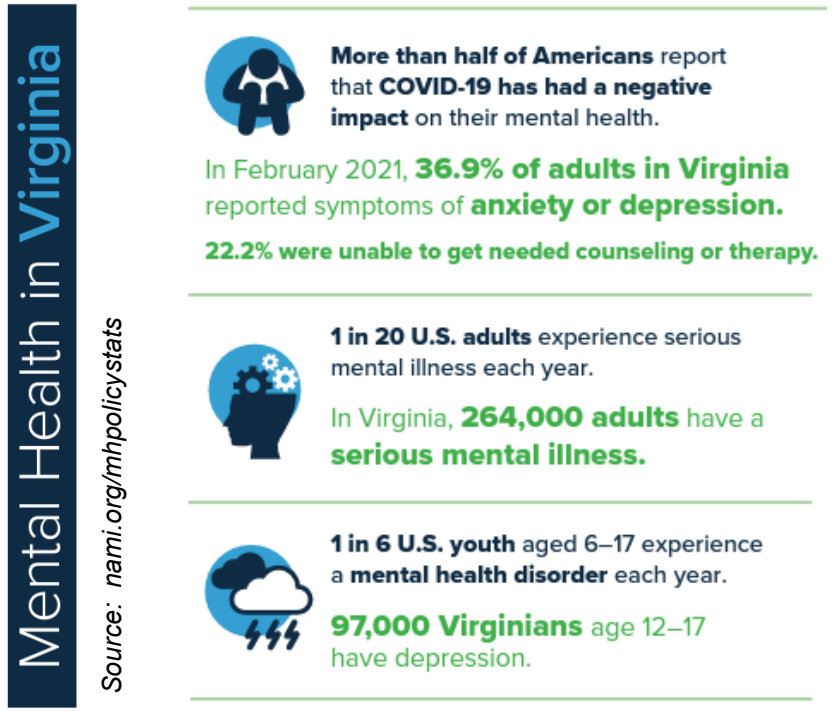


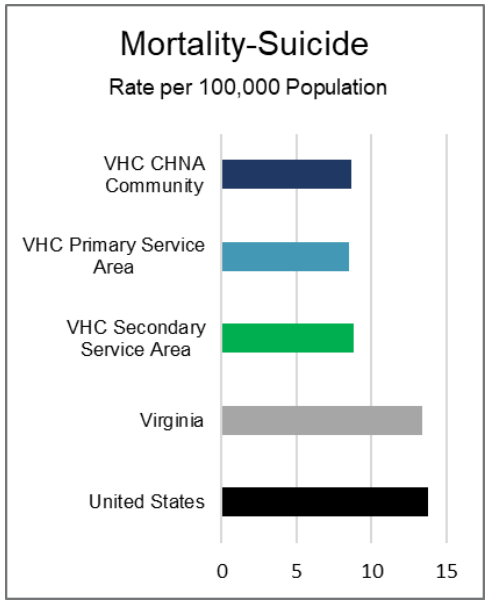
Mental Health

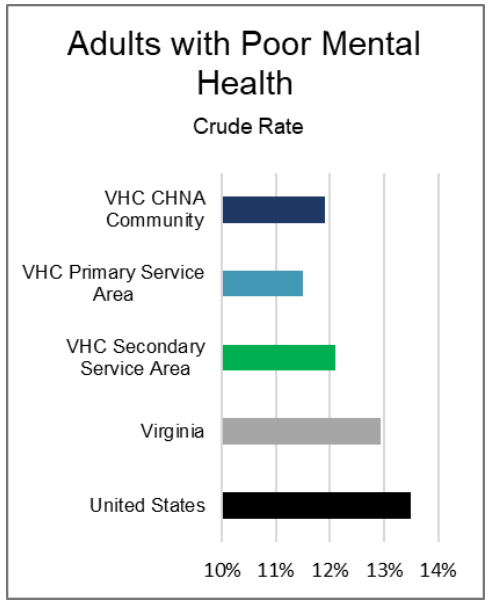
According to the National Alliance on Mental Illness, 264,000 adults in Virginia have a serious mental illness and approximately 97,000 youth have depression. **Approximately 12% of adults in VHC Health's CHNA Community report poor mental health.**

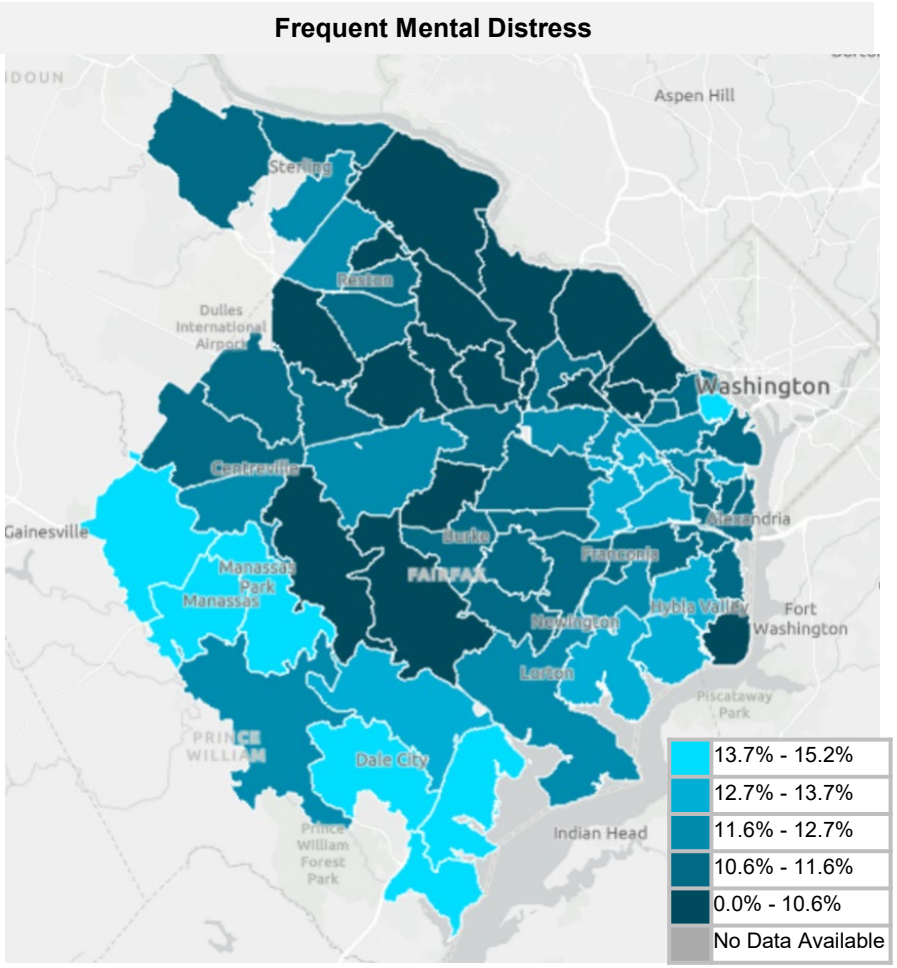
The map to the right reports the percentage of adults (ages 18 years and older) in VHC Health's CHNA Community reporting 14 days or more of poor mental health per month by county. In the VHC Health CHNA Community, **it is estimated that approximately 229,000 adults have frequent mental distress in VHC Health's CHNA Community. Zip codes with the highest percentage of population living with frequent mental distress are 20109, 22026, 22191, 22193, 20110, 20111, and 22211.**

Data Tables









Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2020. Source geography: Tract

Nutrition, Physical Activity and Obesity

Healthy diets and physical activity contribute to healthy lifestyles and overall well-being. These factors are relevant because current behaviors are determinants of future health and well-being and these indicators may be linked to significant health issues, such as obesity and poor cardiovascular health.

- **Nearly 6% of the population (123,819 persons) live with food insecurity in VHC Health's CHNA Community.**
- **374,305 persons, or 23.6% of adults, are obese in VHC Health's CHNA Community**. Obesity rates in Virginia have increased significantly over the last 15 years.
- **16.8% of adults, age 20 and older, self-report no active leisure time physical activity**. This is significantly lower than the national rate of 22.0%.
- 98.6% of the residents in VHC Health's CHNA Community have access to exercise opportunities, which is higher than the state and national benchmarks which are 83.0% and 84.3% respectively.

The map to the right depicts the food insecurity prevalence by locality for persons with low income. **The following zip codes report over 50% of persons with low income also have low food access: 22060, 22066, 20111, 22039.**

In Virginia, 17.6% of youth ages 10 to 17 have obesity, giving Virginia a ranking of 17 among the 50 states and D.C.

Data Tables

123,819
Food Insecure Population

374,305
Adults with BMI>30 (Obese)

Childhood Obesity

In Virginia, 17.6% of youth ages 10 to 17 have obesity, giving Virginia a ranking of 17 among the 50 states and D.C.

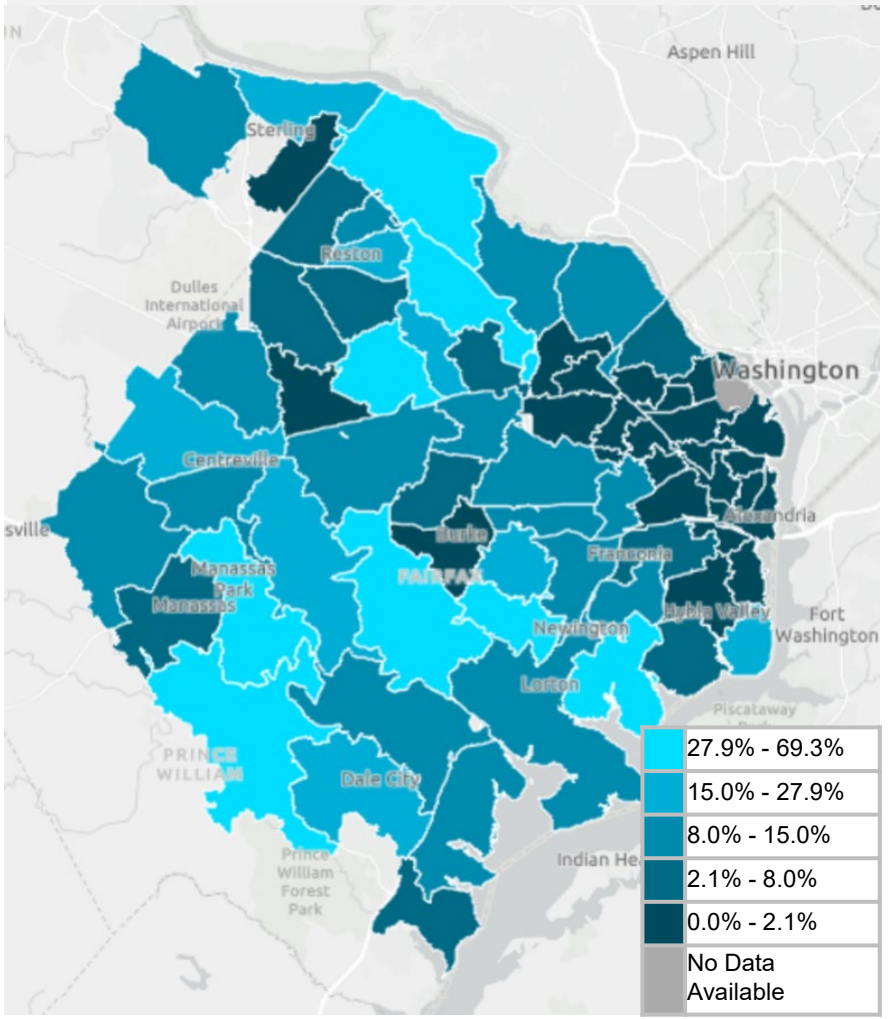
17.6%
Youth ages 10 to 17 are obese

44.8%
High Computer Usage

22%
Physically active at least 60 minutes

Source: https://stateofchildhoodobesity.org/state-data/?state=va

Percentage of Low-Income Population with Low Food Access



Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2019. Source geography: Tract

