Fairfax County Health Department

CALENDAR YEAR 2024 EQUITY IMPACT PLAN

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Departmental Equity Guiding Statement:

Transform the Health Department's organizational culture by applying a racial and social equity lens to all aspects of our work, policies, and practices, in order to identify and address the root causes of health inequities in the community.

Context:

As the Health Department's approach to equity evolves, we make use of multiple sets of data and information to update our plans. In updating the 2024 plan, we focused on two different sets of data/information as context for our actions: 1) the 2023 Community Health Assessment conducted by the Health Department in collaboration with the Partnership for a Healthier Fairfax, and 2) our two years of FCHD workforce point-in-time demographic data.

1. The Health Profile of Fairfax County from the 2023 Community Health Assessment (CHA) is a careful review of health-related data and statistics to determine the health issues facing the community. In 2023, FCHD conducted a comprehensive review of the quantitative data available in the Fairfax community to identify the key health-related areas, called the Community Status Assessment. This data was supplemented with a collection and review of qualitative data which helps explain why, how, or what happened, called the Community Context Assessment. Together these form the basis of the information that the Partnership for a Healthier Fairfax will use to create their Community Health Improvement Plan (CHIP) for 2024-2028. Because a central focus of both the CHA and the CHIP is equity and addressing the health needs of communities that are most vulnerable or at highest risk for negative health outcomes, FCHD uses this data to inform our Equity Impact Plan for 2024.

   In general, Fairfax compares favorably to other jurisdictions on a majority of health metrics, ranking in the top 20 Healthiest Communities in the nation of 2022 (Source: Healthiest Communities - Rankings, News, Data | US News Healthiest Communities). A majority of local health indicators are either stable, fluctuating, or trending in a positive direction with two key exceptions—drug overdoses and mental health indicators. Recent trends in the rates of non-fatal opioid overdose emergency department visits document substantial increases in the 10-17 and 18-24 age groups, and rates of non-fatal opioid overdose emergency department visits are highest within the Black/African American and Hispanic/Latino communities, both of which have increased in recent years.

   Despite this growing trend, chronic diseases and conditions pose the biggest burden on the community, and we know that there may be underlying connections to structural inequalities found in the community. The Black/African American community disproportionately experiences adverse social, economic and health outcomes. Interestingly, despite being disproportionately impacted by adverse social and economic conditions, the health status of the Hispanic/Latino community overall

appears better than many other racial/ethnic groups based on key indicators. Broad categorization of racial/ethnic groups does not capture potential within-group variation, however.

Geographic disparities are consistent across social, economic, and health related indicators with persistent disparities observed predominantly in the central and southeastern regions of the county.

2. FCHD workforce compared to the county population and the population served:

Beginning in 2022, the Health Department has conducted an annual point-in-time analysis of its workforce demographic data to develop a profile that can be compared to the Fairfax County demographic profile to see how representative our staff is of the community we serve. The results of this comparison can be seen in the table below:

	2022 FCHD Workforce Demographics (Summer PIT Analysis)	Percent of Fairfax County by Race/Ethnicity (2022 ACS 1-year Estimate)	2023 FCHD Workforce Demographics (August PIT Analysis)
Total Population	N = 886	**N = 1,138,331**	N = 730
Hispanic/Latinx	15.1%	**17%**	17.6%
Non-Hispanic Asian	15.5%	**20%**	16.4%
Non-Hispanic Black	17.7%	**10%**	17.2%
Non-Hispanic Multiracial	1.4%	**5%**	1.6%
Non-Hispanic Other	0.4%	**1%**	0.5%
Non-Hispanic White	49.8%	**47%**	46.4%

While overall Fairfax County shows growing diversity, with an increase in the non-White population percentage increasing from 45% in 2010 to 53% in 2022, the population is also aging. 31% of Fairfax residents were born outside of the U.S., and 1 in 10 are not U.S. citizens. The top five nations of origin for those born outside of the U.S. are 1) India, 2) South Korea, 3) China, 4) Vietnam, and 5) El Salvador. We are also seeing increasing language diversity as one in three individuals ages 18 and older speak a language other than English at home. The size of the population 65 and older increased 60% between 2010 and 2022, with individuals ages 35 to 49 representing the largest share (21.3%) of the population.

Comparatively, the FCHD workforce is also becoming more diverse over time (operationalized as an increasingly lower percentage of non-Hispanic Whites that make up the workforce), when looking overall, the demographic profile of our workforce in 2023 is fairly representative of the Fairfax County population with the following exceptions:

- The portion of our workforce that is non-Hispanic Black is slightly larger than that population is represented in the County Demographic Profile

- The portion of our workforce that is non-Hispanic Asian is slightly smaller than the corresponding population of the County

In addition, the overall demographic profile of Fairfax County does not represent the population of those served by FCHD, which generally come from communities that are most vulnerable to poor health outcomes across the county. Our workforce demographics are slightly less representative of the populations we serve.
Finally, it should be noted that the diversity of the FCHD workforce is not distributed evenly across all pay grade and supervisory/managerial levels. As we progress up the organizational hierarchy, the organization becomes less diverse.

