Metropolitan Washington
Council of Governments

BOARD OF DIRECTORS

Wednesday, June 10, 2020
12:00 P.M. - 2:00 P.M.
WebEx Virtual Meeting (provided to members only by email)
Audio livestream available to public on COG website

AGENDA

12:00 P.M. **1. CALL TO ORDER**
Derrick L. Davis, COG Board Chair

2. CHAIRMAN'S REPORT
Derrick L. Davis, COG Board Chair

12:05 P.M. **3. EXECUTIVE DIRECTOR'S REPORT**
Chuck Bean, COG Executive Director

4. AMENDMENTS TO THE AGENDA
Derrick L. Davis, COG Board Chair

12:15 P.M. **5. APPROVAL OF THE MINUTES FROM MAY 13, 2020**
Derrick L. Davis, COG Board Chair

Recommended Action: Approve minutes.

6. ADOPTION OF CONSENT AGENDA ITEMS
Derrick L. Davis, COG Board Chair

A. R22-2020 - Resolution Authorizing COG to Procure and Enter a Contract with the Occoquan Watershed Monitoring Laboratory to Research Freshwater Salinization Syndrome (FSS) in the metropolitan Washington Region.

Recommended Action: Adopt Resolution R22-2020.

12:20 P.M. **7. 2020 REGIONAL HOMELESS ENUMERATION**
Kim Ball, Montgomery County Department of Health and Human Services Homeless Services Administrator
Tony Turnage, Prince William County Homeless Services Division Chief

The board will be briefed on the results of the Point in Time count completed by COG's Homeless Services Committee. The report is an annual enumeration of persons experiencing homelessness in the metropolitan Washington region.

Recommended Action: Receive briefing.

12:45 P.M. **8. HEALTH EQUITY: HOW OPPORTUNITIES FOR HEALTH ARE SHAPED BY RACE & ETHNICITY**

Dr. Travis Gayles, Montgomery County Department of Health and Human Services Health Officer and Chief of Public Health Services
Dr. Reuben Varghese, Arlington County Public Health Director
Dr. Steven Woolf, Virginia Commonwealth University Center on Society and Health Director Emeritus

The board will receive an overview of a health equity brief produced by the VCU Center on Society and Health for the COG Health Officials Committee (HOC). This brief is a tool to normalize the conversation on why equity matters and the importance of addressing the conditions that restrict opportunities for good health and economic mobility. Findings are based on the *"Uneven Opportunities: How Conditions for Wellness Vary across the Metropolitan Washington Region"* released in 2018.

Recommended Action: Receive briefing.

1:15 P.M. **9. RE-OPENING COORDINATION**

Marc Elrich, County Executive, Montgomery County
Phyllis J. Randall, Chair-at-Large, Loudoun County Board of Supervisors

The board will be briefed on the experience of entering Phase 1 and the importance of continued coordination as the metropolitan region makes plans to enter Phase 2 of reopening.

Recommended Action: Receive briefing.

1:55 P.M. **10. OTHER BUSINESS**

2:00 P.M. **11. ADJOURN**

The next meeting is scheduled for Wednesday, July 8, 2020.

AGENDA ITEM #2

CHAIRMAN'S REPORT

Metropolitan Washington Council of Governments

NEWS RELEASE

Statement by COG Board Executive Committee on George Floyd

Washington, D.C. (June 1, 2020) – The following is a statement from the Metropolitan Washington Council of Governments (COG) Board of Directors Executive Committee: COG Board Chair Derrick Leon Davis, Prince George's County; COG Board Vice Chair Christian Dorsey, Arlington County; and COG Board Vice Chair Robert C. White Jr., District of Columbia.

“As individual lawmakers and as a collective body, we mourn the loss of yet another unarmed Black American at the hands of law enforcement. We condemn the murder of George Floyd, and we grieve with residents across our jurisdictions and across our nation. It is the responsibility of governments in their entirety to protect and serve our residents. Too often, we fall short of that responsibility.

"George Floyd’s death is not the first. The killings of Eric Garner, Tamir Rice, Freddie Gray, Sandra Bland, Walter Scott, Michael Brown, Breonna Taylor, Philando Castile, Samuel DuBose, Terence Crutcher, Eric Harris, Botham Jean, and hundreds of others in the last decade alone, and the countless others in our nation’s history, have been enough to require systemic change.

"The initial shock of brutality must not fade to apathy. We must listen to those who are grieving, re-commit ourselves to racial justice and true equality, and take action."

CONTACT: Steve Kania: skania@mwcog.org, (202) 962-3278

Metropolitan Washington Council of Governments

2020 COG Board of Directors Meeting Dates

Note: The COG Board of Directors typically meet from 12–2 P.M. on the second Wednesday of every month except July and August.

- January 8
- February 12
- March 11
- April 8
- May 13
- June 10
- July 8*
- July 10 - 12 – Annual Retreat -- Cancelled
- August 12*
- September 9
- October 14
- November 12**
- December 9 – Annual Meeting

*Due to COVID-19 precautions, the annual retreat has been cancelled and the board will meet in July and August.

**Due to Veteran's Day on Wednesday, November 11, the meeting will be held on Thursday, November 12.

Updated: 6/3/2020

AGENDA ITEM #3

EXECUTIVE DIRECTOR'S REPORT

Metropolitan Washington Council of Governments

MEMORANDUM

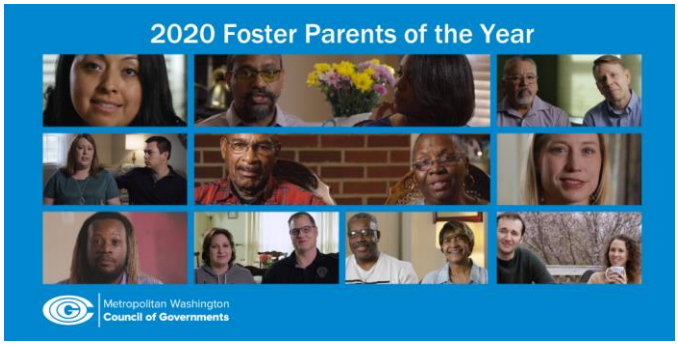
TO: COG Board of Directors
FROM: Chuck Bean, COG Executive Director
SUBJECT: Executive Director's Report – June 2020
DATE: June 3, 2020

COVID-19 COORDINATION

COG has continued to support the Chief Administrative Officers (CAO) Committee on COVID-19 coordination—sharing information on reopening plans, health metrics (cases, hospitalizations), and changes to government operations. COG has begun to coordinate with state-level efforts to expand contact tracing capabilities and improve communication and information exchange. Emergency managers, health officials, public information officers, and other groups continue to regularly connect and explore opportunities for coordination, such a new joint radio ad to share messaging on stopping the spread of COVID-19 with the region's Latino population.

POLICY BOARD & COMMITTEE UPDATES

National Capital Region Transportation Planning Board (TPB) – At its May virtual meeting, the TPB was briefed on the results of its *Regional Roadway Safety* study, which analyzed the factors contributing to fatal and serious injury crashes. The briefing included an in-depth look at crashes involving pedestrians and at certain intersections and arterials. Also related to the board's focus this year on safety, the Washington Regional Alcohol Program updated the board on the findings of its *How Safe Are Our Roads?* report, which tracks the prevalence of impaired driving in the region. The TPB also received a briefing on the draft results of an assessment of the market potential for commuter rail service between points in Maryland and Virginia, known as VRE-MARC run-through service, including how it could influence regional development and revitalization of commercial centers.



COG RECOGNIZES OUTSTANDING FOSTER PARENTS FROM 10 AREA JURISDICTIONS
Each year, COG partners with local and state child welfare agencies around the region to recognize exceptional foster parents.

View a video and news release on the awardees

Climate, Energy, and Environment Policy Committee (CEEPC) – At its May virtual meeting, CEEPC members approved the *FY-2021 Regional Environmental Fund Work Program and Budget*. Members were briefed on the estimated impact of the COVID shutdown on energy consumption and greenhouse gas emissions. COG staff provided updates on the *2030 Climate and Energy Action Plan* and members shared updates on local climate action plans, metrics, developments, and initiatives.

Chesapeake Bay and Water Resources Policy Committee (CBPC) – At its May virtual meeting, CBPC received presentations from the authors of the top two submissions to the inaugural CBPC Paper Competition and announced the winner, Hailey Clark, a student at the University of Maryland Institute of Applied Agriculture. The board was also briefed on WSSC Water's COVID-19 response which includes providing essential employees with PPE equipment and safety measures, and messages to customers about bill payment programs and pipe protection.

Metropolitan Washington Air Quality Committee (MWAQC) – At its May virtual meeting, MWAQC reviewed the emissions inventory for the 2015 Ozone National Ambient Air Quality Standard and opened it to the public for comments. The board was also briefed on the 2020 Ozone season and reviewed a preliminary analysis of the impact of COVID-19 related behavior changes and their impact on regional air quality.

OUTREACH & PROGRAM HIGHLIGHTS

Air Quality Awareness Week – To celebrate Air Quality Awareness Week May 4 – 8, 2020, COG partnered with Clean Air Partners to inform residents, through a blog and social media, on how they can do their part to improve air quality from home while following Stay-at-Home orders.

Go Recycle Campaign – COG will be running its annual *Go Recycle* radio and digital media campaign beginning the first week in June, with the theme of "Help to Keep our Trash & Recycling Workers Safe." The campaign will encourage everyone to properly dispose of masks and gloves in the trash, to bag trash, to not bag recyclables, to reduce waste, and to recycle right.

Census Coordination - In partnership with local governments and non-profits, COG continues to share and promote information to encourage regional participation in the 2020 Census.

STREET SMART
As Stay-at-Home orders and other actions to slow the spread of COVID-19 reduced traffic on the region's roadways, law enforcement reported an increase in drivers speeding, so COG's Street Smart safety program and area officials have been urging residents to keep their guard up when venturing out on area streets..

View the campaign and safety tips

MEDIA HIGHLIGHTS

Washington region's governments are largely committed to a coordinated reopening – COG Board members discuss the importance of a coordinated, scientifically-informed reopening strategy for the region.
The Washington Post story

How Does Transportation and Commuting Change In A Post-Coronavirus World? We Asked Experts – COG Deputy Executive Director for Metropolitan Planning Kanti Srikanth discusses how the pandemic has changed travel patterns and what is to come in the future.

WAMU story

This is Air Quality Awareness Week: How is Air Quality in the DC area? – COG Environmental Programs Director Steve Walz gave an update on the status of air quality in our region and how residents can do their part to improve it.

ABC7 story

AGENDA ITEM #4

AMENDMENTS TO THE AGENDA

AGENDA ITEM #5

APPROVAL OF THE MINUTES

METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS
777 North Capitol Street, NE
Washington, D.C. 20002

MINUTES
COG Board of Directors Meeting
May 13, 2020

BOARD MEMBERS AND ALTERNATES: See attached chart for attendance.

SPEAKERS:
Dr. Reuben Varghese, Arlington County Public Health Director
Dr. George Askew, Prince George's County Deputy CAO for Health & Human Services
Mark Schwartz, Arlington County Manager
Andrew Kleine, Montgomery County Chief Administrative Officer
Phil Mendelson, Council of the District of Columbia Chair
Penny Gross, Fairfax County Board of Supervisors Vice Chair
Reuben Collins, Charles County Board of Commissioners President

1. CALL TO ORDER AND PLEDGE OF ALLEGIANCE
COG Board Vice Chair Christian Dorsey called the meeting to order at 12:00 P.M. and led the Pledge of Allegiance.