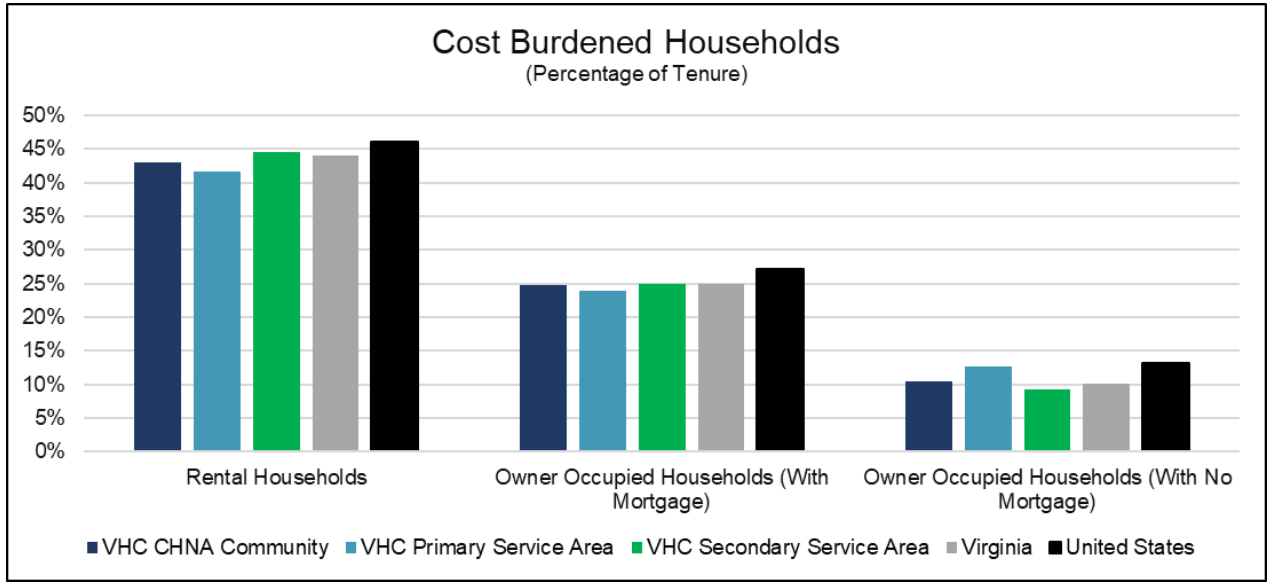
Physical Environment

The structure of housing and families and the condition and quality of housing units and residential neighborhoods are important because housing issues like overcrowding and affordability have been linked to multiple health outcomes, including infectious disease, injuries, and mental disorders.

Within VHC Health's CHNA Community, 229,363 households, or 29.4% of households, have housing costs that are 30% or more of the total household income and are classified as "cost-burdened households."

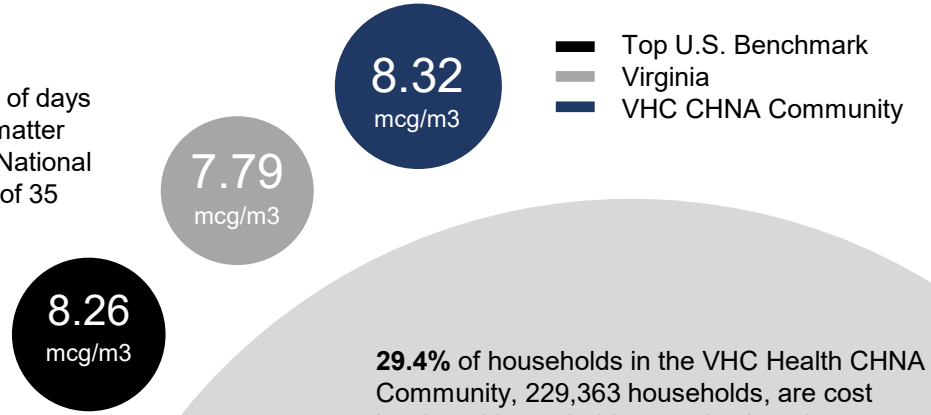
A large number of seniors in the community, age 65+, live alone. This is important because older adults who live alone may have challenges accessing basic needs, including health needs.

Data Tables



Air Pollution-Fine Particulate Matter

Air pollution is the percentage of days per year with fine particulate matter 2.5 (PM2.5) levels above the National Ambient Air Quality Standard of 35 micrograms pers cubic meter.



29.4% of households in the VHC Health CHNA Community, 229,363 households, are cost burdened households meaning housing costs exceed 30% of household income. **96,687** households have housing costs that **exceed 50%** of household income.

It is estimated that **4.97%** of households (38,803 households) within the community have no or slow internet.

30% of housing units have one or more substandard conditions.

64,343 Seniors, 35% of household with seniors (age 65+), live alone.

Substance Use Disorder

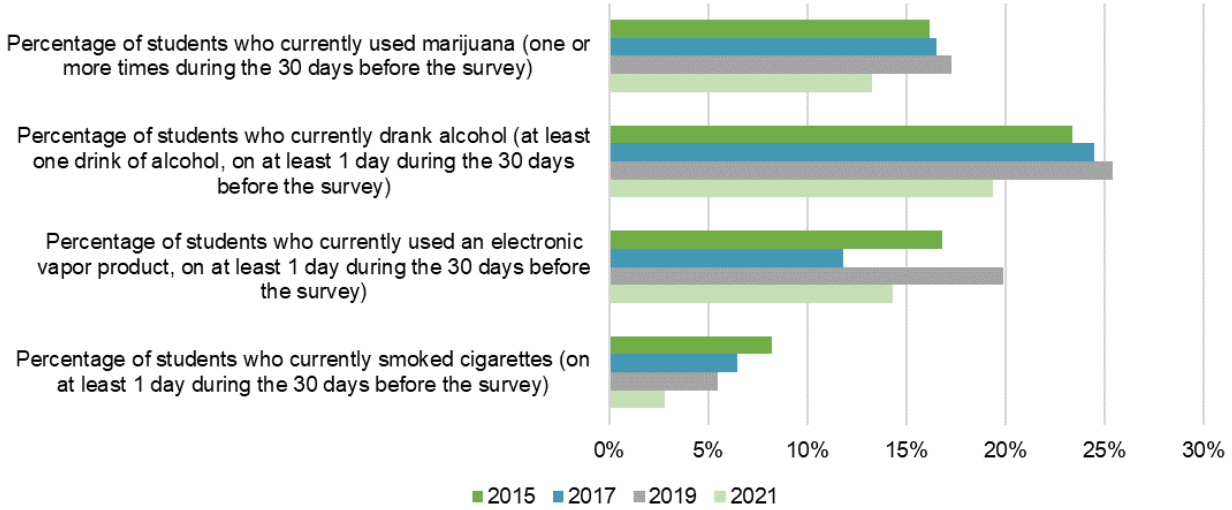
The percentage of adults in the VHC Health CHNA Community who currently smoke is 11.2% and is favorable to state and national benchmarks. This indicator is relevant because tobacco use is linked to leading causes of death, such as cancer and cardiovascular disease.

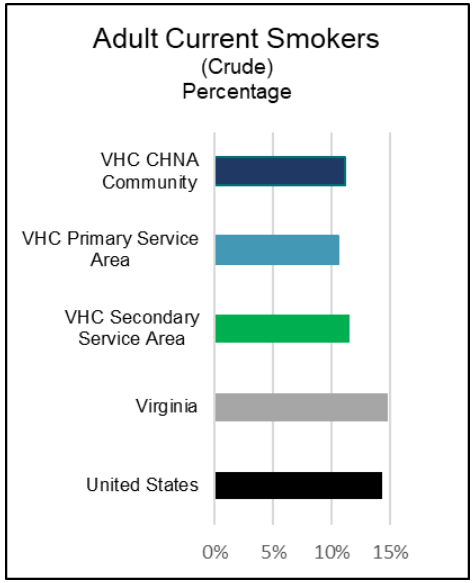
According to the Virginia Department of Health, the increasing trend of drug addiction in Virginia is contributing to multiple adverse public health effects, including but not limited to overdoses requiring emergency care and deaths. However, the Virginia Department of Health 2021 Youth Risk Behavior Survey provided to high schoolers shows that the percentage of students who have used marijuana, drank alcohol, used an electronic vapor product, and smoked cigarettes has declined in 2021, as shown to the right.

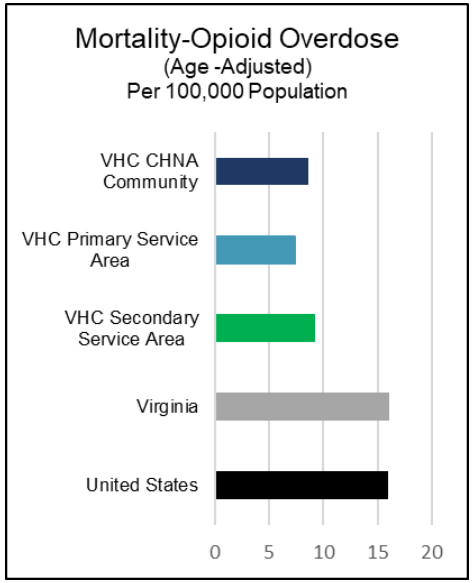
Deaths of despair include deaths due to intentional self-harm (suicide), alcohol-related disease, and drug overdose. **The rate for deaths of despair in VHC Health's CHNA Community is favorable to state and national benchmarks, however, Fairfax City's rate is unfavorable to both.**

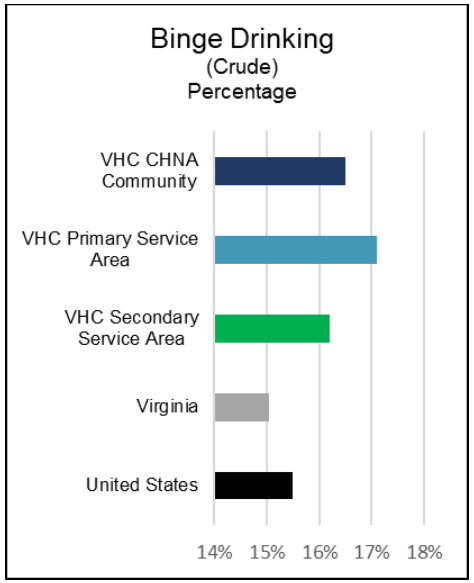
Data Tables

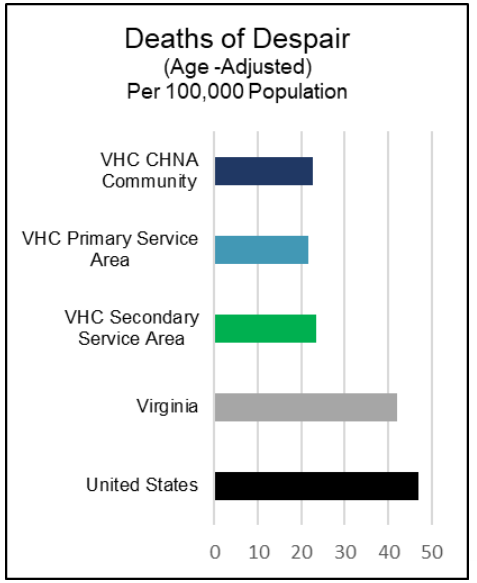
Virginia High School 2021 Youth Risk Behavior Survey





