2026 - 2028

Community Health Improvement Plan

Lord Fairfax Health District

ValleyHealth
Healthier, together.

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Executive Summary of CHIP Priorities

Identified health priorities are the basis for the CHIP. Four community health priorities were selected by community members after identifying areas of need through community health surveys, partner interviews, and local, state, and federal data sources. Collective discussions allowed community members to narrow choices and collaboratively decide on priorities.

Access to Health & Wellness Services:

Access to affordable, quality, and timely clinical care is an essential part of treating and managing health conditions, enabling individuals to live longer and healthier lives.

- Many individuals face barriers to accessing needed care services, such as financial barriers, availability of services, transportation limitations, and stigma.
- Connections to nearby support services can influence a person's wellbeing and quality of life by providing them with opportunities to access the resources needed.
- Improved access to medical services was seen as a potential solution by survey respondents.

CHIP Goals

- Encourage healthcare workforce opportunities.
- Enhance collaboration through service mapping & resource navigation.
- Address the financial burdens associated with health-related services.

Nutrition & Physical Wellbeing:

Numerous chronic health conditions, like obesity, type 2 diabetes, heart disease, cancer, kidney and liver disease, and poor mental health, are linked to poor nutrition and lack of physical activity.

- Incorporating healthy eating and active living practices can support overall health and wellbeing while reducing risk factors for chronic diseases.
- LFHD localities experience chronic diseases at similar or higher percentages than state averages with high percentages of no leisure physical activity time.
- In the Lord Fairfax Health District, 1 in 10 people experience food insecurity. This increases a person's risk of chronic diseases, adverse birth outcomes, and poor mental health.

CHIP Goals

- Increase access to affordable nutritious foods.
- Empower individuals, families, and communities to make informed decisions to enhance physical wellbeing.

Housing:

Affordable, good quality, safe, and stable housing supports health. Living without access to these resources can create poor health that worsens over time, especially among at-risk populations. Housing is a key driver of health outcomes.

- The availability of affordable and safe housing is an increasing concern among community members, who recognize the issue of people struggling to pay rent or resorting to living in substandard living conditions.
- Poor housing conditions are associated with health concerns such as respiratory illnesses and infections, lead poisoning, injuries, and poor mental health.

CHIP Goals

- Support in the reduction of individual barriers to housing access.
- Increase community readiness and feasibility for housing initiatives.

Mental Health:

Poor mental health adversely affects a person's quality of life because of its broad negative health and social consequences.

- Concerns regarding mental health have been increasing, and data shows that people experiencing frequent mental distress have increased consistently over time in the US, VA, WV, and locally.
- Mental health is influenced by not only biological factors, but also the environmental and societal factors in a person's life.
- Mental health conditions often require specialized providers for the support and treatment needed to ensure the best outcomes. Financial barriers and provider availability are two limiting factors for people to access these services.

CHIP Goals

- Develop a diverse group of mental health supports to increase awareness of available resources
- Communicate broadly through the community about mental health and the diverse resources available to support people in their wellness and recovery

Foundations of the CHIP

Introduction

Purpose

Service Area & Structure

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Introduction

This 2026–2028 Community Health Improvement Plan (CHIP) builds on the findings of the 2025 Community Health Assessment (CHA) and reflects the ongoing commitment to improving health outcomes. This plan is the result of a meaningful collaboration between Valley Health, Lord Fairfax Health District (LFHD), and numerous community partners undertaken with the shared goal of understanding and improving the health and wellbeing of everyone in the Northern Shenandoah Valley.

What is a CHA?

A CHA is a careful, systematic examination of the health status of the community that is used to identify key health problems and assets in the community. The information gathered through this assessment is valuable to community organizations and agencies and allows for updated and timely data regarding the community and its wellbeing. The data collected from this assessment informs decision-making, prioritization of health problems, and development of plans for continuous improvement of the health of the community.

The 2025 CHA engaged thousands of community members and stakeholders through surveys, interviews, and focus groups, including vulnerable populations served by local shelters and food pantries. This collaborative process incorporated both quantitative and qualitative data and was guided by principles of health equity and community engagement.