2. CHAIRMAN'S REPORT
A. A brief review of WebEx functions, virtual meeting operations.
B. Census completion rates.

3. EXECUTIVE DIRECTOR'S REPORT
COG Executive Director Chuck Bean highlighted the Transportation Planning Board's Regional Safety Study and the MARC-VRE Rail Run-Through Service study. COG's Director of Homeland Security & Public Safety Scott Boggs and Jennifer Schitter, COG's Principal Health Planner, introduced some new tools COG is using to track COVID-19 data and forecasts. COG Deputy Executive Director Tom Gates gave an update on COG's consortium purchase of personal protective equipment (PPE) for the region.

4. AMENDMENTS TO AGENDA
There were no amendments to the agenda.

5. APPROVAL OF MINUTES
The minutes from the April 8 & 22, 2020 board meetings were approved.

6. ADOPTION OF CONSENT AGENDA ITEMS
A. Resolution R19-2020 – Resolution Authorizing COG to Receive a Grant to Contract Professional Statistical Analysis Services for Stream Survey Trash Data.

ACTION: Approved Resolution R19-2020.

7. FISCAL YEAR 2021 WORK PROGRAM AND BUDGET
COG Executive Director Chuck Bean and Chief Financial Officer Julie Mussog briefed the board on the FY 2021 Work Program and Budget recommended by the COG Budget and Finance Committee. The board adopted Resolution R20-2020 approving the work program and budget of $41.2 million for FY 2021.

ACTION: Received briefing and Approved Resolution R20-2020.

8. ALLOCATION OF ADDITIONAL FEDERAL FUNDS TO STATES AND LOCALITIES

COG Board Vice Chair Christian Dorsey briefed the board on the Coronavirus Aid, Relief, and Economic Security (CARES) Act to combat the epidemic and provide economic relief. The COG Board concurred that the bill does not provide adequate funding for states and localities and approved a resolution supporting the allocation of additional federal funds.

ACTION: Received briefing and Approved Resolution R21-2020.

9. COVID-19 CRISIS: PERSPECTIVES ON REOPENING & REGIONAL COORDINATION

Arlington County Public Health Director Dr. Reuben Varghese and Prince George's County Deputy CAO for Health and Human Services Dr. George Askew briefed the board on the health challenges the region faces if the reopening strategy is not coordinated across jurisdictions. Arlington County Manager Mark Schwartz and Montgomery County Chief Administrative Officer Andrew Kleine briefed the board on the jurisdiction-level efforts to build a regional strategy to combat COVID-19. Council of the District of Columbia Chair Phil Mendelson, Fairfax County Board of Supervisors Vice Chair Penny Gross, and Charles County Board of Commissioners President Reuben Collins briefed the board on local plans for reopening the region.

ACTION: Received briefing.

10. OTHER BUSINESS

There was no other business.

11. ADJOURN

Upon motion duly made and seconded, the meeting was adjourned at 2:00 P.M.

May 13, 2020 Attendance

Jurisdiction	Member	Y/N	Alternate	Y/N
District of Columbia				
Executive	Hon. Muriel Bowser		Ms. Beverly Perry Mr. Wayne Turnage Ms. Lucinda Babers	Y
	Mr. Rashad Young		Eugene Kinlow	Y
Council	Hon. Phil Mendelson	Y		
	Hon. Robert White	Y		
Maryland				
Bowie	Hon. Tim Adams			
Charles County	Hon. Reuben Collins	Y	Thomasina Coates Gilbert Bowling	
City of Frederick	Hon. Michael O'Connor	Y		
Frederick County	Hon. Jan Gardner		Ms. Joy Schaefer	Y
College Park	Hon. Monroe Dennis	Y	Hon. Patrick Wojahn	
Gaithersburg	Hon. Robert Wu	Y	Hon. Neil Harris	
Greenbelt	Hon. Colin Byrd		Hon. Emmett Jordan	Y
Laurel	Hon. Craig Moe	Y	Hon. Michael Leszcz	(P)
Montgomery County				
Executive	Hon. Marc Elrich		Mr. Andrew Kleine	Y
Council	Hon. Tom Hucker			
	Hon. Nancy Navarro			
Prince George's County				
Executive	Hon. Angela Alsobrooks		Mr. Major F. Riddick	Y
	Hon. Derrick Leon Davis			
Rockville	Hon. Bridget Newton	Y		
Takoma Park	Hon. Kate Stewart	Y	Hon. Cindy Dyballa Hon. Peter Kovar	
Maryland General Assembly	Hon. Brian Feldman	Y		
Virginia				
Alexandria	Hon. Justin Wilson	Y	Hon. Redella Pepper	
Arlington County	***Hon. Christian Dorsey***	Y		
City of Fairfax	Hon. David Meyer	Y	Michael DeMarco	
Fairfax County	Hon. Jeff McKay		Hon. James Walkinshaw	
	Hon. Penelope Gross	Y	Hon. Daniel Storck	
	Hon. Rodney Lusk		Hon. Walter Alcorn	Y
Falls Church	Hon. David Snyder	Y	Hon. David Tarter	
Loudoun County	Hon. Juli Briskman	Y		
Loudoun County	Hon. Phyllis Randall	Y		
Manassas	Hon. Mark Wolfe			
Manassas Park	Hon. Hector Cendejas	Y	Hon. Miriam Machado	
Prince William County	Hon. Ann Wheeler	Y		
	Hon. Andrea Bailey			
Virginia General Assembly	Hon. George Barker	Y		

Y = Present, voting
(P) = Present as Alternate in addition to Primary

AGENDA ITEM #6

ADOPTION OF CONSENT AGENDA ITEMS

ADOPTION OF CONSENT AGENDA ITEMS
June 2020

Resolution R22-2020 – RESOLUTION AUTHORIZING COG TO PROCURE AND ENTER INTO A CONTRACT WITH THE OCCOQUAN WATERSHED MONITORING LABORATORY TO RESEARCH FRESHWATER SALINZIATION SYNDROME (FSS) IN THE METROPOLITAN WASHINGTON REGION.

The board will be asked to adopt Resolution R22-2020 authorizing the Executive Director, or his designee, to expend COG funds from the Department of Environmental Program's Regional Water Fund in the amount not to exceed $720,000 for a five-year contract with four option years. The first-year amount is $120,000. The resolution also authorizes the Executive Director, or his designee, to proceed with procurement for a contractor, or contractors, and enter a five-year contract, contingent upon availability of funds, to research freshwater salinization syndrome across the COG region. Freshwater salinity is rising across our region and threatens regional drinking water supplies and stream health. This project will identify the emerging impacts and types of watersheds and streams that are most at risk, inform management actions, and measure the effectiveness of mitigation efforts. No COG matching funds are required.

RECOMMENDED ACTION: Adopt Resolution R22-2020.

AGENDA ITEM #7

2020 REGIONAL HOMELESS ENUMERATION

HOMELESSNESS IN METROPOLITAN WASHINGTON

Executive Summary from the 2020 Report

June 2020

Metropolitan Washington
Council of Governments

EXECUTIVE SUMMARY

For the 20th consecutive year, the Metropolitan Washington Council of Governments (COG) Homeless Services Planning and Coordinating Committee has conducted a regional enumeration of the area's residents experiencing homelessness and those who were formerly homeless.

This year's enumeration and survey occurred on January 22, 2020. The report provides a one-night "snapshot" of the region's residents experiencing homelessness within nine metropolitan Washington area jurisdictions. It is important to note that this "snapshot," by definition, provides only one perspective on the state of homelessness in metropolitan Washington on only one night, and the count may be influenced by numerous variables, such as weather and bed availability by jurisdiction.

At the time the count was conducted, the impact of the pandemic caused by COVID-19 was not apparent within this region. It did not alter the methodology or results of the 2020 count. By the time the data were gathered and analyzed from the annual enumeration, however, the challenges facing people experiencing homelessness and those who are working to end their housing crisis had grown exponentially. This report will not cover the significant needs that the metropolitan Washington region's Continua of Care require to manage the public health crisis, but this year perhaps more than ever, it is apparent that *housing is health care*.

Key findings, highlights, and trends from the 2020 Point-in-Time (PIT) Enumeration follow below:

LITERALLY HOMELESS COUNT

- The 2020 Point-in-Time (PIT) Enumeration resulted in a total count of 9,763 literally homeless individuals. This is the lowest number of persons counted experiencing homelessness since the region began coordinating in 2001, and the second year in a row that the literally homeless total has been below 10,000 persons.

- The region's number of persons experiencing homelessness decreased by 31 persons from 2019.

This decrease is smaller than the decrease noted in the 2019 count and remains essentially unchanged on a percentage basis. Two of nine jurisdictions recorded decreases in the number of persons experiencing homelessness in 2020 from the 2019 count.

SHORT-TERM CHANGES IN THE HOMELESS ENUMERATION, 2019 TO 2020

- The District of Columbia had the greatest reduction in the number of persons experiencing homelessness from 2019 to 2020 (141 fewer persons), followed by Arlington County (16 fewer persons).

LONGER TERM CHANGES IN THE HOMELESS ENUMERATION, 2016 TO 2020

- **Seven of nine participating Continua of Care experienced a decline in the number of people experiencing homelessness between the 2016 and 2020 enumerations.**

- During the period from 2016 to 2020, the District of Columbia experienced the greatest reduction in persons experiencing homelessness, counting 1,970 fewer individuals. The District of Columbia also has the largest proportion of the region's residents experiencing homelessness (65 percent). Montgomery County had the second largest reduction between 2016 to 2020, with 311 fewer homeless persons counted, followed by Prince George's County (91 fewer persons) and Prince William County (74 fewer persons).

- Montgomery County reported the highest percentage reduction in its literally homeless count from 2016 to 2020 (32 percent).

VETERANS EXPERIENCING HOMELESSNESS

The region's count of veterans experiencing homelessness is essentially unchanged from 2019; there were 3 additional veterans on the night of the count from the previous year's enumeration.

- In 2020, the total number of veterans counted on the night of the PIT was 418, or three more individuals than were counted in 2019;

- The total number of veterans experiencing homelessness counted in 2020 has increased since its regional lowest count of 408 veterans in 2018, but remains below the number recorded during the PIT counts in 2016 and 2017; only two jurisdictions (Arlington County and Fairfax County) noted a decrease from 2019 to 2020, for a combined total of 16 fewer veterans counted.

- The District of Columbia recorded the greatest reduction in the number of veterans between 2016 and 2020 (48 fewer veterans counted), followed by Prince William County (12 veterans), and Frederick and Fairfax Counties (six and four fewer veterans respectively).

- The greatest percentage reduction between 2016 and 2020 was recorded by Frederick County (50 percent fewer veterans counted), followed by Prince William County (43 percent reduction) and Arlington County (40 percent reduction)[1].

- Six of nine CoCs reduced the incidence of veteran homelessness since 2016, for a regional reduction of 14 percent.

[1] It's important to note that these percentages are based on small total numbers; for example, in Frederick County, the 69 percent reduction is based on a difference of six individuals.

CHRONICALLY HOMELESS

The trend noted for the number of persons counted as chronically homeless follows similar results, holding steady, as noted for other persons experiencing homelessness in 2020.

- **Five of the nine participating jurisdictions experienced decreases in their chronically homeless single adult counts since 2016, and six Continua of Care recorded a decrease between the PIT counts of 2019 and 2020. Overall, the region counted 13 percent fewer single persons who were considered chronically homeless on the night of the enumeration between 2016 and 2020.**

- The District of Columbia had the greatest reduction in the region in the number of chronically homeless single adults from 2016 to 2020 (164 fewer persons counted in 2020), followed by Montgomery County and the city of Alexandria, (135 and 32 fewer chronically homeless persons respectively).

- The jurisdiction with the greatest percentage reduction in chronically homeless single adults since 2016 is Montgomery County (93 percent for the second year in a row), followed by the city of Alexandria (68 percent) and Arlington County (51 percent).