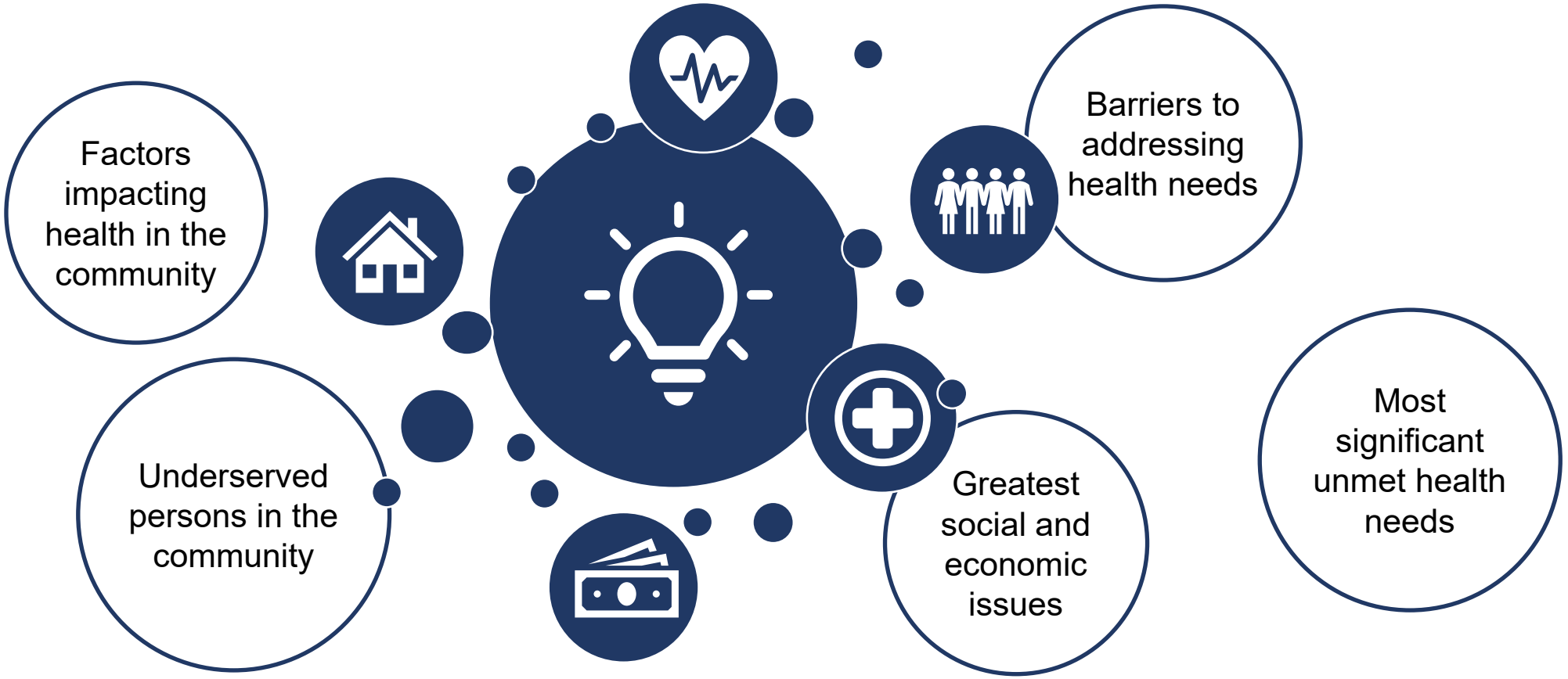




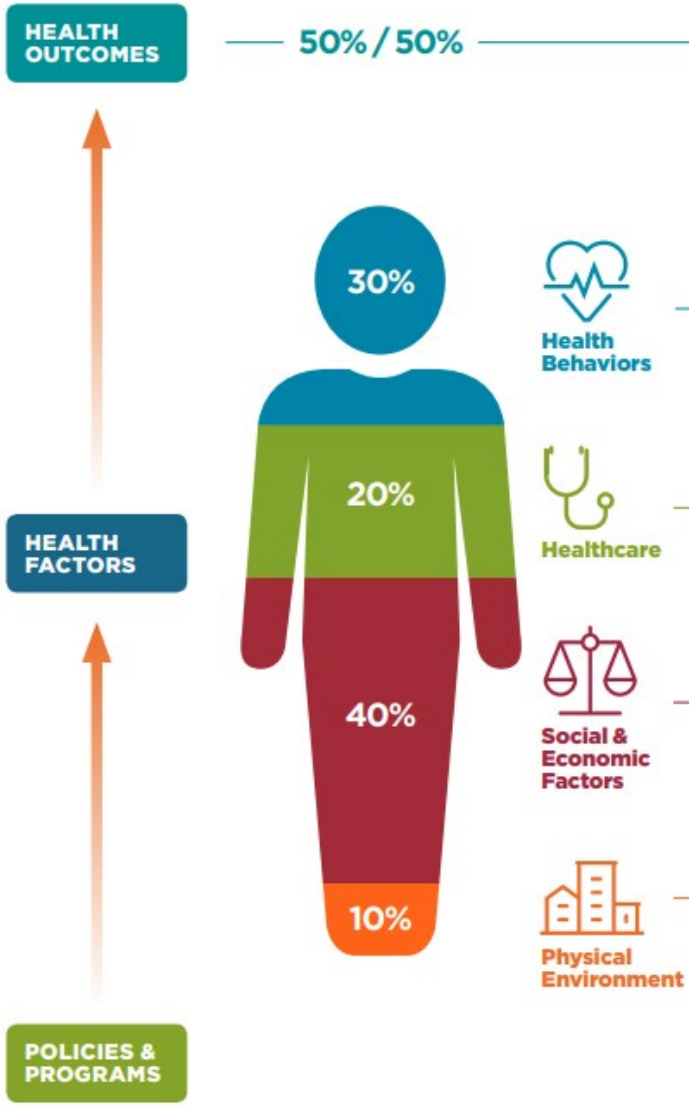


Focus Groups

Focus groups were conducted with 31 participants representing public health, major employers, public schools, social services, and representatives from underserved communities through two focus groups. Focus groups were conducted on May 22nd and June 8th. Focus groups explored multiple areas to identify significant health needs of the community as well as potential ways to address identified needs including the areas below.



Focus Groups



Factors Impacting Health in the VHC Health Community

- Individuals Must Choose Between Basic Needs and Health Needs
- Individual Health Conditions are Treated by Multiple Providers
- Isolation (Elderly Population)
- Inability to Navigate Health Resources if They are Dependent on Technology (Especially for Older Adults)
- Increase in Persons with Depression

- Difficulty in Getting Medical Appointments (Long Wait Times for Appointments, Challenges with Getting Off Work for Medical Appointments, Lack of Affordable Care)
- Complexity in Navigating Healthcare Systems
- Number of Medical Providers Accepting Medicaid is Decreasing
- Quality of Care Issues/Lack of Holistic Care
- Increased Need for Inclusive and Culturally Competent Care (LGBTQ+, Seniors, Immigrants, Veterans)
- Lack of Mental Health Providers
- Lack of Affordable Assisted Living Facilities
- Access to Telemedicine has Improved

- Lack of Available Resources for Undocumented Individuals/Language Barriers
- Income Disparity and Poverty
- High Cost of Living
- Homelessness

- Limited Food Access
- Lack of Safe and Affordable Housing
- Poor Air Quality

Focus Groups - Most Significant Unmet Healthcare Needs

Access to Healthcare; Navigating the Healthcare System

- Insufficient number of medical providers
- Lack of effective communication of health information and available resources
- Inability to obtain health resources due to complexity health system
- Lack of discharge coordination and transition between hospital and at-home care
- Lack of comprehensive health and long-term care options
- Disparities in healthcare based on where you live
- Lack of affordable health care

Behavioral Health

- Increased demand for mental health services
- Lack of mental health professionals
- Cost of mental health care
- Alcohol and drug abuse

Housing/ Food Insecurity

- Lack of affordable housing
- Lack of stability with basic needs
- Increasing homeless population

Identification of Most Underserved Populations

- People who are low-income, uninsured / underinsured, or homeless
- People with serious mental illness / behavioral health issues
- Minority populations and indigenous communities
- Immigrants, undocumented workers and individuals who are not U.S. residents
- LGBTQ+ (including youth)
- Elderly populations
- People with disabilities
- Veterans

Key Stakeholder Survey

Representatives from public health, public schools, local government officials, social services, neighborhood groups and various non-profit organizations participated in a key stakeholder survey. A link to the survey was distributed via e-mail to community stakeholders with a total of 26 stakeholders completing the survey.

Most Important Health Concerns

- Mental Health Conditions (other than depression)
- Depression
- Aging Concerns
- Substance Abuse – Illegal Drugs
- Alcohol Use

Which community services and supports need strengthening?

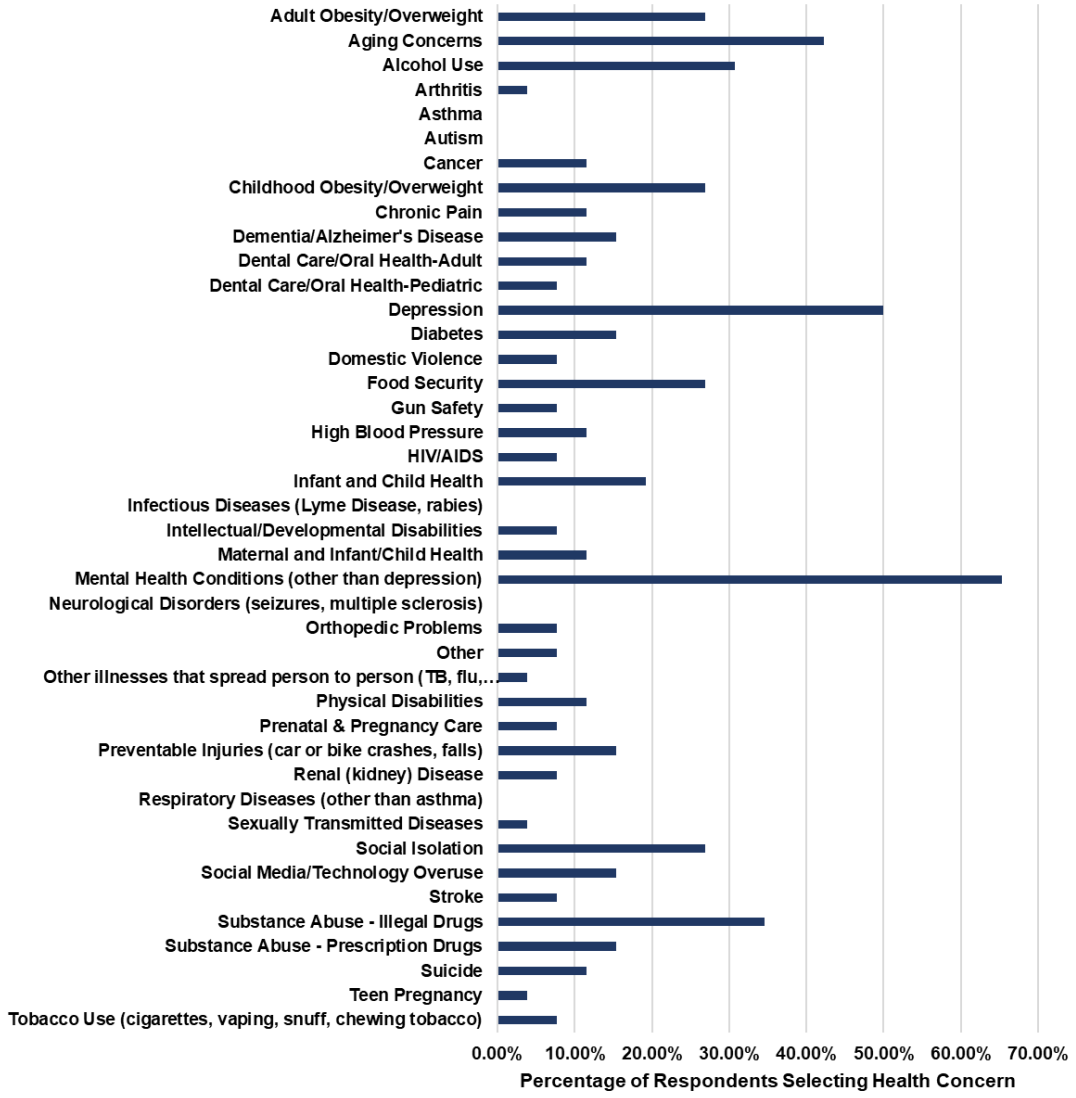
- Behavioral Health Services
- Health Care Services for the Uninsured and Underinsured
- Substance Use Services
- Culturally Appropriate Services
- Food Safety Net

What should VHC Health focus on over the next 3-5 years?