The 2025 CHA can be found at Lord Fairfax Health District - 2025 CHA and at Valley Health - Community Health Needs

The CHIP translates these findings into actionable strategies designed to improve access to care, promote healthy behaviors, and address critical social drivers of health such as housing and food security. While not exhaustive of all community health initiatives, this plan outlines specific, measurable actions our community will implement and monitor from 2026 through 2028 in partnership with local organizations and stakeholders.

This plan is intended to be dynamic. Strategies will be reviewed annually and adjustments will be made as necessary to respond to emerging health priorities or new opportunities for collaboration. Evaluation will include tracking progress toward stated objectives, reporting measurable outcomes, and publishing updates for public review to ensure accountability and transparency. Through these efforts, we remain committed to creating healthier communities and reducing health disparities.

Purpose

The Community Health Improvement Plan (CHIP) is a collective community which aims to build a dynamic, community-informed roadmap designed to address the identified community health concerns. By working collaboratively, our community has developed goals, objectives, strategies, and evaluation metrics for each of these priorities, ensuring clear accountability within this process. The timeline for this CHIP is three years and include 2026, 2027, and 2028.

As part of this process, a community health steering committee was established with a guiding mission and vision in order to prioritize the array of needs that presented throughout the assessment process.

Project Mission Statement: "Our mission is to collaboratively assess, understand, and address the health needs of our community by engaging diverse stakeholders, gathering data, advocating for policies and programs and using evidence-based strategies to improve the overall health and well-being of all community members."

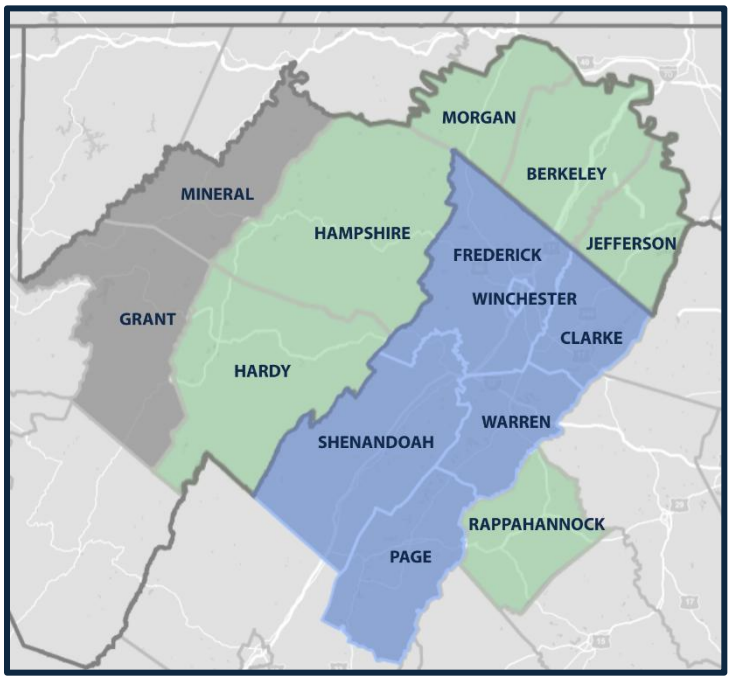
Project Vision Statement: "Our vision is to foster a community where innovative, evidence-based health solutions are embraced, and where collaborative partnerships lead to sustainable improvements in optimal health and quality of life for every resident."

Federal regulations require that tax-exempt hospital facilities, such as Valley Health, conduct a Community Health Needs Assessment every three years and develop an implementation strategy that addresses priority community health needs. This process is in compliance with the Patient Protection and Affordable Care Act of 2010 and Section 501(r)(3) of the Internal Revenue Code.

Service Area

The following report focuses on the shared service areas of the Lord Fairfax Health District and Valley Health (indicated below in blue). This area includes Clarke, Frederick, Page, Shenandoah, and Warren counties and the City of Winchester. These localities are nestled in the northwestern corner of Virginia and encompass a 1,632 square mile area of the Northern Shenandoah Valley. This area encompasses a mix of rural communities and suburban areas and has seen a growth of its population by 8.1% from 2014 to 2023.[1]

[1] Virginia Department of Health, Demographics Dashboard, 2014 – 2023.