Being able to intervene in other systems of care to prevent a housing crisis challenges the jurisdictions in the region from preventing a person from becoming chronically homeless. Persons seeking a permanent home may wait long enough to find housing they can afford that they eventually meet the HUD definition for chronically homeless. It is a conundrum faced nationwide in communities with high housing costs and limited housing affordable to those with the lowest incomes.

FORMERLY HOMELESS

The number of individuals who are in permanent housing and no longer experiencing homelessness was double the number of people counted as literally homeless on the night of the annual enumeration. The region measured a decrease from 2019 to 2020 of 19 percent of the single individuals and persons in families who were counted in permanent housing on the night of the PIT and are no longer considered homeless, but have increased the regional total of persons who are formerly homeless by 10 percent since 2016.

In addition, in 2020:

- 4,387 formerly homeless individuals were rapidly re-housed;

- 11,072 formerly homeless persons were counted in Permanent Supportive Housing; and

- 3,335 formerly homeless persons were counted in other permanent housing.

This brings the regional total of formerly homeless persons in 2020 to 18,794 additional people housed than at this time last year. The significant number of people placed in permanent housing has constrained the incidence of homelessness in the region and helped prevent it from growing unchecked.

CONCLUSION

Data collected this year confirm what each jurisdiction has observed in practice, that the single greatest barrier to ending homelessness in our communities is the insufficient number of affordable and available permanent housing opportunities for the lowest income households.

The 2020 report highlights several key, recurring themes:

1. The significant increase in the number of formerly homeless persons in permanent housing;
2. The positive impact of shelter diversion and homeless prevention programs;
3. The critical need to increase the supply of housing affordable to the lowest-income households and appropriate supportive resources.

Dedication to addressing the region's homelessness challenges has resulted in steady, measurable progress in providing shelter and wrap-around services to homeless individuals and families. The region should celebrate the achievements made to reduce the number of people counted experiencing homelessness in 2020. These reductions reflect the dedication and coordinated efforts of many to prevent people from entering the homeless system, to improve service delivery, and to increase permanent housing solutions. Reductions in chronically homeless and veteran subpopulations reflect focused efforts to ensure that the experience of homelessness is *brief, rare,* and *one time only.*

However, there remain significant challenges highlighted in this year's numbers. The challenges laid bare by the global pandemic caused by COVID-19 have highlighted the lifesaving protections that housing provides.

The successes reflected in the numbers in the report demonstrate that effective strategies are in place, but a sustained commitment to creating and adequately funding viable housing solutions for the lowest-income individuals and families, continuously improving data tracking and interpretation, and providing service paths to ensure successful housing placements are among the most critical components to making further significant reductions in the annual Point-in-Time count.

The full report is forthcoming.

View the full annual Point-in-Time (PIT) Count of Homeless Persons on the COG website here:

https://www.mwcog.org/documents/2020/05/21/homelessness-in-metropolitan-washington-results-and-analysis-from-the-annual-point-in-time-pit-count-of-homeless-persons-featured-publications-homelessness/

AGENDA ITEM #8

HEALTH EQUITY: HOW OPPORTUNITIES FOR HEALTH ARE SHAPED BY RACE & ETHNICITY

HEALTH EQUITY

How Opportunities for Health are Shaped by Race and Ethnicity

Across the jurisdictions served by the Metropolitan Washington Council of Governments (COG) and throughout the nation, health outcomes vary starkly by race and ethnicity. The coronavirus pandemic has provided a harsh example, but the problem of health inequities is larger and older. For generations, African Americans have experienced higher mortality rates than whites, and Hispanic Americans have died at higher rates from diabetes and other chronic diseases. Such inequities help explain why life expectancy varies by 28 years across the COG region. African Americans account for 93% of the population in the five census tracts with the lowest life expectancies but only 7% of the population where life expectancy is highest.

Health is shaped by more than our individual choices or health care. Health is also influenced by place, and health inequities are influenced by structural racism, the "systems, social forces, institutions, ideologies, and processes that generate and reinforce inequities among racial and ethnic groups." Minority communities often have lower household income and less access to education, healthy foods, green space, affordable housing and transportation, and health care. And they often face greater health threats such as air pollution and violence. A study by Virginia Commonwealth University's Center on Society and Health estimated that nearly half (47%) of the variation in health across census tracts in the COG region was associated with race and immigrant status.

The neighborhood disadvantages that exist for many people of color did not arise by chance; they are products of policies, both past and present. Disparities in today's communities were shaped by decades of exclusionary practices—from post-Reconstruction racial violence and Jim Crow laws to exclusionary housing policies (e.g., redlining) that isolated people of color from white neighborhoods. Non-white families were prevented from acquiring property and transferring generational wealth, reducing revenue for schools, neighborhood infrastructure, economic development, and jobs. Exclusionary policies continue to reinforce inequities today, perpetuating transgenerational poverty, blight, and disparate treatment—conscious and unconscious—in school, labor, and criminal justice systems.

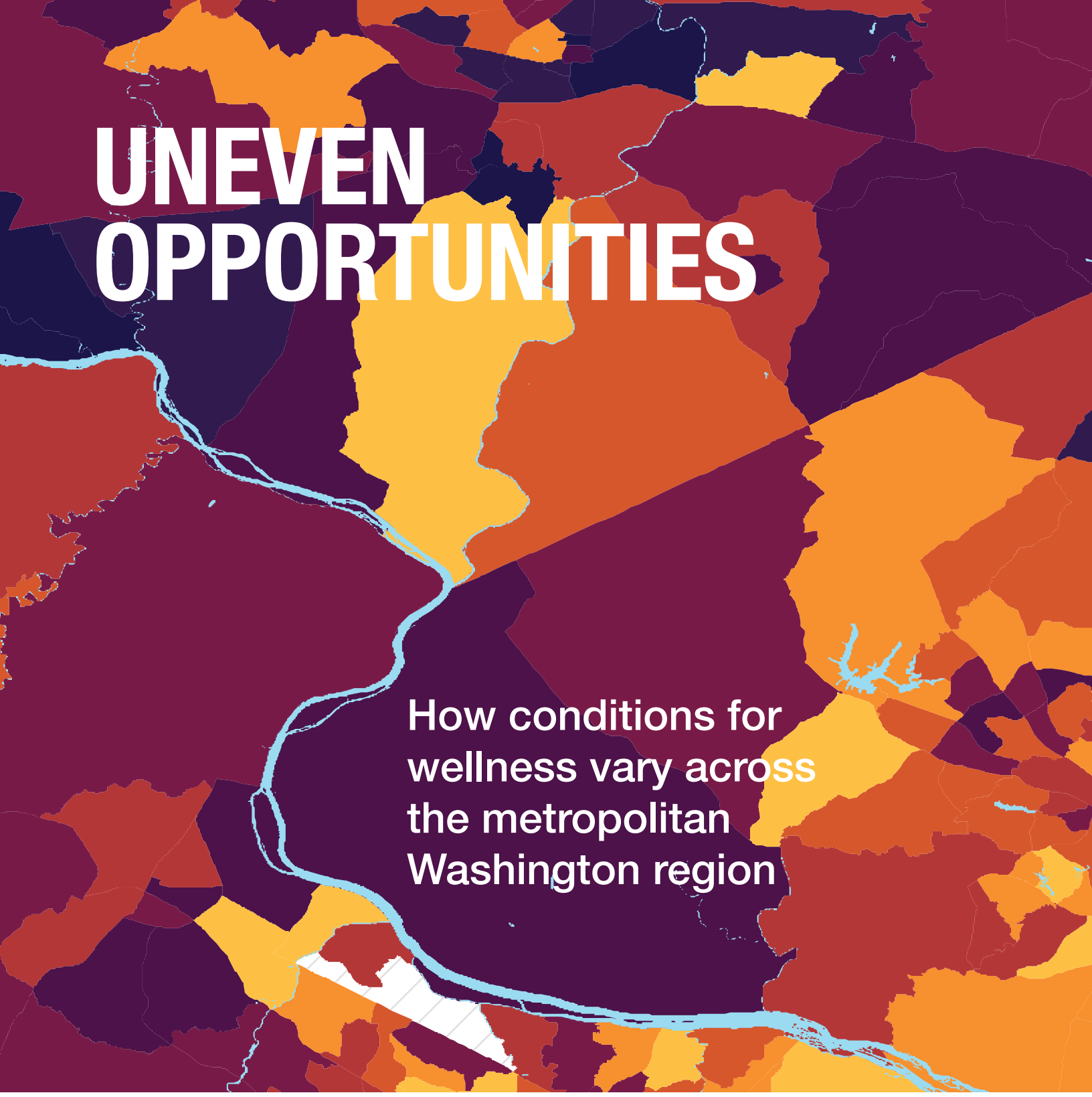
Nearly half (47%) of the variation in health across census tracts in the COG region was associated with racial inequities

Health is also damaged by exposure to discrimination itself, which systematically devalues marginalized groups—including women (e.g., sexism), racial and ethnic groups (e.g., racism), immigrants (e.g., xenophobia), the LBGTQ community (e.g., homophobia), and religious faiths. African and Hispanic Americans in particular have lived not only with subtle and overt expressions of interpersonal racism but also the institutional racism that exists in the courts, education, employment, lending, and other facets of life. Daily exposure to prejudice produces chronic stress and harms the body, causing changes in the brain, hormones, and immune system. Genetic research suggests that racism can alter chromosomes, transmitting the trauma of past generations to today's descendants.

Many jurisdictions in the COG region have committed themselves to equity initiatives to reduce health inequities. They are addressing neighborhood conditions that restrict opportunities for good health and economic mobility, and are hosting open discussions about racism, dismantling exclusionary policies that disadvantage groups, investing in neglected neighborhoods, and curbing gentrification and the displacement of residents. They seek a future in which the opportunity for good health is available to all residents.

Many jurisdictions in the COG region have committed themselves to equity initiatives to reduce health inequities and are building strategies to address neighborhood conditions that restrict opportunities for good health and economic mobility.

For more resources on health equity, visit:
mwcog.org/healthindicatorsreport/



UNEVEN OPPORTUNITIES

How conditions for wellness vary across the metropolitan Washington region

Steven Woolf, MD, MPH
Derek Chapman, PhD
Latoya Hill, MPH
Heidi Schoomaker, BA
David Wheeler, PhD
Lauren Snellings, MPH, CHES
Jong Hyung Lee, MS

VCU Center on Society and Health

October 2018

ACKNOWLEDGMENTS

The Virginia Commonwealth University Center on Society and Health produced this report for the Health Officials Committee of the Metropolitan Washington Council of Governments and was funded through the support of the Healthcare Initiative Foundation, Kaiser Permanente, Northern Virginia Health Foundation, and Potomac Health Foundation. The analyses and conclusions in this report were generated independently by researchers at VCU and do not necessarily represent the views of the Health Officials Committee or the Metropolitan Washington Council of Governments.

THE CENTER ON SOCIETY AND HEALTH

Virginia Commonwealth University Center on Society and Health is an academic research center that studies the health implications of social factors—such as education, income, neighborhood and community environmental conditions, and public policy. Its mission is to answer relevant questions that can "move the needle" to improve the health of Americans. We present our work in formats and venues that are useful to decision-makers and change agents. The Center pursues these goals through collaboration with scholars in different disciplines at VCU and other institutions, and by nurturing partnerships with community, government, and private-sector stakeholders.