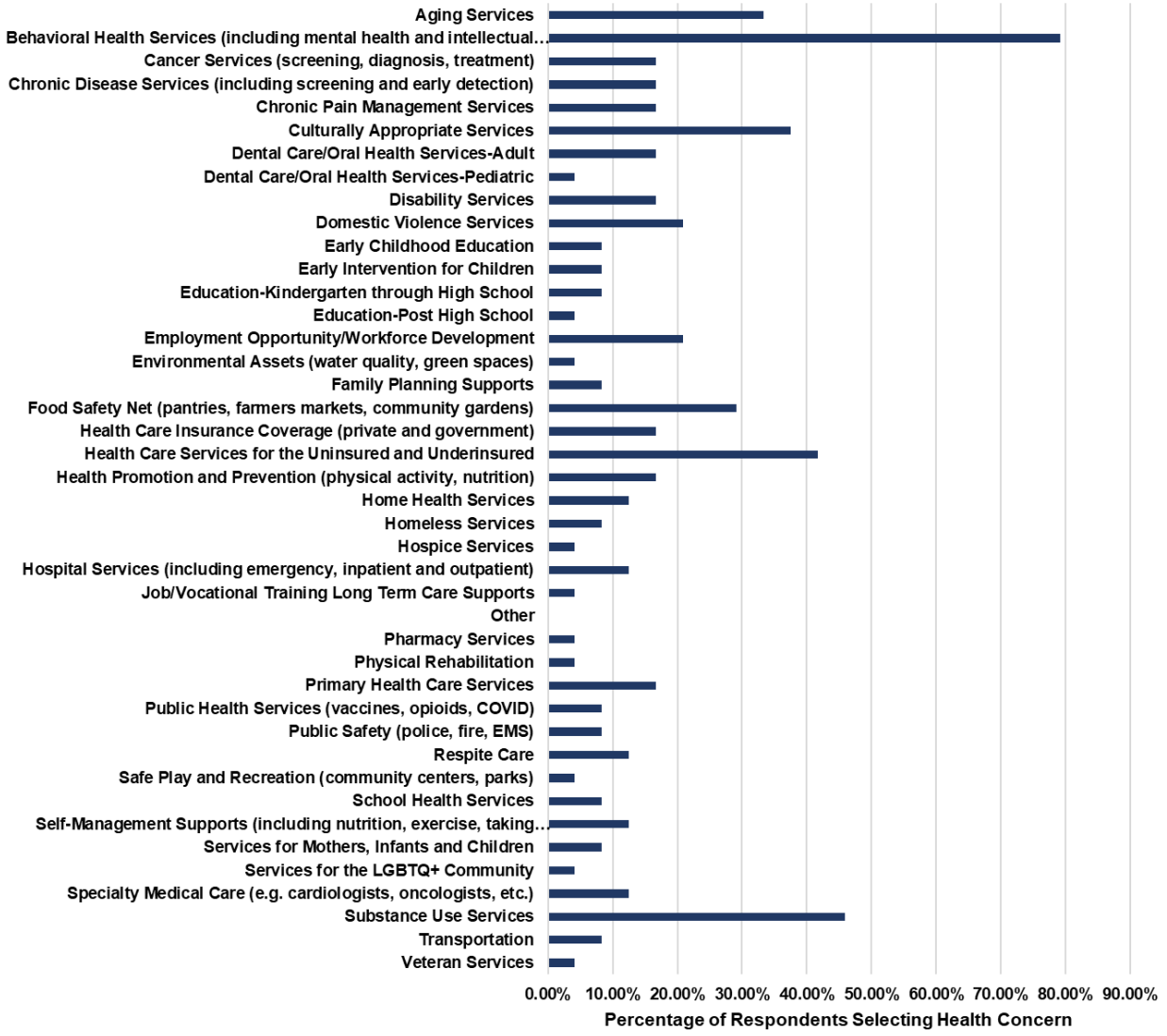
- Behavioral Health
- Substance Abuse
- Services for persons aged 55+

Key Stakeholder Survey

Most Important Health Concerns



Which community services and supports need strengthening?



Key Stakeholder Surveys

What structures, policies and practices are either promoting or hindering access to services and support?

Supportive Services
- Often access is difficult to obtain due to lack of information and proper awareness of where to go to find support. There are several barriers for those who have limited access due to culture, language, transportation or information and support of any kind.
- The county is doing a good job in providing information in multiple languages and providing outreach to vulnerable communities, but we are still not reaching everyone that needs help. More targeted outreach is needed to particular communities using trusted leaders within those communities who can help expand their reach and identify needs in housing, food security, mental health, etc.
- There is a need for comprehensive, wrap-around services for persons requiring assistance.

Access to Health Services
- Lack of health insurance and lack of doctors accepting certain insurance is a barrier to accessing care. Virginia needs to expand healthcare services.
- Patients are unable to afford follow-up and specialty care.
- There is inadequate education and navigation on availability and access.
- There is a lack of appropriate healthcare facilities, especially for children an adults suffering from mental health issues.
- Lack of home health care for older adults.
- Barriers to accessing care include language barriers, transportation issues, childcare issues and cultural differences. Black and brown, and people of color are disproportionately affected by these challenges.

Social Determinants of Health
- There is very limited affordable housing Arlington and Northern Virginia. Housing costs are too high.
- Housing stability and food insecurity affect everything else in the lives of persons in the community.

Health Equity
- For immigrant communities, immigration legal status is a major barrier to being able to access affordable, quality health care. Since undocumented persons don't qualify for Medicaid and most are unable to access insurance through employers, they often do not go to the doctor; nor do they engage in preventative health. Language and culturally appropriate services also hinders access to services and support.
- Arlington is not competitive with DC and Maryland health providers who do much more to better serve the LGBTQ+ community. This leads to LGTBQ+ residents in Arlington leaving the county and often Virginia to seek appropriate care.
- Lack of food is a health equity issue.

What should VHC Health Address over the next three to five years?

Key stakeholders were asked to recommend the most important issue that VHC Health should address over the next three to five years. The most frequently recommended focus areas are listed below.

- Focus on addressing behavioral health needs of youth, adults and older adults. Provide additional mental health support.

- Substance abuse, opioid crisis and drug overdoses.

- Services and support for people aged 55+.

Evaluation of the Impact of Actions Taken Since the Last CHNA

Mental Illness – Behavioral Health

Goals	Objectives	Progress to Meeting Goal
• Expand psychiatric inpatient capacity • Expand substance abuse services • Expand substance abuse services • Acute inpatient & outpatient recovery & wellness program with focus on assisting military personnel	• Less transfers out due to no inpatient capacity • Ability to offer more private room options for patients in need of that environment • Better space accommodations in ED for evaluation and assessment • Increased outpatient capacity which is straining inpatient care	• Completed construction of the Outpatient Pavilion which creates on-campus space for expansion of behavioral health services and the emergency department. • Successfully received Certificate of Public Need (COPN) certification/licensure for the addition of 16 acute care behavioral health beds. • Submitted applications to Virginia Department of Behavioral Health Services to expand outpatient programs which include: Adult Behavioral Health Intensive Outpatient Program (IOP); Adolescent Behavioral Health Intensive Outpatient Program (IOP); Adult Partial Hospitalization Program (PHP); and Outpatient Behavioral Health Clinic. • Collaborated with Arlington County to develop and implement “Diversion First” a program to divert community youth, with behavioral health crises, from hospitalization. • Developed and executed a Letter of Intent (LOI) with Arlington County to establish a free-standing Wellness & Behavioral Health Hospital in Arlington County.

Evaluation of the Impact of Actions Taken Since the Last CHNA

Childhood and Adult Obesity

Goals	Objectives	Progress to Meeting Goal
• Regular, ongoing community education and exercise programs for weight management • Full-service weight management and bariatric surgery program • Nationally-recognized Center for Excellence for weight management • APC obesity program	• Community residents self-reporting healthier behaviors – being physically active, eating healthier, reducing stress, getting more sleep and adopting a progressive approach to good health (like regular medical check-ups and checking blood pressure)	• Expanded ongoing community education and exercise programs for weight management. • Hospital's full-service weight management & bariatric surgery program successfully received national recognition as a Center for Excellence for weight management. • Received BCBS's Blue Distinction Plus – Bariatrics designation. • Received the Aetna Institutes of Quality recognition for Bariatric Surgery. • Received Cigna's Centers of Excellence designation for Bariatric Surgery. • Provided care, at no cost, to over 20,000 underserved adults and children through more than 75,000 clinic visits.

Evaluation of the Impact of Actions Taken Since the Last CHNA

Availability and Expansion of Medical/Surgical Services

Goals	Objectives	Progress to Meeting Goal
• Expand inpatient med/surg bed capacity • State-of-the-art Heart & Stroke Centers; Nationally Recognized Centers of Excellence • Cancer Center – CoC Accredited & recipient of the Outstanding Achievement Award • Radiation Oncology – linear accelerator & stereotactic radiosurgery expansion • Diabetes screening, counseling & education • Expansion of outpatient physical therapy services • Expansion of primary care network – Centers in Arlington, Alexandria, Falls Church, McLean & Shirlington • Outpatient Pavilion project – completion in 2022	• Reduction in Emergency Department “left without being seen” • Reduction in the boarding of patients in the ED and PACU • Expansion of new patient encounters (inpatient & outpatient) • Reduction in hospital’s CMI (severity of patient admissions	• Completed construction of the Outpatient Pavilion which is the first step in creating additional med/surg and emergency capacity. • Successfully received State approval to expand the licensed med/surg bed capacity, at the hospital campus, by an additional 87 beds. • Reduced the Emergency Department “left without being seen” rate to under 1%. • VHC Physician Group expanded with new offices in Arlington North, Arlington South, Vienna, Annandale, Tysons and Mt. Vernon, opened additional space in Old Town and National Landing, and added a gastroenterology practice. • Earned The Joint Commission’s Gold Seal of Approval® and the American Stroke Association’s Heart-Check mark for Advanced Certification for Comprehensive Stroke Centers.