An additional report encompassing the entire Valley Health service area, including its primary and secondary service areas, is available online at [Community Health Needs | Valley Health](#).

Legend:

- Shared primary service areas between Valley Health & LFHD
- Additional Valley Health primary service areas
- Valley Health secondary service areas

Structure

Three primary groups of individuals assisted in this process, the Core Team, Steering Committee, and a broad group of community members and stakeholders. These groups gave input about community needs, current programs, and service gaps regarding these priority areas. This involvement provided essential feedback regarding the development of this report.

Core Team: This group lays the groundwork for the CHA and CHIP by devoting initial resources such as staff time or funding. The Core Team consists of leaders from both Lord Fairfax Health District and Valley Health:

Katherine Schroeder, MPH, Population Health Manager, LFHD

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Susie Hammock, MS, Change Management Specialist, LFHD

Methodology

The development of this 2026–2028 Community Health Improvement Plan (CHIP) was guided by the findings of the 2025 Community Health Assessment (CHA) and incorporates the following steps:

Establish Assessment Infrastructure

Valley Health and the Lord Fairfax Health District convened participation from the service area represented by this joint report, which included community members from the hospital foundations, local leaders, community members, and system leadership. This group has provided supervision for the CHA and CHIP development process.

Conduct Community Health Assessment

The 2025 CHA identified health needs through a mixed-method approach, including community surveys, key informant interviews, and focus groups. Quantitative data on demographics, health indicators, and social determinants of health were supplemented with qualitative insights from vulnerable populations and stakeholder groups.

Analyze Data and Selecting Priorities

Valley Health and the Lord Fairfax Health District facilitated work sessions with core team members, hospital leadership, and community partners to review CHA findings, assess internal resources, and examine evidence-based best practices. Needs were prioritized based on prevalence, severity, health equity considerations, and potential for measurable impact. Four system-wide priority areas emerged:

- **Access to Health & Wellness Services**
- **Mental Health**
- **Nutrition & Physical Wellbeing**
- **Housing**

Develop Goals, Objectives, and Strategies

Goals, objectives and strategies were developed for each priority area by a collective group of CHIP leadership and community partners, especially those who work in the direct areas of each priority area. These are designed to leverage the community's resources and partnerships for sustainable impact. Both traditional and non-traditional partners will be engaged to address identified needs.

Create the Community Health Implementation Plan

The CHIP outlines actionable strategies, timelines, and measurable objectives for each priority area. Plans incorporate best practice models and focus on health equity, addressing social, economic, and environmental factors that influence health outcomes.

Plan for Monitoring and Evaluation

Progress will be tracked through a community-wide dashboard with defined metrics for each strategy. The community stakeholders and hospital representatives will meet quarterly to review progress, recommend adjustments, and ensure accountability. Annual evaluations will include reporting measurable outcomes and publishing updates for public review.

Limitations

While Valley Health and LFHD are convening this CHIP process, the efforts and outcomes of this process are not limited to those two organizations nor is there direct funding provided for organizations participating in these activities. Organizations participating in the activities of the priority areas are doing so voluntarily, whether because they view the work as important or because it aligns with their mission or current initiatives. Organizations may incorporate CHIP activities into their existing workload or programs without additional resources.

This plan requires participation and collaboration from diverse community partners; therefore, the success of certain goals or objectives may be dependent on another. There is always the potential for delays in progress which may impact other aspects of CHIP priorities.

To encourage accountability and follow-through for CHIP contributors, a process of reporting actions, achievements, and progress will be established. Updates regarding this progress will be shared on www.LFHD.org. This will allow the CHIP Core team to be aware of any progress but will allow for clear transparency for our community regarding this process. Quarterly meetings for contributors and conveners will be held to encourage continued collaboration and to ensure continued support.

Clarke County, VA

CHIP

Priority Areas

Access to Health & Wellness Services

Nutrition & Physical Wellbeing

Housing

Mental Health

Access to Health & Wellness Services

Access to care refers to a person's ability to obtain timely, affordable, and quality medical services, such as primary, specialty, diagnostic, or preventative care, to achieve their best health outcomes. This is essential for promoting overall wellbeing, reducing unnecessary disability, disease, or premature death for community members.