CONTENTS

INTRODUCTION

Washington, D.C. is the nation's capital and a center of geopolitical influence. The metropolitan Washington region—the District of Columbia and the surrounding suburbs of suburban Maryland and Northern Virginia—is not only the seat of government but also home to major industries such as information technology, health care, research, and tourism, among others. The population of the District of Columbia was approximately 680,000 in 2016, but more than 4.5 million people lived in the suburban Maryland and Virginia communities that surround the city.[a]

At first glance, the health of this population is excellent, well above the national average. According to an Institute for Health Metrics and Evaluation report, as of 2014, life expectancy in Fairfax County and Loudoun County was among the highest of any county in the United States.[1] For many years, the counties in the metropolitan Washington region have ranked among the healthiest in Maryland and Virginia.[2]

But the health status of the local population is not uniform across the region. In fact, the statistics of individual neighborhoods vary dramatically. As discussed below, this study examined mortality rates across the region's 1,223 census tracts[b] and found that life expectancy at birth—how long a newborn baby can expect to live—varied by 27 years (see Figure 1). The census tracts with the lowest and highest life expectancies were both in the District, ranging from 67 years in a neighborhood of Trinidad near Gallaudet University (tract 88.04) to 94 years in the Foxhall area of Georgetown (tract 8.01). Other reports have shown striking geographic differences in other health measures such as infant mortality, obesity, heart disease and diabetes.[3,4]

a. This report defines the metropolitan region as including the District of Columbia; Maryland (Charles County, Frederick County, Montgomery County, Prince George's County); and Virginia (City of Alexandria, Arlington County, City of Fairfax, Fairfax County, City of Falls Church, Loudoun County, City of Manassas, City of Manassas Park, and Prince William County).

b. Census tracts are small, relatively permanent statistical subdivisions of a county (or independent city in states like Virginia) created by the U.S. Census Bureau and updated every 10 years. Designed to provide stable estimates of population data, and typically smaller than ZIP codes, census tracts contain a population between 1,200 and 8,000 people, with an optimum size of 4,000 people. For more information see: https://www.census.gov/geo/reference/gtc/gtc_ct.html.

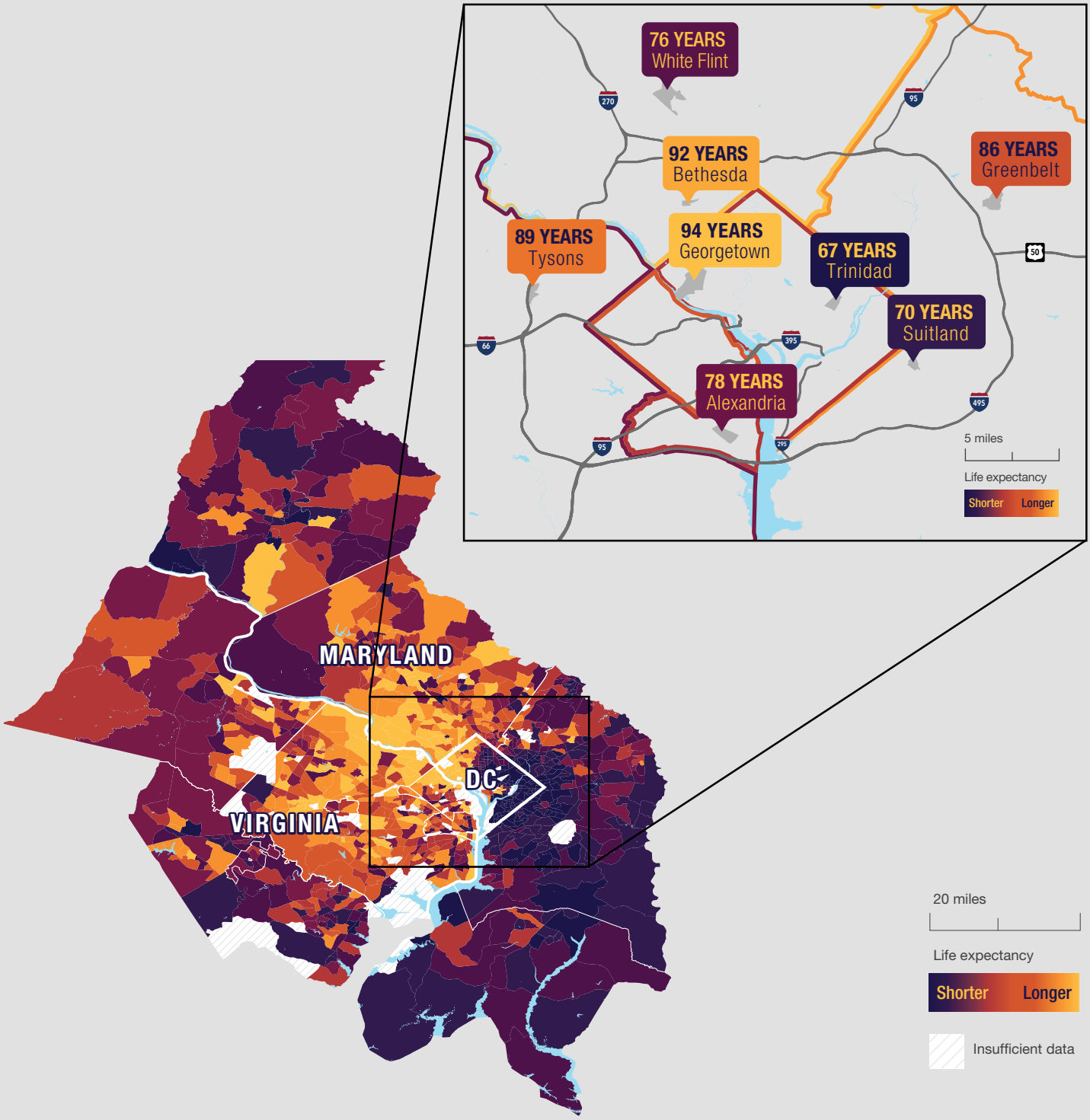


FIGURE 1. LIFE EXPECTANCY AT BIRTH IN THE METROPOLITAN WASHINGTON REGION

Life expectancy, how long a newborn can expect to live, varies 27 years across the census tracts of the metropolitan Washington region. Darkly shaded tracts, reflecting lower life expectancy, exist in every jurisdiction—not just the District of Columbia and nearby neighborhoods but also suburban Maryland (Charles County, Frederick County, Montgomery County, Prince George's County) and Virginia (Alexandria, Arlington County, Fairfax County, Loudoun County, and Prince William County). See Table 1-A in the appendix for life expectancy ranges for individual jurisdictions and Figure 1-A in the appendix for a full-size map.

WHAT EXPLAINS DIFFERENCES IN HEALTH?

A common misconception in American society is that health is determined by health care, but studies show that health care accounts for only 10–20% of health outcomes.[5] Access to affordable, high-quality health care—including health insurance—is "necessary but not sufficient" for good health. We need access to doctors and hospitals to prevent and treat disease, but our health is shaped at a more fundamental level by other factors. For example, by some estimates, tobacco use (e.g., smoking), physical inactivity, unhealthy diets, and problem drinking account for 40% of deaths from chronic diseases like diabetes and heart disease.[6]

Another common misconception is that our personal health choices—whether to engage in healthy behaviors or go to the doctor—are matters of personal responsibility that are fully under our own individual control. People can only make the choices they have. An individual's access to medical care or ability to live a healthy lifestyle depends partly on personal choice but also on socioeconomic circumstances and one's environment.[7] For example, families cannot eat healthy diets if nutritious food is unaffordable or sold only outside their neighborhoods, or if local restaurants consist largely of fast food outlets. Low income urban families without transportation are living in a "food desert" if a supermarket or other outlet is more than a half mile from where they live. Children cannot regularly exercise if their neighborhoods lack access to sidewalks, playgrounds, parks, or other areas for safe, active play. Our health, and the large geographic differences in health that exist across neighborhoods or the metropolitan Washington region, is shaped largely by the social determinants of health.

THE SOCIAL DETERMINANTS OF HEALTH AND WHY THEY MATTER

Education: why it matters

Individuals with less education (e.g., adults who have not graduated from high school or attended college) have significantly poorer health than those with more education. We live in a knowledge economy. Manufacturing jobs are on the wane and pay inadequate wages to support the cost of living, especially the high costs that exist in areas like the metropolitan Washington region. Education is the pathway to better jobs, higher income, health insurance, and the resources to live in healthier and safe neighborhoods. Social mobility—the chances that a low-income child can earn more than his or her parents—is now lower in the United States than in other industrialized countries.[8] Workers with less education or training cannot compete for jobs that provide a livable wage. And children who cannot obtain a higher education are less likely to climb the economic ladder and escape the cycle of poverty. It is precisely in low-income neighborhoods, where property tax revenues are low, that school districts (which depend on this revenue) have inadequate funds for schools and teachers and cannot always deliver an educational experience that prepares young people for success.

Economic and other household resources: why they matter

Income is necessary to live a healthy lifestyle—to afford fresh produce and other healthy foods, gym memberships, or programs to help quit smoking. The high cost of living in the metropolitan Washington region prices even the most basic needs for good health out of reach, especially among low- and middle-income families. For example, food security requires a stable income—to not worry about feeding one's family. A recent study found that a family of four in Virginia needs to earn at least $61,068 per year to cover basic expenses; the same family needs $100,004 to support and sustain an economically viable household.[9] People with limited incomes cannot afford to live in neighborhoods that are healthy, free of violent crime, and have other resources for good health. To have a stable economic future, people need not only income but also the means to build wealth (also called net worth) such as savings, retirement funds, and assets (e.g., a home) to serve as an economic cushion during hard times. All these factors shape health; families who have trouble making ends meet are forced to forego medical care, prescription medicines, and other costly resources needed for their health.

Housing: why it matters

The notoriously high cost of housing in the metropolitan Washington region makes it difficult for people to purchase homes or afford rental properties. Median home values, even in the area's poorest neighborhoods, exceed median home values in typical American communities. This results in the accumulation of housing cost burdens, where 30% (*moderate*) or 50% (*severe*) of one's income is spent on housing—money that an individual cannot spend on health care or other basic needs. Unstable housing—when housing costs force people to relocate, move in with others in overcrowded conditions, or become homeless—affects all aspects of life, including mental health and physical well-being. Substandard housing conditions such as water leaks and poor ventilation can lead to increased mold and other allergens associated with poor health. Overcrowding or exposure to lead and other toxins can cause or exacerbate illnesses. People living in areas with poor housing are also more likely to be exposed to other unfavorable living conditions outside the home such as vehicle emissions from nearby highways and higher crime rates. Conversely, people living in areas with quality housing are more likely to have access to neighborhood amenities financed by higher property taxes, such as bicycle paths and green spaces for outdoor activity, and to have few safety concerns.

Transportation: why it matters

Transportation is needed not only to access health care but also to reach jobs, child care, supermarkets that sell healthy foods, and other basic resources on which health and economic stability depend. This is especially true in commuting environments like the metropolitan Washington region where workers often travel long distances, frequently in heavy traffic, to reach their jobs. Families with limited incomes may not be able to own their own car or to afford public transit (e.g., Metro and commuter rail services) fares and highway tolls. Such families may lack convenient access to bus stops or Metrorail stations, and many must endure long trips that require multiple changes in bus or train routes to reach their destination. The accumulated hours of stress and sedentary inactivity from commuting are themselves harmful to health, even among people of higher socioeconomic status. But low-income commuters often lack the convenience (and health benefits) of being able to walk or cycle to work.

Air and water: why they matter

Clean air is essential to good health, especially for children with asthma and adults with chronic respiratory ailments. As the recent incident in Flint, Michigan demonstrated, water pollution and the risk of lead poisoning remain challenges in many cities. Low-income communities often fall victim to environmental injustice, as when low-income neighborhoods—often populated by people of color—are selected as sites for building factories or highways. Such communities also face higher risks of soil pollution, runoff from toxic effluents, and flooding.