Evaluation of the Impact of Actions Taken Since the Last CHNA

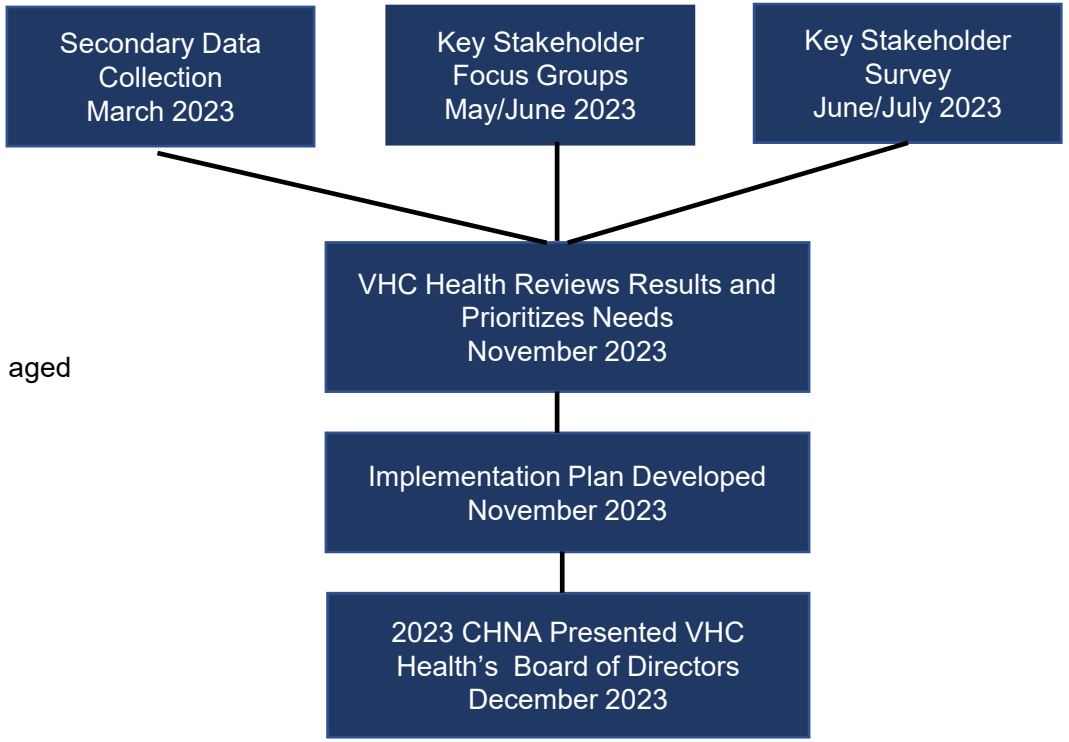
Availability and Expansion Aging Services

Goals	Objectives	Progress to Meeting Goal
• Ongoing “Healthy Aging” series and Alzheimer Support Group • Lifeline Response System to community and low-income seniors • Comprehensive senior services: exercise, nutrition, disease management, falls prevention, safety and memory screening	• Increased participation in healthy aging series and Alzheimer Support Group • Increased participation in Lifeline Response Systems • Reduction in readmission rate • Reduction in preventable admissions from Senior Living Facilities • Increased participation in Senior services programs and classes (includes telehealth options)	• Expanded VHC’s ongoing “Healthy Aging” series and Alzheimer Support Groups. • Expanded the Hospital’s Lifeline Response System to community and low-income seniors. • Expanded hospital’s offering of comprehensive senior services: exercise, nutrition, disease management, falls prevention, safety and memory screening. • Increased participation in hospital’s healthy aging series and Alzheimer Support Group. • Increased participation in Lifeline Response Systems. • Reduced the hospital’s readmission rate, and the preventable admissions from Senior Living Facilities. • Increased the participation in senior services programs and classes (includes telehealth options). • Continued the hospital’s partnership with Arlington and Fairfax offices on aging, local communities and churches. • Continued community support of Lifeline Fund.

Prioritization of Identified Health Needs

Primary and secondary data were gathered and compiled from March 2023 to September 2023. Based on the information gathered through the CHNA process, the following summary list of needs was identified. Identified health needs are listed in alphabetical order.

- Access to Health Services/Navigating Healthcare Services
- Binge Drinking
- Chronic Health Conditions
- Food Insecurity
- Isolation for Seniors
- Health Equity/Culturally Competent Care
- Lack of Affordable Housing
- Lack of Mental Health Providers
- Lack of Prenatal Care
- Lack of Substance Abuse Providers
- Mental Distress/Behavioral Health
- Obesity
- Poor Air Quality
- Poverty/High Cost of Living/Homelessness
- Shortage of facilities and services for persons aged 55+
- Substance Abuse/Youth Substance Abuse



Health needs were prioritized with input from a broad base of members of VHC Health's Leadership Team.

Based on the information gathered through this Community Health Needs Assessment and the prioritization process described above, VHC Health chose the needs below to address over the next three years.

- Health Equity & Culturally Competent Care
- Mental Illness & Behavioral Health
- Childhood & Adult Obesity
- Aging Services

Appendix A

Population by Age & Gender

Return to Report

	Age 0-4	Age 5-17	Age 18-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65+	Total	Male	Female
VHC CHNA Community	**136,343**	**355,271**	**173,694**	**318,812**	**324,548**	**294,436**	**254,099**	**258,894**	**2,116,097**	**1,053.971**	**1,062,126**
VHC Primary Service Area	**45,844**	**103,075**	**54,309**	**132,315**	**115,887**	**97,896**	**83,973**	**96,189**	**729,488**	**361,834**	**367,654**
VHC Secondary Service Area	**90,499**	**252,196**	**119,385**	**186,497**	**208,661**	**196,540**	**170,126**	**162,705**	**1,386,609**	**692,137**	**694,472**
Arlington County, VA	13,309	29,594	19,384	55,060	39,207	30,128	23,534	25,548	235,764	118,565	117,199
Fairfax County, VA	71,509	198,424	95,095	150,463	166,681	162,124	146,315	156,214	1,146,825	572,190	574,635
Loudoun County, VA	27,970	87,735	31,065	47,341	70,716	65,421	44,193	39,133	413,574	206.626	206,948
Prince William County, VA	33,551	95,412	42,013	62,807	72,542	68,285	54,667	47,947	477,224	239,956	237,268
Alexandria City, VA	11,062	18,042	9,194	32,745	29,601	21,284	17,619	18,638	158,185	76,596	81,589
Fairfax City, VA	1,767	3,609	2,249	3,151	3,310	3,171	3,175	3,548	23,980	11,713	12,267
Falls Church City, VA	753	2,803	1,178	1,690	2,061	2,216	1,883	1,910	14,494	7,227	7,267
Manassas City, VA	3,304	8,051	3,557	6,367	6,453	5,326	5,118	4,420	42,596	21,618	20,978
Manassas Park City, VA	1,147	3,174	1,572	2,511	3,048	2,416	1,769	1,444	17,081	8,893	8,188
State / National Benchmark											
Virginia	501,494	1,391,258	807,206	1,175,445	1,136,245	1,119,597	1,122,634	1,328,600	8,582,479	4,245,281	4,337,198
United States	19,423,121	54,810,954	30,339,089	45,360,942	42,441,883	41,631,458	42,829,413	52,888,621	329,725,481	163,206,615	166,518,866

	Age 0-4	Age 5-17	Age 18-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65+	Total	Male	Female
VHC CHNA Community	**6.44%**	**16.79%**	**8.21%**	**15.07%**	**15.34%**	**13.91%**	**12.01%**	**12.23%**	**100%**	**49.81%**	**50.19%**
VHC Primary Service Area	**6.28%**	**14.13%**	**7.44%**	**18.14%**	**15.89%**	**13.42%**	**11.51%**	**13.19%**	**100%**	**49.60%**	**50.40%**
VHC Secondary Service Area	**6.53%**	**18.19%**	**8.61%**	**13.45%**	**15.05%**	**14.17%**	**12.27%**	**11.73%**	**100%**	**49.92%**	**50.08%**
Arlington County, VA	5.65%	12.55%	8.22%	23.35%	16.63%	12.78%	9.98%	10.84%	100%	50.29%	49.71%
Fairfax County, VA	6.24%	17.30%	8.29%	13.12%	14.53%	14.14%	12.76%	13.62%	100%	49.89%	50.11%
Loudoun County, VA	6.76%	21.21%	7.51%	11.45%	17.10%	15.82%	10.69%	9.46%	100%	49.96%	50.04%
Prince William County, VA	7.03%	19.99%	8.80%	13.65%	15.20%	14.31%	11.46%	10.05%	100%	50.28%	49.72%
Alexandria City, VA	6.99%	11.41%	5.81%	20.70%	18.71%	13.46%	11.14%	11.78%	100%	48.42%	51.58%
Fairfax City, VA	7.37%	15.05%	9.38%	13.14%	13.80%	13.22%	13.24%	14.80%	100%	48.84%	51.16%
Falls Church City, VA	5.20%	19.34%	8.13%	11.66%	14.22%	15.29%	12.99%	13.18%	100%	49.86%	50.14%
Manassas City, VA	7.76%	18.90%	8.35%	14.95%	15.15%	12.50%	12.02%	10.38%	100%	50.75%	49.25%
Manassas Park City, VA	6.72%	18.58%	9.20%	14.70%	17.84%	14.14%	10.36%	8.45%	100%	52.06%	47.95%
State / National Benchmark											
Virginia	5.85%	16.21%	9.41%	13.70%	13.24%	13.05%	13.08%	15.48%	100%	49.46%	50.54%
United States	5.89%	16.62%	9.20%	13.76%	12.87%	12.63%	12.99%	16.04%	100%	49.50%	50.50%

Data Source: US Census Bureau, American Community Survey. 2017-21. Source geography: Tract

Population by Combined Race & Ethnicity

Return to Report

	Non-Hispanic White	Non-Hispanic Black	Non-Hispanic Asian	Non-Hispanic Other	Non-Hispanic Multiple Races	Hispanic or Latino	Total
VHC CHNA Community	**48.16%**	**12.27%**	**15.52%**	**.68%**	**4.13%**	**19.24%**	**100.00%**
VHC Primary Service Area	**52.49%**	**11.06%**	**14.34%**	**.65%**	**3.97%**	**17.50%**	**100.00%**
VHC Secondary Service Area	**45.88%**	**12.91%**	**16.15%**	**.69%**	**4.22%**	**20.15%**	**100.00%**
Arlington County, VA	60.20%	9.09%	10.18%	.69%	4.31%	15.52%	100.00%
Fairfax County, VA	49.32%	9.54%	19.94%	.69%	4.11%	16.40%	100.00%
Loudoun County, VA	54.12%	7.32%	19.91%	.78%	4.13%	13.74%	100.00%
Prince William County, VA	40.82%	20.31%	9.37%	.63%	4.35%	24.51%	100.00%
Alexandria City, VA	51.51%	21.06%	6.37%	.43%	4.14%	16.49%	100.00%
Fairfax City, VA	54.62%	5.36%	18.37%	.33%	3.67%	17.66%	100.00%
Falls Church City, VA	70.65%	4.54%	9.24%	.32%	4.60%	10.66%	100.00%
Manassas City, VA	38.93%	12.63%	5.63%	.39%	4.29%	38.13%	100.00%
Manassas Park City, VA	31.10%	13.54%	10.99%	.12%	3.29%	40.95%	100.00%
State / National Benchmark							
Virginia	60.60%	18.65%	6.69%	.59%	3.68%	9.79%	100.00%
United States	59.45%	12.19%	5.63%	1.13%	3.17%	18.43%	100.00%

Data Source: US Census Bureau, American Community Survey. 2017-21. Source geography: Tract

Household Income and Poverty

Return to Report

	Population Below 100% FPL	Percentage of Population Below 100% FPL	Population < Age 18 in Poverty, Percent	Average Family Income
VHC CHNA Community	**135,128**	**6.45%**	**8.62%**	**$184,484**
VHC Health Primary Service Area	**55,782**	**7.72%**	**11.10%**	**$202,529**
VHC Secondary Service Area	**79,346**	**5.79%**	**7.54%**	**$175,668**
Arlington County, VA	15,030	6.46%	6.77%	$214,949
Fairfax County, VA	69,741	6.13%	8.30%	$194,035
Loudoun County, VA	13,668	3.32%	3.07%	$201,683
Prince William County, VA	27,324	5.80%	7.57%	$149,346
Alexandria City, VA	15,002	9.58%	17.01%	$180,802
Fairfax City, VA	2,331	10.07%	10.14%	$175,380
Falls Church City, VA	359	2.48%	0.79%	$233,101
Manassas City, VA	2,385	5.62%	8.75%	$126,653
Manassas Park City, VA	746	4.40%	8.12%	$112,625
State/National Benchmark				
Virginia	828,664	9.94%	13.02%	$130,284
United States	40,661,636	12.63%	17.05%	$114,099

Data Source: US Census Bureau, American Community Survey. 2017-21. Source geography: Tract

Average Family Income
This indicator reports average family income based on the latest 5-year American Community Survey estimates. A family household is any housing unit in which the householder is living with one or more individuals related to him or her by birth, marriage, or adoption. Family income includes the incomes of all family members age 15 and older.