During community conversations, individuals shared barriers which caused difficulties in getting the care needed for themselves and their families. Themes such as financial constraints, service and provider availability, transportation, and stigma were all mentioned.

Goal 1 Encourage healthcare workforce opportunities

Objective 1.1 Engage local students in healthcare professions and opportunities through educational outreach.

- **(1.1.1)** Support school outreach programs for healthcare careers.
- **(1.1.2)** Support local clinical programming to enhance availability of healthcare education opportunities.

Objective 1.2 Increase the number of local residents who enter healthcare career pathways through education, training, and mentorship initiatives.

- **(1.2.1)** Encourage utilization of existing healthcare programs and scholarship opportunities for community members.
- **(1.2.2)** Promote accessible certification and training programs for community health supports.

Objective 1.3 Identify policy avenues to improve, encourage, and retain healthcare workforce

- **(1.3.1)** Communicate resources for healthcare workforce opportunities, supports, and career pathways.
- **(1.3.2)** Identify and promote additional support services for those utilizing healthcare workforce pathways.

Goal 2 Enhance collaboration through service mapping & resource navigation.

Objective 2.1 Identify the community pathways to care to support individuals accessing the correct and appropriate level of care for their needs.

- **(2.1.1)** Utilize community asset mapping to clarify appropriate health services and gaps to better support a streamlines referral and navigation process for individuals.

Objective 2.2 Utilize a centralized location for service map of local health care organizations.

- **(2.2.1)** Build and maintain an accessible online portal or hub listing healthcare organizations, services, and eligibility.

Goal 3 Address the financial burdens associated with health-related services.

Objective 3.1 Facilitate better awareness of programs for alternate educational tracts & finance options for medical education and healthcare careers.

- **(3.1.1)** Develop and share materials highlighting non-traditional and accelerated tracks toward healthcare careers.

Objective 3.2 Identify and reduce financial barriers for consumers accessing healthcare.

- **(3.2.1)** Enhance collaboration between safety-net care providers to best support the needs of community members with services and supports.
- **(3.2.2)** Conduct further analysis regarding cost barriers to understand the specific needs of community members and to prioritize targeted efforts to support these areas of need.

City of Winchester, VA

Frederick County, VA

Nutrition & Physical Wellbeing

Poor nutrition and lack of physical activity contribute to chronic diseases such as obesity, diabetes, and heart disease. Moreover, to support long-term health, it begins with the food that we eat and the physical activities that we incorporate into our lives.

Many people continue to experience barriers regarding nutrition and physical wellbeing. Food insecurity, high costs of healthy foods, limited access to fitness facilities and activities, and knowledge gaps are all examples of these. Locally, food insecurity affects 1 in 10 people.

Goal 1 Increase access to affordable nutritious foods.

Objective 1.1

Determine and communicate a broader understanding of food resources in the community.

- **(1.1.1)** Map the available community resources for food and transportation.

Objective 1.2

Develop and communicate pathways to access healthy food options and programs.

- **(1.2.1)** Support and promote community food assistance programs
- **(1.2.2)** Explore innovative community-based food access partnership
- **(1.2.3)** Support individual nutritional wellbeing through various food delivery systems.

Objective 1.3

Support education opportunities about the importance of proper nutrition and family wellbeing.

- **(1.3.1)** Promote online resources for food budgeting, nutrition, wellness, and disease prevention for easily accessible information for community members

Frederick County, VA

Goal 2 Empower individuals, families, and communities to make informed decisions that enhance physical well-being.

Objective 2.1

Develop and communicate activities and programs that engage youth in physical wellbeing opportunities.

- **(2.1.1)** Map the available community resources for physical wellness programs and related resources.
- **(2.1.2)** Connect individuals, families and communities together to enhance knowledge around physical wellbeing.
- **(2.1.3)** Identify, support, and promote community-based wellness programs at free or low costs
- **(2.1.4)** Encourage physical outdoor activities and educational opportunities for adults and youth alike.
- **(2.1.5)** Develop and communicate activities and programs that engage youth in physical wellbeing opportunities.