The social environment: why it matters

Just as the physical environment affects health, so does our social environment. This includes not only the family dynamics in our households but also the social fabric of our communities. Research shows that health is influenced by shared values and norms among our networks of friends and family (*social capital*), the sense that our neighbors "have our back" (*social cohesion*), and by levels of social support within the community, including the support provided by faith-based organizations (e.g., churches, synagogues, mosques) and other places and events that bring the community together.[10] Conversely, our health is harmed by stresses incited by social division, trauma, violence, social isolation, and loneliness. When stress becomes chronic, it induces changes in body hormones that can damage the heart, kidneys, and immune system, and alter our genes—allowing the effects of trauma to be passed on to the next generation.[11] Among young children in particular, exposure to chronic stress and adverse childhood events (ACEs) affects growth and development, and alters the architecture of the developing brain with lasting lifelong consequences. ACEs are connected to adverse health outcomes later in life such as obesity, alcoholism, depression, and high blood pressure.[12,13]

The effects of chronic stress are intensified among people of color and other population groups that are victims of systemic discrimination (e.g., immigrants, religious faiths, the LGBT community, the disabled), both through the prejudices they experience in daily life and through the accumulated effects of historical trauma. The experience of racism, in particular, produces its own form of stress, resulting in a cascade of harmful social and biological effects.

RACE, ETHNICITY, AND THEIR INFLUENCE ON OPPORTUNITY AND HEALTH

Throughout the United States, as in the metropolitan Washington region, health varies starkly by race and ethnicity.[14] *Race* refers to whether we are white/Caucasian, black/African American, Asian, Native American, or a combination of races. *Ethnicity* refers to whether we are Hispanic/Latino or have other ethnic orientations. Skin color plays no biological significance in explaining differences in health or life outcomes. Race is a social construct—a concept created by society, not derived from biological or genetic research—but the lived experience and differences in health experienced by different racial and ethnic groups in America are very real.

Consider the stunning health disparities experienced by the black population in the United States. The life expectancy of African Americans is four years lower than that of whites, due largely to the large disparity in cardiovascular disease mortality.[15] Black infants are twice as likely to die before their first birthday as white infants.[16] Black mothers are 3–4 times as likely to die in childbirth compared to white mothers.[17] Older black adults (ages 45–64 years) have a stroke mortality rate more than triple

that of their white counterparts.[18] Black-white health disparities persist even after adjusting for other factors that affect health such as education, household resources, and housing.

These different lived experiences across racial and ethnic groups are the outcome of historical policies and practices that are still playing out today. Beginning in the 1600s, the transatlantic slave trade brought slavery to the Americas—an institution that lasted for nearly 300 years and upon which much of the southern plantation economy relied. The end of slavery was followed by decades of racist "Jim Crow" policies designed to disempower African Americans. Generations of blacks were traumatized by acts of ongoing and overt violence.[19] Segregation intensified through redlining practices to segregate residential communities, the segregation of schools, and policies to restrict access to public places (e.g., buses, hotels, restaurants, theaters).[20] Generations of black children were undereducated; black schools were chronically underfunded and rarely provided opportunities to learn on par with their white counterparts. Black workers were denied jobs in particular sectors or promotions to positions that paid higher wages.[20]

The historical trauma of slavery, Jim Crow policies, and multigenerational poverty have produced a cumulative effect on the health of today's black population. African Americans carry the damage "under their skin" and in their genes, and they face real-time threats to their health—from the psychological trauma of bigotry to the physical dangers of racially motivated violence. Racism affects the health of black Americans, not only because exclusionary policies—shaped by institutional racism—limit access to education and other social determinants of health, but also because the experience of discrimination is itself biologically harmful. Chronic stress due to frequent exposures to discrimination and poverty can accumulate, creating wear and tear on the body (known as allostatic load, a condition associated with poor health outcomes and mortality).[21]

Institutional racism not only directly affects to individual health, but also limits access to the social determinants of health along racial and ethnic lines. People of color (blacks, Hispanics, and others) continue to have less access to education: their children tend to have greater difficulty accessing early childhood education, their districts receive less funding for schools and teachers, and students face greater barriers to entering (and graduating from) college. People of color therefore are often less able to compete for jobs that pay a living wage or provide a future for a stable career; their families therefore have lower incomes, smaller net worths, and higher poverty rates. These individuals are more likely to be turned down for home loans[22,23] and are often targeted by predatory lending companies[24] (e.g., "pay-day" lending). They are more likely to live in racially and ethnically segregated neighborhoods that suffer from decades of disinvestment. As a result, neighborhoods of color often lack access to affordable high-quality housing, stores that sell healthy foods, green space, clean air, and clean water. These communities are often targets for fast food outlets, tobacco and alcohol marketing, and liquor stores.

These conditions affect not only the health, economic opportunity, and social mobility of people of color, but they also weaken the health and economy of the entire region. The consequences of limited opportunities and the damaging effects of racism extend well beyond communities of color. They affect economic growth and community cohesion. Studies show that cities with more inclusive policies attract new businesses, developers, and residents. They have more productive workforces, and incur fewer costs for social services and law enforcement.[25]

THE ROLE OF PUBLIC POLICY: WORKING TOGETHER TO MAKE MEANINGFUL CHANGES

The social determinants of health are not controlled by doctors and hospitals, nor are they shaped exclusively by an individual's choices. Our living conditions are shaped by the choices we make as a community—as a nation, state, or locality. They reflect the priorities set by policymakers, whether elected officials in government, business leaders and financial institutions, or other change agents in the private and nonprofit sectors. The social determinants of health are interconnected: no single factor—neither education, housing, nor race—affects health in isolation. Workers need employable skills to earn a living wage and find jobs with health insurance benefits. Parents need stable housing and child care to keep a job or visit the doctor as well as transportation to get there. Children with uncontrolled asthma cannot succeed in school, and their asthma cannot be controlled if they live amid allergens in their apartment, air pollution in the streets, and high ozone levels in the atmosphere.

These interconnections mean that policy solutions must be holistic. Regional strategies to improve health and economic well-being in the community must embrace cross-sectoral solutions that improve schools, employment, the environment, and transportation. One benefit of a cross-sectoral philosophy is that it builds a stronger case for return on investment. For example, better education means not only better health outcomes and lower health care costs but also better jobs, higher wages, more tax revenue, and less crime. When unstable housing or poor transportation are common concerns among different stakeholders—doctors, school principals, employers, law enforcement, etc.—policies to address these challenges yield benefits across sectors and culminate in a bigger return on investment.

The Metropolitan Washington Council of Governments (COG) embraced this philosophy in its planning strategy, *Region Forward*, which COG launched in 2010 to "create a more prosperous, accessible, livable, and sustainable metropolitan Washington." COG takes a holistic approach to achieving these ends by working across nine domains: land use, transportation, climate and energy, the environment, public safety, education, housing, health and human services, and the economy. Committees devoted to each of these sectors work together to develop interlinked policy solutions for the region in an effort to achieve collective impact.

STUDY OVERVIEW: DEVELOPING THE METROPOLITAN WASHINGTON HEALTHY PLACES INDEX

Prioritizing policies and investments in any one domain—whether health, transportation, or safety—requires a "deep dive" into the data to understand the greatest needs at the neighborhood level, which vary across a region like metropolitan Washington. To understand the health domain, the COG Health Officials Committee, composed of the region's public health officers, commissioned a study by Virginia Commonwealth University (VCU) to analyze the health of the region at the neighborhood level. The study summarized here, conducted by the VCU Center on Society and Health, measured differences in life expectancy across census tracts and the degree to which social determinants of health contribute to those differences. Researchers defined the metropolitan Washington region as the District of Columbia, four areas of suburban Maryland, and five areas of Northern Virginia (see Table 1).

TABLE 1. GEOGRAPHIC AREAS WITHIN THE METROPOLITAN WASHINGTON REGION

District of Columbia

- All Wards (8)

Maryland

- Charles County
- Frederick County (plus the City of Frederick)
- Montgomery County (plus Gaithersburg, Rockville, and Takoma Park)
- Prince George's County (plus Bladensburg, Bowie, College Park, and Greenbelt)

Virginia

- Arlington County
- City of Alexandria
- Fairfax County (plus Fairfax City and Falls Church City)
- Loudoun County
- Prince William County (plus Manassas and Manassas Park cities)

For each of these areas, life expectancy at birth at the census tract-level was determined using mortality data that was geocoded by the state health department responsible for recoding the deaths. Life expectancy for Northern Virginia by census tract was provided by the Virginia Department of Health (based on 2007–2013 death data). Tract-level life expectancy for Maryland and Washington, D.C. areas was computed by VCU using the most recently available 10 years of death data (MD: 2005–2014, DC: 2006–2015) provided by the District of Columbia Department of Health and the Maryland Department of Health. All life expectancy calculations were made using the adjusted Chiang II abridged life table method.[26]

Census tract-level data for each area were also collected on 48 indicators covering six broad policy action areas or "domains," as well as 16 additional indicators to assess the influence of race-ethnicity and immigrant status (see Table 2). These included data on the number of whites, blacks, Asians, and Hispanics in each census tract, as well as the number of immigrants and their continents of origin. Using these data and detailed statistical methods described in the Technical Appendix, the degree to which the six domains (and the indicators within them) contributed to life expectancy was computed and used to develop a new tool: The Metropolitan Washington Healthy Places Index (HPI).[c] The HPI provides a snapshot measure of the conditions in a census tract that are associated with increased (or decreased) life expectancy. Additional details about the indicators, life expectancy computations, and computation of the Healthy Places Index can be found in the Technical Appendix.

c. The Metropolitan Washington Healthy Places Index (HPI) builds upon the methods and approach of the California Healthy Places Index, which was jointly developed by the Public Health Alliance of Southern California and Virginia Commonwealth University's Center on Society and Health. More information about the Healthy Places Index family of projects can be found at: http://healthyplacesindex.org/.

UNDERSTANDING THE HEALTHY PLACES INDEX: HOW LOCAL FACTORS INFLUENCE HEALTH

The impetus for developing the HPI was to help policymakers, providers, and residents explore local factors that contribute to the health of residents in the metropolitan Washington region. The HPI provides an overall score, ranging from zero (lowest opportunity for health) to 100 (most opportunity for health). This score is available for each census tract in the region. The overall HPI score is composed of six "domain" scores, each representing the independent contribution of one of the following policy action domains: Air Quality, Education, Economic/Other Household Resources, Health Care Access, Housing, and Transportation.