Children Eligible for Free/Reduced Price Lunch
Free or reduced price lunches are served to qualifying students in families with income between under 185 percent (reduced price) or under 130% (free lunch) of the US federal poverty threshold as part of the federal National School Lunch Program (NSLP).

Population with a Disability

Return to Report

	Total Population (For whom Disability Status is Determined)	Population with a Disability	Percentage of Population with a Disability
VHA CHNA Community	**2,087,173**	**151,764**	**7.27%**
VHA Primary Service Area	**718,232**	**51,655**	**7.19%**
VHA Secondary Service Area	**1,368,941**	**100,109**	**7.31%**
Arlington County, VA	230,765	14,158	6.14%
Fairfax County, VA	1,132,442	82,321	7.27%
Loudoun County, VA	411,218	25,585	6.22%
Prince William County, VA	468,730	37,432	7.99%
Alexandria City, VA	154,529	11,428	7.40%
Fairfax City, VA	23,537	1,585	6.73%
Falls Church City, VA	14,382	964	6.70%
Manassas City, VA	42,480	3,342	7.87%
Manassas Park City, VA	17,081	1,453	8.51%
State/National Benchmark			
Virginia	8,357,984	994,331	11.90%
United States	324,818,565	41,055,492	12.64%

Data Source: US Census Bureau, American Community Survey. 2017-21. Source geography: Tract

Population with Any Disability
This indicator reports the percentage of the total civilian non-institutionalized population with a disability. This indicator is relevant because disabled individuals comprise a vulnerable population that requires targeted services and outreach by providers.

Educational Attainment

Return to Report

	Total Population Age 25+	Population Age 25+ with No High School Diploma	Population Age 25+ with No High School Diploma, Percent	Population age 25+ with Bachelor's Degree or Higher, Percent
VHC CHNA Community	**1,450,789**	**112,458**	**7.75%**	**60.33%**
VHC Primary Service Area	**526,260**	**39,351**	**7.48%**	**67.02%**
VHC Secondary Service Area	**924,529**	**73,107**	**7.91%**	**56.53%**
Arlington County, VA	173,477	8,860	5.11%	76.30%
Fairfax County, VA	781,797	51,874	6.64%	63.53%
Loudoun County, VA	266,804	15,832	5.93%	62.98%
Prince William County, VA	306,248	31,771	10.37%	42.74%
Alexandria City, VA	119,887	8,213	6.85%	65.18%
Fairfax City, VA	16,355	1,176	7.19%	61.38%
Falls Church City, VA	9,760	262	2.68%	78.70%
Manassas City, VA	27,684	3,920	14.16%	32.11%
Manassas Park City, VA	11,188	2,286	20.43%	25.61%
State/National Benchmark				
Virginia	5,882,521	539,599	9.17%	40.33%
United States	225,152,317	25,050,356	11.13%	33.67%

Data Source: US Census Bureau, American Community Survey. 2017-21. Source geography: Tract

Education
Education metrics can be used to describe variation in population access, proficiency, and attainment throughout the education system, from access to pre-kindergarten through advanced degree attainment. These indicators are important because education is closely tied to health outcomes and economic opportunity.

Access to Healthcare Services

Return to Report

	Number of Primary Care Providers	Primary Care Providers per 100,000 Population	Number of Dental Health Providers	Dental Health Providers per 100,000 Population
VHC CHNA Community	2,385	112.13	897	42.17
VHC Primary Service Area	1,016	137.42	363	49.10
VHC Secondary Service Area	1,369	98.65	534	38.48
Arlington County, VA	1,503	130.66	528	45.90
Fairfax County, VA	44	182.22	38	157.38
Loudoun County, VA	102	130.66	528	45.90
Prince William County, VA	107	61.59	143	29.66
Alexandria City, VA	207	86.74	76	31.85
Fairfax City, VA	0	0.00	5	29.04
Falls Church City, VA	91	620.82	21	143.27
Manassas City, VA	79	184.70	17	39.75
Manassas Park City, VA	313	74.35	124	29.46
State/National Benchmark				
Virginia	8,825	102.24	3,056	35.41
United States	359,096	107.28	120,491	36.00

Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES). February 2023. Source geography: Address

Primary Care
This indicator reports the number of primary care physicians per 100,000 population. Doctors classified as "primary care physicians" by the AMA include General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs and General Pediatrics MDs. Physicians aged 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Dental Care
This indicator reports the number of oral healthcare providers with a CMS National Provider Identifier (NPI). Providers included in this summary are those who list "dentist," "general practice dentist," or "pediatric dentistry" as their primary practice classification, regardless of sub-specialty. Data are from the latest Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file.

Access to Behavioral Health

Return to Report

	Number of Mental Health Providers	Mental Health Providers per 100,000 Population	Number of Addiction/ Substance Abuse Providers	Addiction/ Substance Abuse Providers per 100,000 Population
VHC CHNA Community	**1,795**	**84.39**	**84**	**3.95**
VHC Primary Service Area	**775**	**104.82**	**31**	**4.19**
VHC Secondary Service Area	**1,020**	**73.50**	**53**	**3.82**
Arlington County, VA	182	76.26	8	3.35
Fairfax County, VA	1,006	87.45	49	4.26
Loudoun County, VA	243	57.73	16	3.80
Prince William County, VA	196	40.65	10	2.07
Alexandria City, VA	193	121.03	9	5.64
Fairfax City, VA	105	434.85	6	24.85
Falls Church City, VA	50	341.11	1	6.82
Manassas City, VA	49	114.56	1	2.34
Manassas Park City, VA	3	17.42	0	0.00
State/National Benchmark				
Virginia	6,947	80.49	472	5.47
United States	490,547	146.55	78,455	23.44

Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES). February 2023. Source geography: Address

Mental Health Care
This indicator reports the number of mental health providers in the report area as a rate per 100,000 total area population. Mental health providers include psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental healthcare.
Data from the 2020 Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file are used in the 2021 County Health Rankings.

Addiction Substance Abuse Providers
This indicator reports the number of providers who specialize in addiction or substance abuse treatment, rehabilitation, addiction medicine, or providing methadone. The providers include Doctors of Medicine (MDs), Doctor of Osteopathic Medicine (DOs), and other credentialed professionals with a Center for Medicare and Medicaid Services (CMS) and a valid National Provider Identifier (NPI).

Core Preventable Services – Primary Service Area

Return to Report

	Percentage of Males age 65+ Up to Date on Core Preventative Services	Percentage of Females age 65+ Up to Date on Core Preventive Services
VHC CHNA Community	**50.00%**	**41.90%**
VHC Primary Service Area	**50.40%**	**40.40%**
VHC Secondary Service Area	**49.80%**	**42.60%**
Arlington County, VA	53.10%	42.00%
Fairfax County, VA	50.20%	40.90%
Loudoun County, VA	49.40%	43.90%
Prince William County, VA	49.90%	47.40%
Alexandria City, VA	49.00%	42.70%
Fairfax City, VA	52.30%	47.30%
Falls Church City, VA	51.70%	52.90%
Manassas City, VA	46.60%	40.30%
Manassas Park City, VA	43.40%	41.40%
State/National Benchmark		
Virginia	48.09%	42.73%
United States	43.70%	37.90%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2020. Source geography: Tract

Male Preventive Services
This indicator reports the percentage of males age 65 years and older who report that they are up to date on a core set of clinical preventive services. Services include: an influenza vaccination in the past year; a PPV ever; and either a fecal occult blood test (FOBT) within the past year, a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or a colonoscopy within the past 10 years.

Female Preventive Services
This indicator reports the percentage of females age 65 years and older who report that they are up to date on a core set of clinical preventive services. Services include: an influenza vaccination in the past year; a pneumococcal vaccination (PPV) ever; either a fecal occult blood test (FOBT) within the past year, a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or a colonoscopy within the previous 10 years; and a mammogram in the past 2 years.

Preventive Services – Blood Pressure, Diabetes, and Preventable Hospitalizations

Return to Report

	Blood Pressure Medication Nonadherence (Medicare)	Medicare Enrollees with Diabetes with Annual Exam	Preventable Hospitalizations per 100,000 Beneficiaries
VHC CHNA Community	**21.4%**	**86.5%**	**2,160**
VHC Primary Service Area	**21.5%**	**86.0%**	**2,089**
VHC Secondary Service Area	**21.4%**	**86.7%**	**2,197**
Arlington County, VA	20.3%	83.3%	1,852
Fairfax County, VA	20.2%	86.1%	1,851
Loudoun County, VA	20.2%	88.0%	2,512
Prince William County, VA	20.3%	87.1%	3,109
Alexandria City, VA	20.1%	82.6%	2,932
Fairfax City, VA	19.9%	90.9%	1,811
Falls Church City, VA	20.3%	90.5%	2,505
Manassas City, VA	20.3%	81.3%	2,484
Manassas Park City, VA	20.3%	86.9%	No Data
State / National Benchmark			
Virginia	21.5%	89.0%	3,214
United States	21.8%	87.5%	2,865

Blood Pressure Medication Nonadherence Data Source: Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke 2018. Source geography: County

Diabetes Annual Exam Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2019. Source geography: County

Preventable Hospitalizations Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2020. Source geography: County

Blood Pressure
This indicator reports the number and percentage of Medicare beneficiaries not adhering to blood pressure medication schedules. Nonadherence is defined having medication coverage days at less than 80%.

Diabetes Annual Exam
This indicator reports the percentage of diabetic Medicare patients who have had a hemoglobin A1c (hA1c) test, a blood test which measures blood sugar levels, administered by a health care professional in the past year. This indicator is relevant because engaging in preventive behaviors allows for early detection and treatment of health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

Preventable Hospitalizations
This indicator reports the preventable hospitalization rate among Medicare beneficiaries for the latest reporting period. Preventable hospitalizations include hospital admissions for one or more of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection. Rates are presented per 100,000 beneficiaries.

Preventive Services – Cancer Screenings

Return to Report

	Adults with Adequate Colorectal Cancer Screening	Females age 21-65 with Recent Pap Smear	Females age 50-74 with Recent Mammogram
VHC CHNA Community	**72.90%**	**84.70%**	**78.20%**
VHC Primary Service Area	**73.60%**	**84.70%**	**78.40%**
VHC Secondary Service Area	**72.50%**	**84.70%**	**78.10%**
Arlington County, VA	75.40%	86.60%	76.90%
Fairfax County, VA	74.10%	83.00%	75.40%
Loudoun County, VA	73.90%	84.80%	76.00%
Prince William County, VA	75.10%	86.10%	78.20%
Alexandria City, VA	77.00%	87.60%	78.80%
Fairfax City, VA	74.40%	83.00%	77.40%
Falls Church City, VA	77.70%	87.30%	79.30%
Manassas City, VA	71.10%	83.20%	76.70%
Manassas Park City, VA	67.90%	81.50%	75.80%
State / National Benchmark			
Virginia	74.60%	83.80%	76.00%
United States	72.40%	82.80%	78.20%

Colorectal Cancer Screening Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2020.

Pap Smear Screening Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2020.

Mammogram Screening Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2020.

Colorectal Cancer Screening
This indicator reports the percentage of adults with adequate colorectal cancer screening.

Pap Smear Screening
This indicator reports the percentage of females age 21–65 years who report having had a Papanicolaou (Pap) smear within the previous 3 years.

Mammogram Screening
This indicator reports the percentage of females age 50-74 years who report having had a mammogram within the previous 2 years.

Health Outcomes and Mortality – Cancer Incidence Rates

Return to Report

Cancer Incidence Rates
These indicators report the age adjusted incidence rate (cases per 100,000 population per year) of individuals with cancer adjusted to 2000 U.S. standard population age groups (Under Age 1, 1-4, 5-9, ..., 80-84, 85 and older).