City of Winchester, VA

Housing

Affordable, safe, and stable housing is critical for positive health outcomes. Poor housing quality and inadequate conditions, such as the presence of lead, mold, asbestos, poor air quality, and overcrowding, can contribute to negative health outcomes, including chronic disease and injury. The availability and affordability of safe housing is a growing concern. When people spend significant portions of their income on housing, it then causes financial stress for families to afford other essentials like nutrition, transportation, childcare, or healthcare.

According to local data collected from the Community Health Survey,[2] community members across all LFHD localities identified housing costs and housing availability as their primary concerns regarding neighborhoods and built environment.

Goal 1 Support in the reduction of individual barriers to housing access

Objective 1.1 Assess regional policies and studies regarding the barriers to housing for individuals and developers.

- **(1.1.1)** Compile trends from local housing studies to identify barriers to housing access.

Objective 1.2 Identify federal & state funding capabilities of regional housing programs

- **(1.2.1)** Determine qualifications timelines for housing funding streams
- **(1.2.2)** Identify homebuyer support programs and improve community knowledge of such programs.

Objective 1.3 Identify programs that encourage housing sustainability

- **(1.3.1)** Determine community needs regarding housing sustainability for at-risk populations.
- **(1.3.2)** Identify home repair programs and improve community knowledge of such programs.
- **(1.3.3)** Support financial and housing literacy education for students

[2] This data can be accessed in the 2025 Community Health Assessment, available at www.vdh.virginia.gov/lord-fairfax/community-health/cha/

Goal 2 Increase community readiness and feasibility for housing initiatives

Objective 2.1 Develop strategic community education of 'housing as community health'

- **(2.1.1)** Identify and communicate the health implications of housing and built environments.
- **(2.1.2)** Offer organizational trainings regarding the health implications of housing to aid in the recognition and referrals for housing needs.
- **(2.1.3)** Encourage community education on home insurance and emergency preparedness.

Objective 2.2 Involve authentic community voices towards housing initiatives

- **(2.2.1)** Share the voices of individuals as they age at home.
- **(2.2.2)** Communicate the economic benefits of supporting the housing continuum for community members.
- **(2.2.3)** Identify and communicate the legal situations and community assistance programs to prevent negative housing outcomes

Objective 2.3 Conduct an annual readiness assessment of community perspectives on housing initiatives

City of Winchester, VA

Mental Health

Mental health is a critical, foundational health determinant that influences physical health, economic productivity, and social functioning. It is shaped by structural conditions like income, education, housing, and discrimination, with poor mental health raising risks for chronic conditions like heart disease.

Concerns regarding mental health are increasing and local data indicates that adults with frequent mental distress have been increasing consistently since 2020. Some barriers that individuals face to accessing care are financial limitations as well as provider shortages.

Goal 1 Develop a diverse group of mental health supports to increase awareness of available resources.

Objective 1.1 Support access to timely, community-based mental health support.

- **(1.1.1)** Identify pathways for rapid access to clinical supports.
- **(1.1.2)** Identify ways to support individuals through the mental health care continuum.
- **(1.1.3)** Explore and identify peer-led, drop-in, and recovery support spaces.
- **(1.1.4)** Increase co-location of behavioral health services.

Objective 1.2 Develop programs and projects that support coordinated navigation of mental wellness, selfcare resources, and community resources

- **(1.2.1)** Build a Regional Coordinated Navigation Network.
- **(1.2.2)** Explore shared referral infrastructure
- **(1.2.3)** Develop a public facing digital mental health and wellness resource hub

Objective 1.3 Enhance street outreach programs for high-risk populations

- **(1.3.1)** Support proactive behavioral health engagement and street outreach in the community.
- **(1.3.2)** Embed mental health resources into existing outreach efforts.
- **(1.3.3)** Support peer and community-based support services that leverage lived experience and reduce stigma.