The HPI is useful to anyone interested in learning how local neighborhood conditions influence the health of communities. It was designed to be used by state and local governments, community organizations, health care providers and health systems, public health officials, businesses, and financial institutions. For example, the HPI can be used for:

- Prioritization of investments, resources, and programming in neighborhoods where health needs are the greatest
- Program planning and service delivery
- Community profiles and needs assessments
- Understanding community needs (in conjunction with resident experience)
- Research
- Providing data for grant applications

To create the HPI index, a set of 48 indicators was selected based on published research on their association with life expectancy, data quality, and availability at the census tract level. Based on research literature,

TABLE 2. METROPOLITAN WASHINGTON HEALTHY PLACES INDEX INDICATORS BY DOMAIN

Air Quality	
Cancer risk	Lifetime cancer risk from inhalation of air toxins, per million people
Environmental hazards	Exposure to toxins harmful to human health (0–100; higher values = less exposure to toxins)
Respiratory risk	Ratio of exposure concentration to health-based reference concentration (>1 = increased risk)
Economic/Other Household Resources	
Low food access (low income population)	% of low income population living >1/2 mile (urban) or >10 miles (rural) from the nearest supermarket, supercenter, or large grocery store
Income inequality	Gini Index; measures income distribution among the residents of a specified geography (0–1; higher values = more inequality)
Low food access (overall)	% of total population living >1/2 mile (urban) or >10 miles (rural) from the nearest supermarket, supercenter, or large grocery store
Marital status	% of population 15 years and older now married (excluding those who are separated)
Median household income	Median annual household income
Low income (adult)	% of population ages 18 to 64 years with household incomes at or below twice the poverty level (200%)
Poverty (adult)	% of population ages 18 to 64 years with household incomes below the poverty level (100%)
Poverty (child)	% of population under age 18 years living below the poverty level (100%)
Public assistance	% of households receiving public assistance income
Single-parent households	% of children living in households headed by a single parent
Unemployment rate	% of population ages 25 to 64 years who are unemployed
Education	
Preschool enrollment	% of 3- and 4-year-olds not enrolled in school
High school diploma/higher	% with a high school diploma or higher
Lack of English proficiency	% of households where no one age 14 and older speaks English only or speaks English “very well”
Some college/higher	% with some college education or higher
Health Care Access	
Primary care provider access	Ratio of population to primary care providers (internists, family physicians, physician’s assistants, nurse practitioners)
Mental health provider access	Number of mental health providers (county level) divided by the total population per 100,000
OB/GYN provider access	Ratio of population to obstetricians-gynecologists
Private insurance	% of civilian noninstitutionalized population with private insurance
Public Insurance	% of civilian noninstitutionalized population with public insurance
Uninsured adults	% of civilian noninstitutionalized population who are uninsured
Uninsured children	% of children who are uninsured
Housing	
Older age of housing	% of housing units built in 1950 or earlier
Overcrowding	% of households with more than one occupant per room
Housing vacancies	% of housing units that are vacant
Renter occupied	% of occupied housing units not occupied by property owners.
Median home value	Median home value of owner occupied units
Median rent	Median rent
Housing cost burdened (overall)	% of all households (renters and homeowners) paying more than 30% of income on housing
Renter housing cost burdened	% of renter households paying more than 30% of income on housing
Housing cost burdened (homeowners)	% of owner households paying more than 30% of income on housing
Extremely housing cost burdened (overall)	% of all households (renters and homeowners) paying more than 50% of income on housing
Extremely housing cost burdened (renters)	% of renter households paying more than 50% of income on housing
Extremely housing cost burdened (homeowners)	% of owner households paying more than 50% of income on housing
Poor housing conditions (renters)	% of rental properties with one or more poor housing conditions (e.g., no plumbing, no kitchen, overcrowded, cost burdened)
Poor housing conditions (homeowners)	% of homes with one or more poor housing conditions (e.g., no plumbing, no kitchen, overcrowded, cost burdened)
Housing stability	% of population in the same residence within the past 12 months
Housing moves	% of population who moved within the same county within the past 12 months
Housing opportunity index	Potential opportunity for Housing Choice Voucher holders seeking housing (higher values = higher opportunity)
Transportation	
Commute by motor vehicle	% of population who take a car, taxi, or motorcycle to work
Commute by public transit	% of population who take public transport (bus, train, subway) to work
Commute by walking/cycling	% of population who walk or bike to work
Travel time to work	Average travel time to work (min)
Transportation Cost	Low Transportation Cost Index (high value = lower cost)
No access to vehicle	% of households with no access to a vehicle

See HPI Technical Appendix for complete definitions and data sources, as well as indicators for race-ethnicity and immigrant status.

FIGURE 2. CORRELATION BETWEEN LIFE EXPECTANCY AND THE METROPOLITAN WASHINGTON HEALTHY PLACES INDEX

The Healthy Places Index (HPI) score and life expectancy for each census tract in the region are represented by the dots in this figure. The overall pattern shows that higher HPI scores were generally predictive of longer life expectancies ($r=0.77$; $R^2=0.59$).

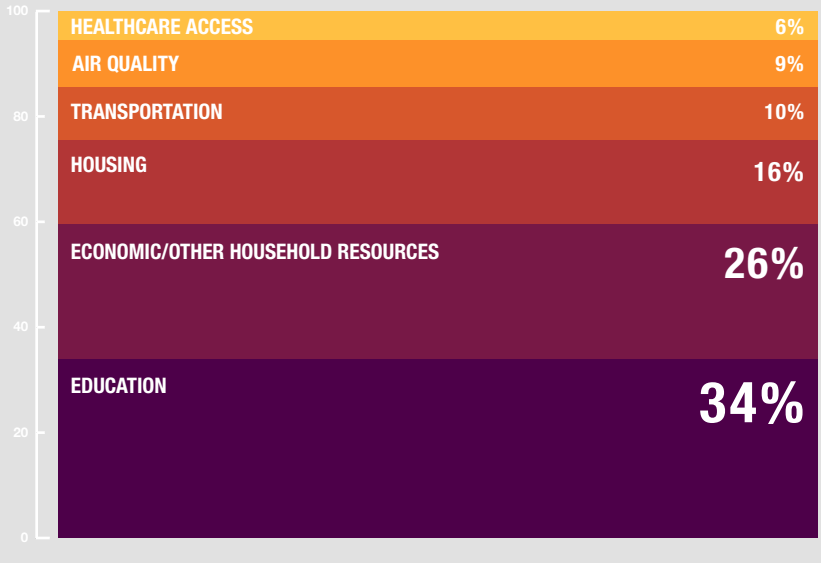
expert opinion, and consultation with the COG Health Officials Committee, the indicators were then grouped into six domains: Air Quality, Education, Economic/Other Household Resources, Health Care Access, Housing, and Transportation. Next, a new statistical method (grouped weighted quantile sum regression) was used to derive weights, which measure how strongly each indicator was associated with life expectancy in the COG region. The COG region weights were then applied to the data from each census tract to derive the six domain scores. The overall HPI score for each census tract is the sum of its six domain scores.

While the indicator list used in the computation of the HPI is comprehensive and evidence-based, data for many important indicators were unfortunately not available at the local level. For example, data about exposure to racism, crime rates, mental health status, drug use, and quality of health care were not available at the census tract level. As a result, the proportions of health that are accounted for by various domains in the model are to be interpreted with care—additional indicators or domains could alter the relative weights of those included in this study. Specifically, the proportions, or weights, can only measure the unique contribution to health among the factors included in the HPI model, not all of the potential factors that shape health. More details about the methods and limitations of this study are provided in the Technical Appendix.

By design, the HPI score characterizes places (e.g., neighborhoods), not individuals. That is, it describes the influence of neighborhood conditions irrespective of individual characteristics. Individual behaviors (e.g., smoking, diet, and exercise) and characteristics (e.g., income, education) are important contributors to health, but place matters to health in ways that transcend individual factors. Tools like the HPI provide metrics about place that can inform policies and actions at the community level, and that can improve health above and beyond the factors that individuals and families can control.

FIGURE 3. DETERMINANTS OF LIFE EXPECTANCY IN THE METROPOLITAN WASHINGTON REGION

Weights reflect the relative, independent contribution of each group of indicators (domains) on the total Healthy Places Index (HPI) score. Higher percentages reflect a stronger association with life expectancy: education exerted the greatest influence. Percentages may not add to 100 due to rounding.



The HPI was highly positively correlated with life expectancy (see Figure 2), meaning that tracts with higher HPI scores typically experienced higher life expectancy and lower HPI scores were associated with lower life expectancy. Even though the HPI did not incorporate data on individual characteristics or neighborhood characteristics for which data were lacking, it explains 59% of the differences in life expectancy by census tract across the metropolitan Washington region. This level of prediction is considered scientifically strong. Although other factors not in the HPI model also shape health, the HPI serves as a useful starting place for understanding the health of communities and generating additional questions. Exploring additional data sources, such as local administrative data and vital statistics, and having conversations with stakeholders and residents can provide insight into other local conditions and specific health outcomes.

WHAT THE HEALTHY PLACES INDEX TEACHES US: HEALTH IS ABOUT MORE THAN HEALTH CARE

What the HPI shows is that life expectancy in the metropolitan Washington region is shaped less by health care than by the social determinants of health. As noted earlier, everyone needs health care—both to prevent disease and manage chronic illnesses—but simply having access to health care does not guarantee good health. Access to health care comprised only 6% of the HPI score, accounting for very little of the 27-year difference in life expectancy that exists across the region's census tracts. Education was the most important HPI domain (34% of the HPI score), followed by economic and other household resources (26% of the HPI score). Education and economic well-being, which are closely interrelated, together accounted for 60% of the HPI score. The other domains include housing (16%) and transportation (10%) (see Figure 3).

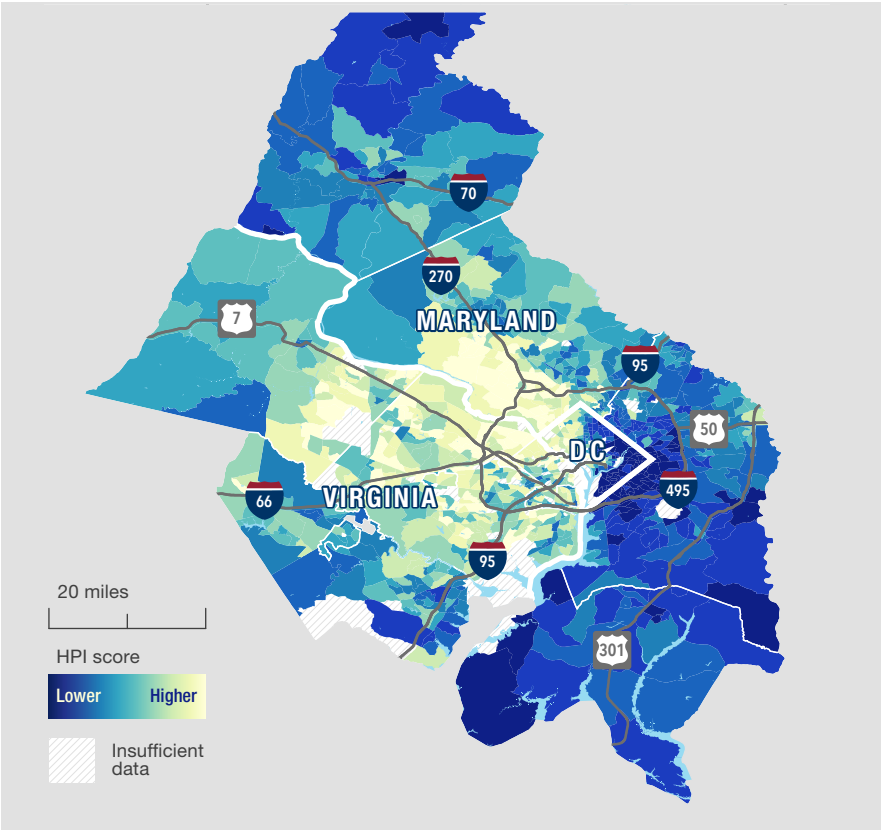
"Education and economic well-being together accounted for 60% of the HPI score"

Importantly, additional analyses found that nearly half (47%) of the HPI variation across census tracts in the region could be explained by race-ethnicity and immigrant status. Among the reasons is that people of color and immigrants are more likely to live in neighborhoods with fewer resources that lacked the conditions for good health (reflected in low HPI scores). For example, in the census tracts with the highest scores (top quartile), 64% of the population was white; the proportion of black and Hispanic[d] residents in these regions was 6% and 10% respectively. In contrast, in the tracts with the lowest HPI scores (bottom quartile), 63% of residents were black, 13% were Hispanic, and only 19% were white. These residential racial segregation patterns did not occur by chance; they are the result of historic policies like Jim Crow laws and redlining practices that concentrated minorities in neighborhoods and perpetuated decades of disinvestment, leaving today's residents with few resources and opportunities for healthy living. Considering the deleterious experience of discrimination and racism, it is evident how unequal opportunity leads to inequities in life expectancy across racial and ethnic groups.

d. This figure includes foreign-born and U.S.-born black and Hispanic residents.