System-Level Infrastructure:

The Health Department is working in multiple ways with a variety of partners across Fairfax County Government and in the community to impact the social determinants of health contributing to population disparities and investing in initiatives that advance racial and social equity. The Health Department knows it cannot work by itself to address health disparities. FCHD is continuing the multifaceted coordination of efforts among county agencies and community partners to expand the health safety net and reduce barriers to medication and specialty care; in land development projects to create safe neighborhoods; and with Fairfax County Public Schools to develop a pipeline to health careers for youth from underserved communities.

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DEPARTMENT GOALS

Goal 1: Build internal infrastructure (including staff capacity) to operationalize health equity practices and support a culture that promotes open dialogue and open discussion.

One Fairfax Area(s) of Focus: 18. Other

Countywide Strategic Plan Community Outcome Area(s): Healthy Communities, Effective and Efficient Government (EEG), Lifelong Learning and Education

Relationship to Countywide Strategic Plan Strategies/Metric(s): Strategy EEG 13. Implement a workplace culture change effort to actively promote equity and inclusion, collaboration, excellence, innovation, customer service, transparency, accountability and trustworthiness.
EEG Indicator: Effective & Representative County & School Workforce; Metric: Difference between demographics of county workforce and the demographics of the community

Actions	Stakeholders	Resources/ Supports	Responsible Parties	Timeline	Performance Measures
1a. Build out the operating framework for the Health Equity Champions Network.	Equity Champions, FCHD Leadership	Facilitator and staff time	HELE Facilitators	Jan-Jun 2024	• # Champions engaged • # activities conducted by Champions
1b. Evaluate impact of the Health Equity Leadership Experience and develop recommendations for future training.	Workforce Development Team, FCHD Leadership	HELE Facilitator time	HELE Facilitators	Jan-Feb 2024	• Participant evaluations • HELE facilitators' report • Recommendations for changes to training
1c. Train new staff to facilitate courageous conversations and staff equity training across the department.	Equity Champions, FCHD Leadership, HELE Facilitators	Facilitator and staff time	HELE Facilitators	TBD	• Metric pending scheduling of train the facilitator
1d. Develop guidance for implementing equity policy analysis (refer to FCHD Strategic Plan 1.1.3).	Health Equity Team, FCHD Leadership	Staff time	Strategic Plan Implementation Team	Mar-Dec 2024	• Creation and adoption of guidance • Effectiveness of guidance based on user feedback
1e. Establish a regular point-in-time analysis of FCHD workforce demographics.	Executive leadership and the Division of Administration	Staff time to pull data; staff time to analyze data, possible data analysis support	HD-HR, Health Equity Coordinator, Health Equity Team	Jun-Aug 2024	• Codify data pull and analysis categories • # of applications of data analysis for equity projects

1f. Establish a working group/committee structure for the Health Equity Team, including the addition of new members.	Health Equity Team, Equity Champions	Staff time	Health Equity Team, Health Equity Team Co-Lead	Jan 2024-Dec 2024	• Approved structure of work groups incorporated into Health Equity Team Charter

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Goal 2: Leverage information from existing data sets, community engagement, and other sources to identify gaps and inform policy direction **and** develop interventions and programs.

One Fairfax Area(s) of Focus: 10. A health and human services system where opportunities exist for all individuals and families to be safe, be healthy and realize their potential through the provision of accessible, high quality, affordable and culturally appropriate services.

Countywide Strategic Plan Community Outcome Area(s): Healthy Communities, Effective and Efficient Government, Empowerment and Support for Residents Facing Vulnerability (ESRFV)

Relationship to Countywide Strategic Plan Strategies/Metric(s):
ESRFV Indicator: All People Are Respected, Understood and Connected; Metric: % of residents utilizing services who feel that their input is strongly considered as part of designing the services they receive