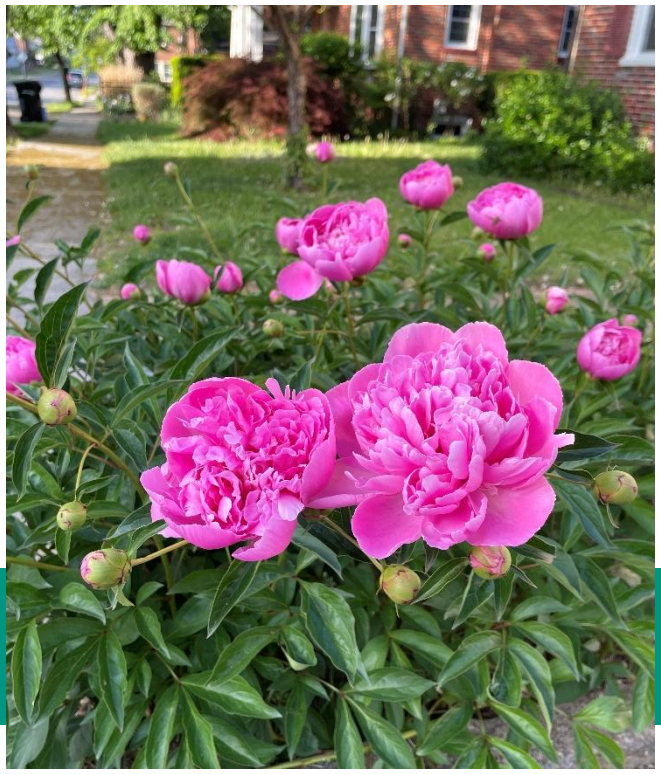
Goal 2 **Communicate broadly through the community about mental health and the diverse resources available to support people in their wellness and recovery**

Objective 2.1 Implement a comprehensive, regional communications campaign about mental health and wellbeing

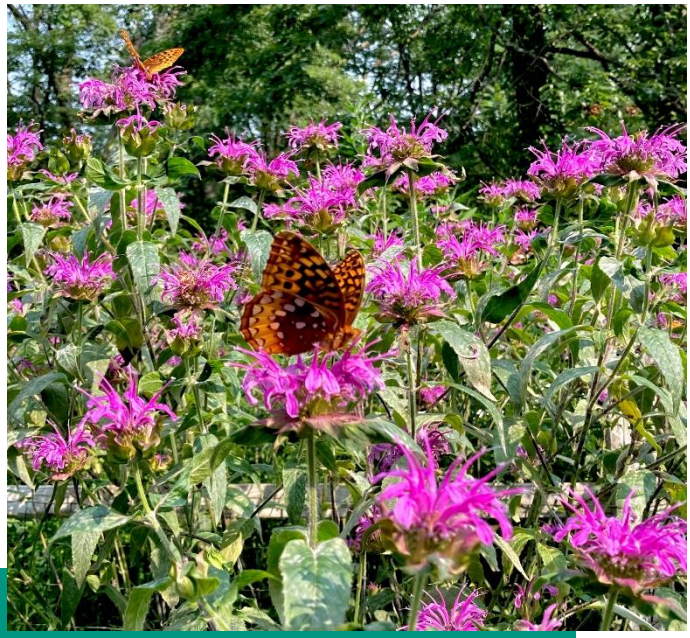
- **(2.1.1)** Implement a coordinated, regional awareness campaign about 988 and other crisis and referral pathways.
- **(2.1.2)** Develop targeted mental health communication strategies to ensure that diverse groups can access understandable, culturally relevant information and resources.

Objective 2.2 Identify and train community organizations in mental-health-informed practices to recognize needs, support individuals, and make appropriate referrals.

- **(2.2.1)** Develop trainings for staff on how to recognize early signs of mental health concerns, start supportive conversations, and make warm referrals.
- **(2.2.2)** Develop a schedule of available community trainings.



City of Winchester, VA



Frederick County, VA

Conclusion & Call to Action

The efforts behind this Community Health Improvement Plan aims to create a shared vision for our community: to create healthier opportunities and more supportive systems for the individuals who live, work, learn, play, and pray in the Northern Shenandoah Valley. This CHIP emphasizes the efforts to include the perspectives and input from local organizations, individuals, and agencies to build a strong foundation for community improvement.