FIGURE 4. HEALTHY PLACES INDEX SCORES IN THE METROPOLITAN WASHINGTON REGION

The map shows that opportunities for good health at the census tract level vary greatly across the region. Colors depict how the Healthy Places Index (HPI) varies across the metropolitan Washington region: yellow reflects high opportunity for health and well-being, dark blue depicts low opportunity. See Figure 4-A in the appendix for a full-size map.



A CLOSER LOOK AT THE REGION

Maps displaying the HPI scores by census tract show that the conditions for good health vary significantly across the metropolitan Washington region (Figure 4). Lighter colors depict areas with high (healthy) scores on a scale of 0–100, whereas darker colors depict lower HPI scores (less healthy neighborhoods). The highest HPI scores were in the northwest wards of the District of Columbia, affluent Maryland suburbs (such as Potomac), and much of Fairfax County. The lowest HPI scores were in the eastern wards of the District of Columbia. As shown in Figure 4, Frederick County and Frederick City in the northern edge of the region, Charles County in the south, and areas of Prince William County in the southwest also had low HPI scores.

But larger regional maps hide big differences within jurisdictions, especially at the neighborhood level. A closer look reveals that conditions for health are segregated in every jurisdiction: areas of affluence are short distances away from areas of concentrated disadvantage, and people of color and immigrants are disproportionately exposed to the most adverse living conditions. We show this below in examples from the District of Columbia, suburban Maryland, and Northern Virginia.

The District of Columbia

For many years, Washington, D.C. has ranked among the most racially segregated cities in the United States. Mapping the HPI scores in the District (Figure 5) reveals the sharp east-west divide between healthy conditions in the affluent Northwest wards and the more challenging conditions east of 16th Street, especially in Southeast D.C. Although some of the highest HPI scores were in Georgetown and other areas of Northwest D.C., contrasts are dramatic—and poignant—in the immediate radius of the U.S. Capitol building. Some of the city's highest HPI scores are on Capitol Hill and in the Penn Quarter area between the Congress and the White House, where many of the nation's leaders and powerful lobbyists live. But some of the lowest HPI scores in the region are a bus stop away, to the immediate east of Capitol Hill just across the Anacostia River.

TABLE 3. SELECTED CHARACTERISTICS OF WARD 3 AND WARD 8, DISTRICT OF COLUMBIA.

	Ward 3	Ward 8
High school graduation	97%	82%
Some college education	94%	41%
Single-parent households	15%	84%
Median household income	$109,909	$31,642
Unemployment	4%	25%
Child poverty	3%	50%
Adult poverty	13%	33%
Income below 200% FPL	14%	59%
Public assistance	2%	41%
Private insurance	92%	39%
Public insurance	17%	62%
Vacant housing	8%	17%
Median home value	$ 788,800	$ 232,100
No vehicle	23%	47%

See Table 2 for full definitions.

The contrasts across the city, in both health and the conditions that shape health, are considerable. For example, the average life expectancy of the population in Ward 3 (located in Northwest D.C., west of 16th Street) is 87 years, compared to 72 years in Ward 8 in Southeast, south of I-295. The average HPI for the tracts in these two wards also differs greatly (76 vs. 9 respectively), reflecting sharp differences in the domains that influence life expectancy (Table 3). For example, whereas 94% of adults in Ward 3 have attended college, the same is true of only 41% in Ward 8. The median household income also differs greatly ($109,909 vs. $31,642, respectively) as do child poverty rates (3% vs. 50%).

These averages, which aggregate data from multiple census tracts in a ward, mask more extreme differences that exist when individual census tracts are compared (Figure 5). Some tracts have striking degrees of disadvantage.

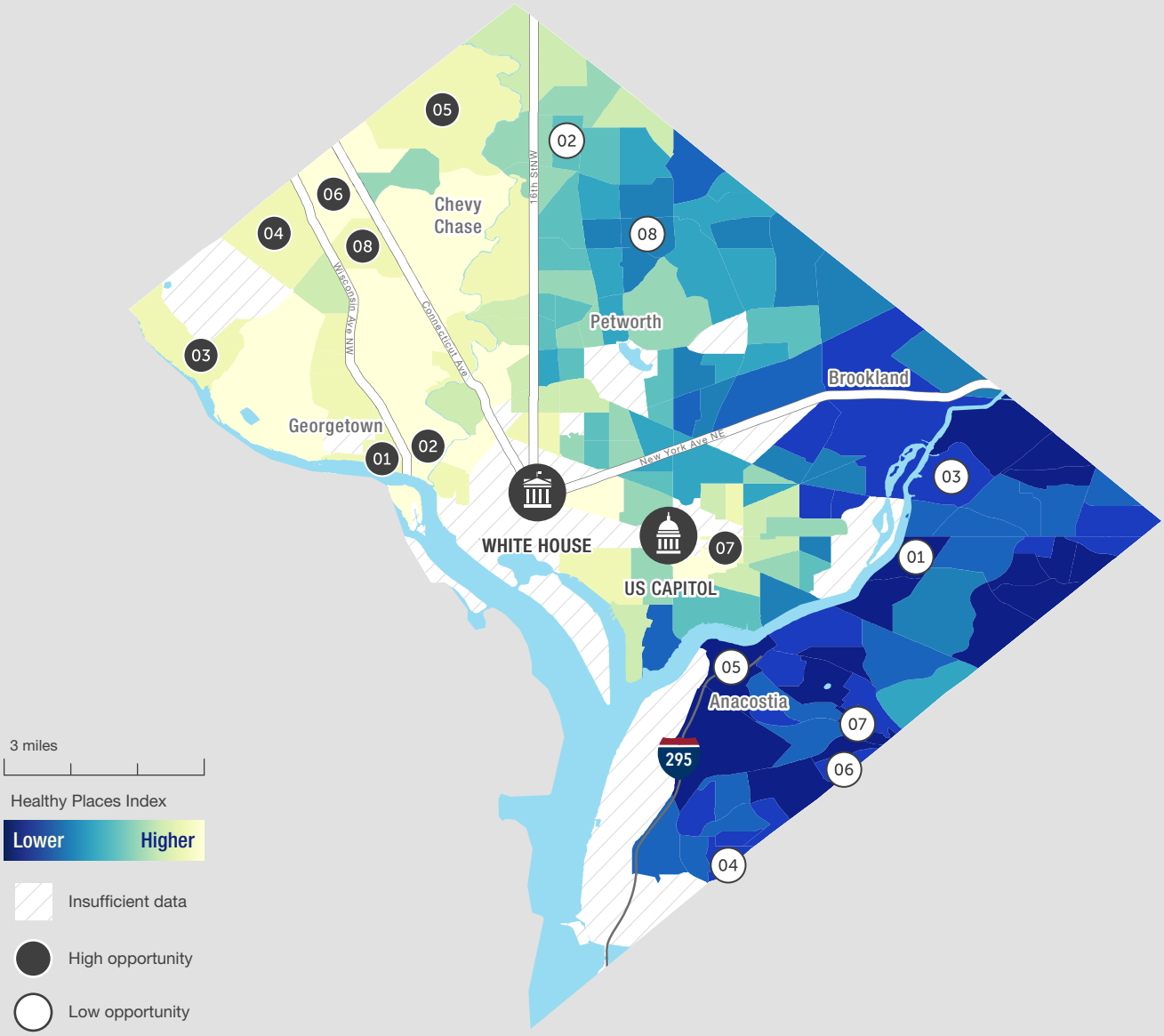


FIGURE 5. EXTREMES IN OPPORTUNITY: THE DISTRICT OF COLUMBIA

Health is about more than health care. Our environment matters: neighborhood conditions affect not only our health but also economic opportunities and social mobility. Statistics that take the average for an entire city mask how conditions vary by neighborhood. This map contrasts living conditions in northwest D.C. and the eastern wards.

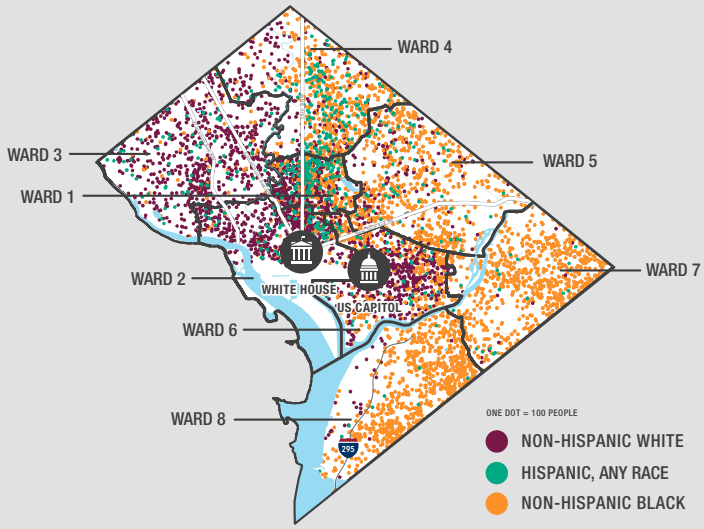
Colors depict the Healthy Places Index in the District of Columbia: yellow reflects high opportunity for health and well-being, dark blue depicts low opportunity. The table contrasts specific living conditions, such as education and housing. Numbered circles in the table refer to census tracts on the map and show how greatly conditions vary across the city. For example, the adult poverty rate in a high-opportunity tract in upper Chevy Chase (05 in a darkly shaded circle) was 4%, whereas the adult poverty rate in an Anacostia tract (05 in lightly shaded circle) was 51%.

	High Opportunity		Low Opportunity
SOME COLLEGE EDUCATION	01	97%	01	20%
HIGH SCHOOL EDUCATION	02	100%	02	70%
MEDIAN HOUSEHOLD INCOME	03	$191,607	03	$22,949
UNEMPLOYMENT	04	1%	04	39%
ADULT POVERTY RATE	05	4%	05	51%
PUBLIC ASSISTANCE	06	0%	06	55%
MODERATE HOUSING COST BURDEN	07	19%	07	63%
UNINSURED ADULTS	08	1%	08	29%

See Table 2 for full definitions

FIGURE 6. POPULATION DISTRIBUTION BY RACE AND ETHNICITY IN THE METROPOLITAN WASHINGTON REGION, 2010–2014

The District of Columbia remains highly segregated: wards 2 and 3, northwest of the White House and U.S. Capitol, have a largely white population, while the population to the southeast (wards 7 and 8) is largely black. Other wards are more diverse and include a large Hispanic and immigrant population. Each dot represents 100 persons.



For example:

- In tract 74.01 (05) in Anacostia (discussed further below), the median household income was only $14,813 and the poverty rate was 87% (74% for children).
- Almost one out of three (29%) adults in a Fort Totten neighborhood (tract 22.02 (08)) lacked health insurance.
- Only 20% of the adults in Greenway (tract 77.08 (01)) had at least some college education.
- The unemployment rate in a Washington Highlands neighborhood (tract 98.11 (04)) was 39%. In contrast, only nine miles away in Northwest, median household income was as high as $191,607 in Potomac Heights (tract 9.02 (03)). The affluent residents of Capitol Hill spend a smaller proportion of their incomes on housing than do the poor residents living only blocks away.