	Breast Cancer Incidence Rate (Per 100,000 Population)	Colorectal Cancer Incidence Rate (Per 100,000 Population)	Lung Cancer Incidence Rate (Per 100,000 Population)	Prostate Cancer Incidence Rate (Per 100,000 Population)
VHC CHNA Community	**412.6**	**90.2**	**112.0**	**324.8**
VHC Primary Service Area	**476.7**	**106.4**	**126.1**	**375.0**
VHC Secondary Service Area	**378.4**	**82.1**	**104.5**	**298.6**
Arlington County, VA	122.8	22.6	29.6	88.6
Fairfax County, VA	118.5	26.4	30.2	89.9
Loudoun County, VA	114.3	25.8	33.5	114.9
Prince William County, VA	108.5	30.6	42.1	94.4
Alexandria City, VA	111.0	22.9	29.4	89.6
Fairfax City, VA	92.8	27.4	27.0	83.0
Falls Church City, VA	137.7	33.9	33.6	121.5
Manassas City, VA	117.0	39.5	54.5	90.1
Manassas Park City, VA	88.9	No Data	52.6	55.6
State / National Benchmark				
Virginia	126.1	34.5	53.6	100.3
United States	128.1	37.7	56.3	109.9

Data Source: State Cancer Profiles. 2015-19. Source geography: County

Health Outcomes and Mortality – Chronic Conditions

Return to Report

	Percentage of Adults with Diagnosed Diabetes	Percentage of Adults Ever Diagnosed with Coronary Heart Disease	Percentage of Adults with High Blood Pressure
VHC CHNA Community	**6.60%**	**3.90%**	**26.50%**
VHC Primary Service Area	**6.20%**	**4.00%**	**26.20%**
VHC Secondary Service Area	**6.80%**	**3.80%**	**26.70%**
Arlington County, VA	6.20%	3.60%	22.80%
Fairfax County, VA	5.90%	4.60%	27.80%
Loudoun County, VA	6.50%	4.10%	26.10%
Prince William County, VA	9.10%	4.60%	29.30%
Alexandria City, VA	6.80%	4.30%	29.70%
Fairfax City, VA	8.70%	5.10%	29.70%
Falls Church City, VA	7.30%	4.30%	28.10%
Manassas City, VA	8.30%	5.10%	29.20%
Manassas Park City, VA	9.10%	4.80%	28.40%
State / National Benchmark			
Virginia	8.70%	5.98%	33.60%
United States	9.00%	6.40%	32.60%

Diabetes Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019. Source geography: County

Coronary Heart Disease Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2020.

High Blood Pressure Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2019.

Diabetes
This indicator reports the number and percentage of adults age 20 and older who have ever been told by a doctor that they have diabetes. This indicator is relevant because diabetes is a prevalent problem in the U.S.; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

Coronary Heart Disease
This indicator reports the percentage of adults age 18 and older who report ever having been told by a doctor, nurse, or other health professional that they had angina or coronary heart disease.

High Blood Pressure
This indicator reports the percentage of adults age 18 who report ever having been told by a doctor, nurse, or other health professional that they have high blood pressure. Women who were told high blood pressure only during pregnancy and those who were told they had borderline hypertension were not included.

Health Outcomes and Mortality – Mortality

Return to Report

Cancer Deaths
This indicator reports the 2016-2020 five-year average rate of death due to malignant neoplasm (cancer) per 100,000 population.

Heart Disease Deaths
This indicator reports the 2016-2020 five-year average rate of death due to heart disease (ICD10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population.

Lung Disease Deaths
This indicator reports the 2016-2020 five-year average rate of death due to chronic lower respiratory disease per 100,000 population.

Stroke Deaths
This indicator reports the 2016-2020 five-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population.

Figures are reported as age-adjusted rates.

	Cancer Death Rate (Per 100,000 Population)	Heart Disease Death Rate (Per 100,000 Population)	Lung Disease Death Rate (Per 100,000 Population)	Stroke Death Rate (Per 100,000 Population)
VHC CHNA Community	**109.3**	**91.9**	**15.1**	**27.1**
VHC Primary Service Area	**107.2**	**90.4**	**14.0**	**26.5**
VHC Secondary Service Area	**110.6**	**92.8**	**15.8**	**27.5**
Arlington County, VA	105.8	94.0	16.4	28.3
Fairfax County, VA	107.2	89.8	13.7	26.4
Loudoun County, VA	116.3	103.2	16.9	25.5
Prince William County, VA	127.9	107.1	26.8	34.2
Alexandria City, VA	112.0	109.2	20.3	26.3
Fairfax City, VA	200.7	181.4	17.4	50.0
Falls Church City, VA	133.9	132.0	No data	51.8
Manassas City, VA	152.8	163.1	38.2	46.8
Manassas Park City, VA	80.3	67.8	No data	No data
State / National Benchmark				
Virginia	149.8	150.8	34.6	38.6
United States	149.4	164.8	39.1	37.6

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

Injury and Violence – Mortality – Unintentional Injury

Return to Report

Death due to Unintentional Injury (Accident)
This indicator reports the 2016-2020 five-year average rate of death due to unintentional injury (accident) per 100,000 population.

	Unintentional Injury Death Rate (Per 100,000 Population)	Five Year Total Deaths, 2016-2020 Total
VHC CHNA Community	**25.7**	**8,913**
VHC Primary Service Area	**24.9**	**3,444**
VHC Secondary Service Area	**26.2**	**5,469**
Arlington County, VA	21.0	238
Fairfax County, VA	25.2	1,441
Loudoun County, VA	23.2	394
Prince William County, VA	32.6	692
Alexandria City, VA	26.5	200
Fairfax City, VA	55.8	72
Falls Church City, VA	29.8	21
Manassas City, VA	46.1	88
Manassas Park City, VA	No data	14
State / National Benchmark		
Virginia	45.3	20,285
United States	50.4	872,432

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

Injury and Violence – Violent Crime and Property Crime

Return to Report

Violent Crime
Violent crime includes homicide, rape, robbery, and aggravated assault.

Property Crime
This indicator reports the rate of property crime offenses reported by law enforcement per 100,000 residents. Property crimes include burglary, larceny-theft, motor vehicle theft, and arson. This indicator is relevant because it assesses community safety.

	Violent Crime		Property Crime	
	Violent Crimes, Annual Rate (Per 100,000 Pop.)	Violent Crimes, 3-year Total	Property Crimes, Annual Rate (Per 100,000 Pop.)	Property Crimes, Annual Average
VHC CHNA Community	**127.2**	**7,957**	**1,396.20**	**28,885**
VHC Primary Service Area	**133.1**	**2,905**	**1,569.60**	**11,344**
VHC Secondary Service Area	**124.1**	**5,052**	**1,303.00**	**17,540**
Arlington County, VA	151.3	1,054	1,669.90	3,850
Fairfax County, VA	94.9	3,268	1,341.00	15,356
Loudoun County, VA	100.9	1,171	940.40	3,507
Prince William County, VA	189.5	2,611	1,263.00	5,722
Alexandria City, VA	185.7	866	1,903.20	2,915
Fairfax City, VA	163.2	120	1,760.20	427
Falls Church City, VA	134.8	57	1,579.60	220
Manassas City, VA	244.4	311	1,818.40	772
Manassas Park City, VA	118.1	56	959.10	156
State / National Benchmark				
Virginia	207.8	52,568	1,903.20	159,257
United States	416.0	4,579,031	2,466.10	7,915,583

Data Source: Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2014; 2016. Source geography: County

Maternal, Infant, and Child Care – Infant Deaths, Low Weight Births, Birth Care

Return to Report

	Infant Deaths per 1,000 Live Births	Low Birthweight Births, Percentage	Births with Late/No Care, Percentage
VHC CHNA Community	**3.9**	**7.00%**	**No Data**
VHC Primary Service Area	**3.4**	**6.80%**	**No Data**
VHC Secondary Service Area	**4.1**	**7.10%**	**No Data**
Arlington County, VA	3.0	7.00%	4.28%
Fairfax County, VA	4.0	7.00%	4.26%
Loudoun County, VA	3.0	7.00%	2.95%
Prince William County, VA	5.0	7.00%	7.79%
Alexandria City, VA	3.0	7.00%	3.70%
Fairfax City, VA	No data	6.00%	No Data
Falls Church City, VA	No data	5.00%	No Data
Manassas City, VA	4.0	7.00%	No Data
Manassas Park City, VA	No data	6.00%	No Data
State / National Benchmark			
Virginia	6.0	8.10%	4.80%
United States	5.6	8.20%	6.12%

Infant Deaths and Low Birthweight Births Data Source: University of Wisconsin Population Health Institute, County Health Rankings. 2014-2020. Source geography: County

Births with Late/No Care Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research. 2019. Source geography: County

Infant Deaths
This indicator reports information about infant mortality, which is defined as the number of all infant deaths (within 1 year) per 1,000 live births.

Low Birthweight Births
This indicator reports the percentage of live births where the infant weighed less than 2,500 grams (approximately 5 lbs., 8 oz.). These data are reported for a 7-year aggregated time period.

Births with Late/No Care
This indicator reports the percentage of women who did not obtain prenatal care until the 7th month (or later) of pregnancy or who didn't have any prenatal care, as of all who gave birth during the three-year period from 2017 to 2019. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

Mental Health – Adult Mental Health

Return to Report

	Average Poor Mental Health Days per Month	Suicide Rate (Per 100,000 Population)
VHC CHNA Community	**No Data**	**8.7**
VHC Primary Service Area	**No Data**	**8.5**
VHC Secondary Service Area	**No Data**	**8.8**
Arlington County, VA	3.8	7.0
Fairfax County, VA	3.5	8.6
Loudoun County, VA	3.5	10.5
Prince William County, VA	3.8	9.4
Alexandria City, VA	3.7	8.7
Fairfax City, VA	3.7	23.7
Falls Church City, VA	3.6	No data
Manassas City, VA	4.1	No data
Manassas Park City, VA	4.1	No data
State / National Benchmark		
Virginia	4.1	13.4
United States	4.4	13.8

Poor Mental Health
This indicator reports the percentage of adults age 18 and older who report 14 or more days during the past 30 days during which their mental health was not good.

Suicides
This indicator reports the 2016-2020 five-year average rate of death due to intentional self-harm (suicide) per 100,000 population.

Poor Mental Health Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via County Health Rankings. 2020. Source geography: County

Suicide Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

Nutrition, Physical Inactivity Obesity – Food Environment

Return to Report

Food Deserts
This indicator reports the number of neighborhoods in the report area that are within food deserts. The USDA Food Access Research Atlas defines a food desert as any neighborhood that lacks healthy food sources due to income level, distance to supermarkets, or vehicle access.

Low Food Access
This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store.

SNAP Authorized Retailers
This indicator reports the number of SNAP-authorized food stores as a rate per 10,000 population. SNAP-authorized stores include grocery stores as well as supercenters, specialty food stores, and convenience stores that are authorized to accept SNAP (Supplemental Nutrition Assistance Program) benefits.