The identified priorities allow the community as a whole to align its efforts towards specific areas of need which, in turn, have the potential to improve health opportunities and outcomes for all. Together, through this community-driven process, we aim to address health disparities, promote equity, and build a vibrant, healthy future for all residents of the Northern Shenandoah Valley.

- **Access to Health & Wellness Services** – Healthcare is a necessary service for a community to promote health. By encouraging workforce development and opportunities, we aim to support our health systems long-term.
- **Nutrition and Physical Wellbeing** – One's daily nutritional habits and the level of physical activity acts as a primary building block for overall wellbeing and health outcomes. By strengthening opportunities for all to live healthier lives, we aim to reduce the burden of chronic diseases and improve quality of life and life expectancy.
- **Housing** – Affordable, stable, and safe housing are foundational pieces of physical and mental well-being and is also directly linked to financial stability.
- **Mental Health** – A fundamental determinant of overall health, mental health acts as a two-way determinant where poor mental health increases the risk of chronic diseases and physical conditions can trigger mental distress.

Public health improvement is a shared responsibility. When neighbors, organizations, and leaders contribute their time, ideas, and resources, change happens faster and lasts longer. Whether you lend your voice, your skills, or your support, together, have the opportunity to build a more healthy, supportive, and resilient region.

To learn more about this process or to see how you can become involved—visit www.LFHD.org & www.ValleyHealthLink.com

Appendices

Key Terminology

Contributors

Appendix A: Key Terminology

Below are terms and the associated definitions of those terms. These are included to provide additional background for terms that may not be commonly used and understood by those with a limited understanding of public health language.

CHA – Community Health Assessment. is a careful, systematic examination of the health status of the community that is used to identify key health problems and assets in the community. The information gathered through this assessment is valuable to community organizations and agencies and allows for updated and timely data regarding the community and its wellbeing.

CHIP – Community Health Improvement Plan. A CHIP is an action plan to address the priorities in the CHA. CHIP goals and objectives should be feasible and achievable within the 3-year window.

Contributors – Those who support the Convener and the CHIP by completing tasks and objectives on time, attending meetings, reporting on task progress, and publicizing their activities and results to their clients and partners.

Conveners – Those who recruit any community organizations or residents who can contribute to specific goals, objectives, sub-objectives, or tasks, organize meetings (remotely or in-person) with Contributors; sustain ongoing attention and progress to their respective CHIP objective and goals; regularly report progress, achievements, risks, and barriers to the CHA/CHIP Core Team; and publicize their activities and results to their clients and partners.

Built Environment – The human-made surroundings that influence overall community health, including the individual behaviors that drive health. The built environment includes many types of physical elements, such as homes, sidewalks, and public transportation.

Goal – Broad target. A projected state of affairs that a person or a system intends to achieve.

Health Disparities – The differences in health outcomes, such as life expectancy, mortality, health status, and prevalence of health conditions. These disparities can be driven by many factors, like social or economic inequities.

Health Equity – This is the state in which everyone has a fair opportunity to attain their full potential for health and wellbeing.

Health Outcome – The health impacts of an individual resulting from a condition, event, or intervention. These impacts can be measured in terms of social, psychological, and physical wellbeing, with an emphasis on the patient's subjective experience of a life worth living.

Objective – The intended measure of change for the community.

Qualitative Data – Information that is summarized without numbers and typically in textual or narrative format (e.g., focus group notes, questionnaire responses, or observational notes).

Quantitative data – Data expressing a certain quantity, amount, or range. Usually there are numerical measurements associated with the data.

Social Drivers of Health (SDOH) – The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH can be grouped into five domains: Economic Stability, Education Access and Quality, Healthcare Access and Quality, Neighborhood and Built Environment, and Social and Community Context. This term may also be referred to as Social Determinants of Health.

Strategy – Statement specifying what the efforts or actions are intended to attain or accomplish in the community.

Appendix B: Contributors

The Core Team is thankful for the time, efforts, and contributions made by the community individuals, organizations, and agencies of the Northern Shenandoah Valley. The details included in this CHIP have been made possible by the contributions of these individuals.

This document was built by and for the community. Thank you to the following:

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