Actions	Stakeholders	Resources/ Supports	Responsible Parties	Timeline	Performance Measures
2a. Collect and analyze data from clients and diverse populations**, including** strengths and assets**, to** inform programmatic decisions (refer to FCHD Strategic Plan 1.2.4).	HD current and future clients, frontline staff, safety net providers		Division of Epidemiology and Population Health, Outreach and Engagement Team	Ongoing	• Process established for routine data collection and analysis • # of report(s) of quantitative and qualitative data analyses completed
2b. Create more opportunities for the collection of qualitative data (refer to Public Health Improvement Initiatives Plan).	HD current and future clients, frontline staff, safety net providers		PHICT, Outreach and Engagement Team,	June 2023-Ongoing	• # of opportunities identified
2c. Develop a system for sharing results of intersectional analysis with staff beyond the Division of Epidemiology and Population Health.	HD Leadership, frontline staff, Equity Champions		Communications staff, Division of Epidemiology and Population Health		• Successful completion of data walk for FCHD staff • Expansion of Division of Epidemiology & Population Health webpage to include data sharing • Development of targeted data dashboards
2d. Identify sub-group to develop an evaluation methodology for impacts of equity actions. (Refer to Action 1f)	HD Leadership, Equity Champions community residents, One Fairfax		Health Equity Team, Equity Champions		• # Equity Team members identified for sub-committee • Creation of charter

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Goal 3: Communicate the importance of racial, social, and health equity to internal and external audiences to keep equity at the forefront of planning, decision making and service provision.

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Countywide Strategic Plan Community Outcome Area(s): Healthy Communities, Efficient and Effective Government, Empowerment and Support for Residents Facing Vulnerability

Relationship to Countywide Strategic Plan Strategies/Metric(s): ESRFV Indicator: All people are respected, understood and connected; Metric: # residents who access services

Actions	Stakeholders	Resources/ Supports	Responsible Parties	Timeline	Performance Measures
3a. Implement internal communications strategy drafted in 2023.	HD staff, HD leadership	HD-IT to build out Equity Share Point page	Communications Team, HE Team workgroup members, Health Equity Coordinator	Jan-Dec 2024	• # of views of Equity Share Point Page • Participant feedback to Champion Engagement Activities
3b. Co-create, with safety-net providers, materials and resources that tell the story about the successes and services provided, using different media platforms.	Clients, Safety-net providers, Health Safety Net Team, Health Integration Team, NCS	HD Communications Team, HD Outreach Team, FQHC Outreach Teams, Multicultural Advisory Committee	Health Safety Net team	Ongoing	• Types of resources to develop identified • # of messages/material shared • Engagement metrics

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Goal 4: Collaborate with customers, clients, and stakeholders to co-create strategies to address health inequities.

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Countywide Strategic Plan Community Outcome Area(s): Healthy Communities, Efficient and Effective Government (EEG), Empowerment and Support for Residents Facing Vulnerability

Relationship to Countywide Strategic Plan Strategies/Metric(s): EEG Indicator: Inclusive Community Engagement; Metric: % of residents who feel they have authentic opportunities to participate in decision-making

Actions	Stakeholders	Resources/ Supports	Responsible Parties	Timeline	Performance Measures
4a. Build a toolbox of strategies for community engagement using a variety of tools and methods that build trust, center community voice and needs, and provide opportunities for storytelling about lived experience.	HD communications and outreach staff, community partners, and community at large	Outreach team, CHWs, One Fairfax, Health Promotion Coordinator	PHICT, Outreach staff,	Ongoing	• Creation of repository for evidence-based models for community engagement
4b. Identify and implement methods to sustain relationships leading to the co-creation of comprehensive health promotion strategies.	HD staff, residents, Community-based organizations, Partnership for a Healthier Fairfax, Multi-cultural Advisory Committee (MAC), Outreach Team, Houses of Worship	One Fairfax Team, GARE engagement tools, Houses of Worship Equity Workshops	PHICT	Ongoing	• Development of asset map of community partnerships • Development of staff accessible electronic system for tracking partnerships and engagement activities (# new partnerships initiated per year)
4c. Collaborate with community health services providers (e.g. FQHCs, Inova) to evaluate current system policies, practices, and procedures to identify areas where disparities in access and outcomes may occur.	FQHCs, Health Safety Net Team, Health Integration Team, NCS, DFS and HCD (OPEH), free and low-cost clinics, other non-profits and philanthropy groups	Data from Health Safety Net Providers, Epidemiology and Population Health team	Health Safety Net team, Health Integration team	Ongoing	• Identification of key health care utilization and outcome measures • Development of cross-organizational data analytic plan

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4d. Operationalize the Public Health Improvements Initiatives Plan (PHIIP)	Community residents, HD staff, HD leadership	Health Promotion Coordinator, Public Health Improvement Coordinating Team (PHICT)	Performance Excellence Leadership Committee (PELC), PHICT	June 2023-Ongoing	• Identification of priority health issue for comprehensive strategy development to ensure coordination of resources and reduce redundancies • Formation of multi-organizational strategy development and implementation team • Development and implementation of strategic plan addressing priority health issue

Department Director's Signature: _____