		Food Desert		Low Food Access		SNAP Authorized Retailers	
	Total Population (2010)	Food Desert Population	Food Desert Population, Percent	Population with Low Food Access	Population with Low Food Access, Percent	Total SNAP-Authorized Retailers	SNAP-Authorized Retailers per 10,000 Population
VHC CHNA Community	**1,925,013**	**642,320**	**33.4%**	**298,330**	**15.50%**	**900**	**4.23**
VHC Primary Service Area	**666,891**	**125,136**	**18.8%**	**52,330**	**7.85%**	**338**	**4.58**
VHC Secondary Service Area	**1,258,122**	**517,184**	**41.1%**	**246,000**	**19.55%**	**562**	**4.05**
Arlington County, VA	207,627	0	0.0%	4,799	2.31%	94	3.92
Fairfax County, VA	1,081,726	12,870	1.2%	195,193	18.04%	422	3.67
Loudoun County, VA	312,311	3,869	1.2%	51,730	16.56%	145	3.43
Prince William County, VA	402,002	52,727	13.1%	112,086	27.88%	210	4.42
Alexandria City, VA	139,966	0	0.0%	No data	No data	78	4.91
Fairfax City, VA	22,565	0	0.0%	2,426	10.75%	30	12.80
Falls Church City, VA	12,332	0	0.0%	No data	No data	16	10.94
Manassas City, VA	37,821	7,678	20.3%	4,224	11.17%	30	7.34
Manassas Park City, VA	14,273	6,248	43.8%	5,783	40.52%	8	4.45
State / National Benchmark							
Virginia	8,001,024	1,147,233	14.3%	1,631,773	20.39%	6,315	7.35
United States	308,745,538	39,074,974	12.7%	68,611,398	22.22%	248,526	7.47

Food Desert and Low Food Access Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2019. Source geography: Tract
SNAP Authorized Retailers Data Source: US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator. Additional data analysis by CARES. 2023. Source geography: Tract

Nutrition, Physical Inactivity Obesity – Obesity and Physical Activity

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	Obesity		Physical Activity	
	Adults with BMI > 30.0	Adults with BMI > 30.0, Percent	Adults with No Leisure Time Physical Activity	Adults with No Leisure Time Physical Activity, Percent
VHC CHNA Community	**374,305**	**23.60%**	**265,565**	**16.80%**
VHC Primary Service Area	**125,800**	**22.00%**	**88,614**	**15.60%**
VHC Secondary Service Area	**248,505**	**24.50%**	**176,950**	**17.50%**
Arlington County, VA	36,551	19.40%	25,890	14.00%
Fairfax County, VA	197,692	22.90%	137,073	15.90%
Loudoun County, VA	72,030	24.50%	49,965	17.30%
Prince William County, VA	97,530	28.90%	71,384	21.40%
Alexandria City, VA	30,307	23.60%	21,861	17.20%
Fairfax City, VA	4,459	25.00%	3,658	20.30%
Falls Church City, VA	2,816	26.00%	1,947	17.80%
Manassas City, VA	6,494	22.00%	5,777	19.70%
Manassas Park City, VA	3,359	25.40%	2,491	19.20%
State / National Benchmark				
Virginia	1,855,024	28.60%	1,403,863	21.30%
United States	69,961,348	29.00%	54,200,862	22.00%

Obesity Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019. Source geography: County

Physical Activity Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019. Source geography: County

Obesity
This indicator reports the number and percentage of adults aged 20 and older self-report having a Body Mass Index (BMI) greater than 30.0 (obese). Body mass index (weight [kg]/height [m]2) was derived from self-report of height and weight. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

Physical Activity
This indicator is based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?" This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues, such as obesity and poor cardiovascular health.

Physical Environment – Cost Burdened Households

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Cost Burdened Households
This indicator reports the percentage of the households where housing costs are 30% or more total household income. This indicator provides information on the cost of monthly housing expenses for owners and renters. The information offers a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels. The following zip codes have the highest percentage of households with severe cost burden of housing.

	Cost Burdened Households (30%)	Total Households	Percentage of Cost Burdened Households
VHC CHNA Community	**229,363**	**780,153**	**29.40%**
VHC Primary Service Area	**94,381**	**304,883**	**30.96%**
VHC Secondary Service Area	**134,982**	**475,270**	**28.40%**
Arlington County, VA	31,818	109,528	29.05%
Fairfax County, VA	117,487	408,673	28.75%
Loudoun County, VA	31,765	135,690	23.41%
Prince William County, VA	44,251	150,488	29.41%
Alexandria City, VA	24,732	74,224	33.32%
Fairfax City, VA	2,624	9,090	28.87%
Falls Church City, VA	1,640	5,630	29.13%
Manassas City, VA	4,356	13,562	32.12%
Manassas Park City, VA	2,026	5,155	39.30%
State / National Benchmark			
Virginia	915,143	3,248,528	28.17%
United States	37,625,113	124,010,992	30.34%

Data Source: US Census Bureau, American Community Survey. 2017-21. Source geography: Tract

Physical Environment – Housing

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	Percentage of Households with No or Slow Internet	Percentage of Substandard Housing Conditions
VHC CHNA Community	**4.97%**	**30.00%**
VHC Primary Service Area	**6.80%**	**31.92%**
VHC Secondary Service Area	**3.80%**	**28.77%**
Arlington County, VA	6.59%	29.90%
Fairfax County, VA	4.64%	29.06%
Loudoun County, VA	3.80%	23.77%
Prince William County, VA	4.16%	29.95%
Alexandria City, VA	6.88%	34.02%
Fairfax City, VA	4.19%	28.59%
Falls Church City, VA	3.61%	30.16%
Manassas City, VA	4.51%	33.78%
Manassas Park City, VA	4.89%	39.19%
State/National Benchmark		
Virginia	12.39%	28.30%
United States	13.00%	31.49%

Internet Access Data Source: US Census Bureau, American Community Survey. 2017-21 Source geography: Tract

Substandard Housing Data Source: US Census Bureau, American Community Survey. 2017-21. Source geography: Tract

Internet Access
This indicator reports the percentage of households who either use dial-up as their only way of internet connection, or have internet access but don't pay for the service, or have no internet access in their home, based on the 2014-2019 American Community Survey estimates.

Substandard Housing
This indicator reports the percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30%, and 5) gross rent as a percentage of household income greater than 30%. Selected conditions provide information in assessing the quality of the housing inventory and its occupants. This data is used to easily identify homes where the quality of living and housing can be considered substandard.

Substance Use Disorder – Adult Alcohol and Tobacco Use

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	Percentage of Adults Binge Drinking in the Past 30 Days (Crude)	Percentage of Adult Current Smokers (Crude)
VHC CHNA Community	**16.5%**	**11.2%**
VHC Primary Service Area	**17.1%**	**10.6%**
VHC Secondary Service Area	**16.2%**	**11.5%**
Arlington County, VA	18.8%	9.3%
Fairfax County, VA	14.9%	9.4%
Loudoun County, VA	14.5%	10.0%
Prince William County, VA	14.5%	13.0%
Alexandria City, VA	16.3%	11.6%
Fairfax City, VA	14.8%	10.9%
Falls Church City, VA	16.0%	8.4%
Manassas City, VA	15.7%	15.1%
Manassas Park City, VA	15.3%	16.4%
State/National Benchmark		
Virginia	15.0%	14.8%
United States	15.5%	14.3%

Adult Alcohol Use
This indicator reports the percentage of adults age 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.

Adult Tobacco Use
This indicator reports the percentage of adults age 18 and older who report having smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days.

Alcohol Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2020. Source geography: Tract

Tobacco Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2020. Source geography: Tract

Substance Use Disorder – Opioid Overdose

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Opioid Overdose
This indicator reports the 2016-2020 five-year average rate of death due to opioid drug overdose per 100,000 population. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because opioid drug overdose is the leading cause of injury deaths in the United States, and they have increased dramatically in recent years.

	Age-Adjusted Death Rate (Per 100,000 Population)	Five Year Total Deaths, 2016-2020 Total
VHC CHNA Community	**8.6**	**913**
VHC Primary Service Area	**7.4**	**277**
VHC Secondary Service Area	**9.2**	**636**
Arlington County, VA	6.3	84
Fairfax County, VA	7.9	446
Loudoun County, VA	6.9	131
Prince William County, VA	13.6	318
Alexandria City, VA	8.0	67
Fairfax City, VA	17.9	20
Falls Church City, VA	No Data	No Data
Manassas City, VA	18.9	40
Manassas Park City, VA	No Data	No Data
State/National Benchmark		
Virginia	16.1	6,708
United States	16.0	256,428

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

Appendix D – Resources Potentially Available to Address Significant Health Needs

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Identified Health Need	Community Resources
Respectful & Inclusive Care Access to Health Services Navigating healthcare services Chronic health conditions Health equity Lack of prenatal care	Hospital: • VHC Health • VHC Health Physician Group • VHC Health Outpatient Hubs • VHC Health – Health Promotions • VHC Health Case Management Health Departments/Clinics: • Arlington County Public Health • Arlington County Department of Human Services • Arlington County School Health Community Board Other: • VOICE (Virginians Organized for Interfaith Community Engagement) • Equity Arlington • Arlington Partnership for Children • Neighborhood Health

Appendix D – Resources Potentially Available to Address Significant Health Needs

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Identified Health Need	Community Resources
Mental Illness & Behavioral Health Lack of providers & resources Lack of outpatient resources Inpatient capacity	Hospital: • VHC Health • VHC Health Physician Group – Psychiatry/Mental Health • VHC Health Inpatient services • VHC Health Outpatient services • VHC Health Emergency Services Health Departments/Clinics: • Arlington Community Services Board (CSB) • Arlington Mental Health Alliance • Senior Adult Mental Health Program • Crisis Intervention Team • Diversion First Program Other: • Crisis Intervention Team • Assertive Community Treatment • Clarendon House • Psychiatrists (independent practitioners)

Appendix D – Resources Potentially Available to Address Significant Health Needs

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Identified Health Need	Community Resources
Childhood & Adult Obesity Food Insecurity/Lack of Affordable Housing/Poverty/High Cost of Living/Homelessness Childhood Obesity Adult Obesity	Hospital: • VHC Health Weight Management Program • VHC Health Bariatric Surgery Services • VHC Health Nutrition Counseling Services • VHC Health Promotions & Healthy Living Classes and Services – fitness classes, healthy living classes, support groups, etc. • VHC Physician Group bariatric surgeons • VHC Health Outpatient Clinic • VHC Health Pediatric Center Health Departments/Clinics: • Arlington Free Clinic • OAR of Arlington • APAH • Arlington School Health Advisory Board • Healthy Communities Action Team (HCAT) Other: • Virginia Cooperative Extension • Northern Virginia Family Services • PathForward • Bridges to Independence • Doorways • Thrive • American Heart Association • American Diabetes Association • Virginia Foundation for Healthy Youth Grant • Northern Virginia Healthy Kids Coalition • National Alliance for Nutrition and Activity

Appendix D – Resources Potentially Available to Address Significant Health Needs

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Identified Health Need	Community Resources
Aging Services Senior Health/Services Isolation for seniors Shortage of facilities/services	Hospital: • Virginia Hospital Center • VHC Physician Group Primary Care and Geriatric physicians and specialists • VHC Senior Health Program • VHC Lifeline Medical Alert Program • VHC Healthy Aging Lectures • VHC Healthy Aging Support Groups – Alzheimer's & Dementia, Parkinson's, etc. • VHC Walking Fit Program and Senior Exercise Classes Health Department/Clinics: • Arlington Agency on Aging • Arlington Mill Senior Center • Walter Reed Adult Day Health Center/Care • Arlington 55+ Program Other: • Primary Care Physicians & Gerontologists • Area Agency on Aging • Virginia Department for Aging & Rehabilitation • Council on Aging

Limitations and Information Gaps

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As with all data collection efforts, there are several limitations related to the assessment's research methods that should be acknowledged. Years of the most current data available differ by data source. In some instances, 2022 may be the most current year available for data, while 2013 may be the most current year for other sources. Likewise, survey data based on self-reports, such as the Behavioral Risk Factor Surveillance Survey (BRFSS), should be interpreted with particular caution. In some instances, respondents may over or under report behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked.

In addition, respondents may be prone to recall bias – that is, they may attempt to answer accurately, but they remember incorrectly. In some surveys, reporting and recall bias may differ according to a risk factor or health outcome of interest. Despite these limitations, most of the self-report surveys analyzed in this CHNA benefit from large sample sizes and repeated administrations, enabling comparison over time. Similarly, while the qualitative data collected for this study provide valuable insights, results are not statistically representative of a larger population due to nonrandom recruiting techniques and a small sample size. Data were collected at one point in time and among a limited number of individuals.

Therefore, findings, while directional and descriptive, should not be interpreted as definitive.