The racial-ethnic groups exposed to distressed neighborhoods also vary dramatically, reflecting longstanding patterns of segregation established early in the city's history (Figure 6). For example, as of 2014, 75% of the population in Ward 3 were non-Hispanic whites, whereas only 6% and 9% were black or Hispanic, respectively. Nearly one-fifth (19%) of the population was foreign born. Conversely, in Ward 8, the proportions of residents that were white, black, and Hispanic were 4%, 93%, and 1%, respectively—and 3% of the population was foreign born. Put simply, people of color are exposed disproportionately to unhealthy living conditions.

"Put simply, people of color are disproportionately exposed to unhealthy living conditions."

The city's past provides the backdrop for current disparities. There is no better example than census tract 74.01, an area of Anacostia (Southeast D.C.) that ranks among the poorest in the city. The history of this area illustrates how past policies shaped present-day disparities (see *History Makes the Difference: Anacostia* callout box).

History Makes the Difference:
ANACOSTIA

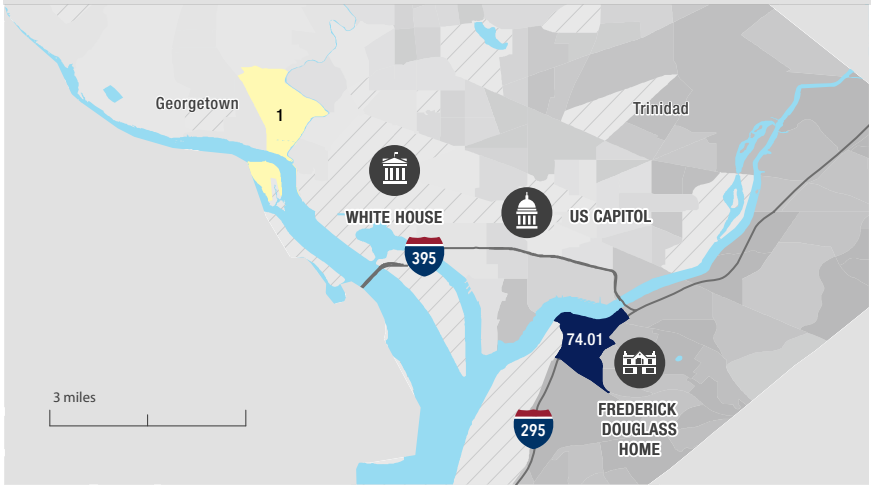
Anacostia has long experienced heavy concentrated poverty and racial segregation. Once used as tobacco farmland, Anacostia became one of Washington, D.C.'s first suburbs after George Washington established the Washington Navy Yard in 1799. The area, then known as Uniontown, catered to whites, barring famed abolitionist Frederick Douglass from owning a home until after the Civil War. Congressional Acts freeing Washington's slaves and giving black men the right to vote gave Washington, D.C. a progressive reputation that attracted blacks to the city during Reformation. The Freedman's Bureau opened nearby Barry Farms for emancipated blacks, further attracting African Americans to Uniontown and dissuading many whites from buying property. With the Great Migration and the passing of *Brown v. Board of Education* in 1954, even more blacks immigrated to the city.

As white residents moved out of Anacostia, they extracted much of the community infrastructure and wealth. The wetlands and waterfront became polluted with runoff from factories and city wastewater. Massive public housing structures were built east of the river. The construction of I-295 (the Anacostia Freeway, which cuts through census tract 74.01) further isolated Anacostia residents. The stagnant economy fueled concentrated poverty and crime.

In recent years, developers and new investments have begun to transform the area. Tourists now visit the home of Frederick Douglass, and enjoy the Anacostia riverfront and nearby aquatic gardens. Yet, census tract 74.01 continues to bear the marks of its difficult history.

Barry Farms Housing Development, 1944.

FIGURE 7. A COMPARISON OF CENSUS TRACTS IN GEORGETOWN AND ANACOSTIA



	TRACT 1 Georgetown	TRACT 74.01 Anacostia
Healthy Places Index	76	3
Life expectancy	86 years	67 years
High school graduation	100%	67%
Some college education	95%	21%
Median household income	$170,338	$14,813
Unemployment	5%	25%
Adult poverty	4%	51%
Child poverty	0%	74%
Public assistance	1%	76%
Children in single-parent households	6%	95%
Private health insurance	96%	16%
Median home value	$945,600	$287,500
Median monthly rent	$1,974	$460
Severe housing cost burden	8%	25%
Poor rental conditions	22%	45%
Commuting to work		
by motor vehicle	39%	30%
by public transit	25%	67%
by walking or cycling	33%	3%
Mean travel time to work	25 minutes	43 minutes

Graphic shows how living conditions in a census tract where Frederick Douglass once lived (tract 74.01) vary from those in a Georgetown neighborhood (tract 1) not far from the White House. See Table 2 for full definitions.

The statistics in Anacostia's census tract 74.01 reflect this history. Of all census tracts in Washington, D.C., this tract had the lowest proportion of adults with a high school education (67%), the lowest median household income ($14,813), the highest adult (51%) and child (74%) poverty rates, and the largest proportion of the population receiving public assistance (76%). This tract also had the lowest proportion with private health insurance (16%), and the largest proportion covered by public insurance such as Medicaid (87%). The population in tract 74.01 was 98% black. Conditions could not be more diverse less than five miles to the west, in tract 1 in Georgetown (Figure 7).

Suburban Maryland

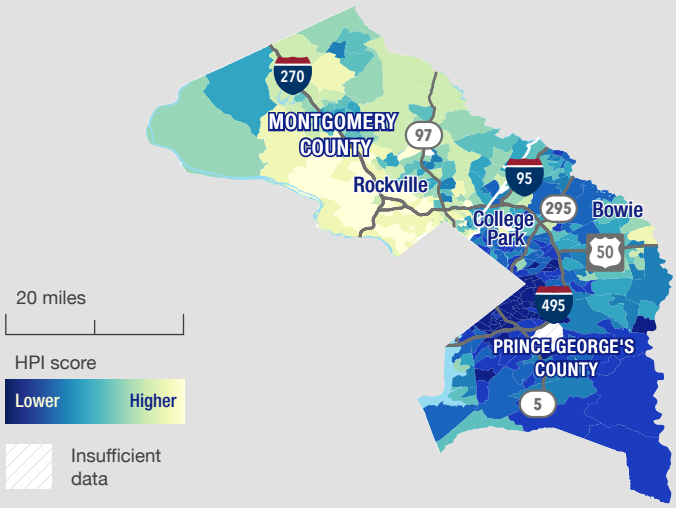
The disparities described above are not restricted to the District of Columbia and have, for many years, extended to the suburbs. The varied histories of the Maryland suburbs of D.C.—Frederick County, Montgomery County, Prince George's County, and Charles County—illustrate the impact that slavery and the Civil War had on the region. For example, adjacent Prince George's County and Montgomery County experienced different economic trajectories. Prince George's County, an area settled by 17th century tobacco farmers and once home to a thriving slave industry, has struggled for generations to recover from economic trauma and persistent poverty. A different dynamic shaped the evolution of Montgomery County, where 18th century immigrants from the Mid-Atlantic profoundly influenced farming practices and worked to abolish slavery in the county. Montgomery County and Prince George's County's northern and southern influences, respectively, had major impacts on their economies, policies, and citizens for decades.

The HPI scores in these counties mirror the social and economic divide that has historically separated the two counties (Figure 8). HPI scores tended to be higher in Montgomery County than in Prince George's County, although Prince George's County did include areas of relative affluence. Higher HPI scores (above 60) characterized neighborhoods near the University of Maryland-College Park and in outlying suburbs such as Beltsville, Bowie, and Greenbelt. More adverse conditions, however, were found inside the Capital Beltway (I-495). Some census tracts in Capitol Heights, Seat Pleasant, District Heights, Forestville, and Hillcrest Height had HPI scores below 10. Areas of disadvantage also existed in the southern, more rural, tracts near Charles County.

Although Montgomery County had relatively high HPI scores as a whole, granular analysis revealed stark contrasts in conditions for health and opportunity across the county. The county is home to great wealth, ranking among the top 10 in the United States in median household income.[27] In areas of Potomac, Rockville, and Bethesda, median household income exceeded $200,000 per year. HPI scores in some of these areas exceeded 85. But not far away, median household income in Montgomery County was below $50,000 per year, such as in areas of Gaithersburg (e.g., tracts

FIGURE 8. HEALTHY PLACES INDEX SCORES IN MONTGOMERY COUNTY, MD AND PRINCE GEORGE'S COUNTY, MD

HPI = Healthy Places Index. The map shows that opportunities for good health at the census tract level vary greatly across Montgomery County and Prince George's County. Areas in yellow have more healthful conditions (high HPI), whereas dark blue census tracts have less favorable conditions (low HPI). See Figure 8-A in the appendix for a full-size map.



7007.24 and 7007.13) and Aspen Hill (7032.13). Areas of low opportunity with low HPI scores were documented throughout the county in western tracts in Poolesville, central tracts in Germantown and Gaithersburg, and eastern tracts in White Oak, Hillandale, and Kemp Mill (Figure 8).

Areas of high and low opportunity in the Maryland suburbs were often short distances apart. For example, Bethesda—home to the National Institutes of Health—included a largely white population. In some tracts, 97% of adults attended college, the unemployment rate was below 1%, or no household lived in poverty. Eight miles away, Langley Park had some of suburban Maryland's most adverse conditions. In census tract 8056.02, only 30% of adults graduated from high school, 11% attended college, 85% of adults lacked health insurance, and 38% of households lived in overcrowded conditions. The challenges in Langley Park, which are well documented,[28] affected a population that was predominately people of color, including many immigrants. Eighty-nine percent of the population was Hispanic, and more than half (53%) of households spoke limited English. Three quarters of the population was foreign born, with 73% having immigrated in 2000–2009.[e]

People of color and immigrants were disproportionately exposed to low opportunity conditions across suburban Maryland. Impacted areas of Prince George's County, from Glenarden southward, had populations that were more than 85% black; whites typically accounted for less than 2% of the population. Many of the Prince George's County tracts featured in Figure 8 included a larger representation of Hispanic and foreign-born residents. Census tract 8048.02 in Mount Rainier—where 61% of households had incomes below 200% of the Federal poverty level—was majority (54%) Hispanic and half (50%) the residents were foreign-born. Almost two thirds (61%) of the population in Chillum (tract 8059.07) were foreign-born, with 59% and 35% having immigrated from Latin America and Africa, respectively.

e. Communities with large Hispanic or immigrant populations may have higher HPI scores because of the so-called "Hispanic paradox," which refers to the tendency of recent immigrants (those having lived in the country for less than 10 years) to have higher life expectancy than people born in the United States.

Impacted areas of Montgomery County also featured large populations of color. Many impacted census tracts in the eastern county were largely black. Other affected areas were more diverse. For example, in census tract 7007.24 in Gaithersburg—where one in three children lived in poverty—38% of the population was Hispanic, 25% was Asian, and 64% was foreign-born. Conversely, in the Glen Echo tract (7057.02) where the median home value was $991,200, the population was 87% white, 10% Hispanic, 2% Asian, and 12% foreign-born.

Examples of the social and economic divide in suburban Maryland are more conspicuous when examined at the census tract level (see Figure 9). As in the District, examples of disadvantage are stark:

- In tract 8048.02 (07) in Mount Rainier, 59% of adults did not have health insurance.
- In a tract across from the University of Maryland-College Park campus (tract 8070 (03)), 39% of adults lived in poverty.
- Whereas the median home value in Glen Echo (tract 7057.02 (05)) was nearly $1 million, the median home value in one Chillum neighborhood (tract 8059.07 (05)) was $67,200.
- The median household income in one Bethesda tract (7047 (02)) was $245,208 per year, more than six times the median income ($36,386 per year) in a Bladensburg tract (8040.01 (02)).
- In one Landover neighborhood (tract 8035.09 (04)), 37% of the population received public assistance.

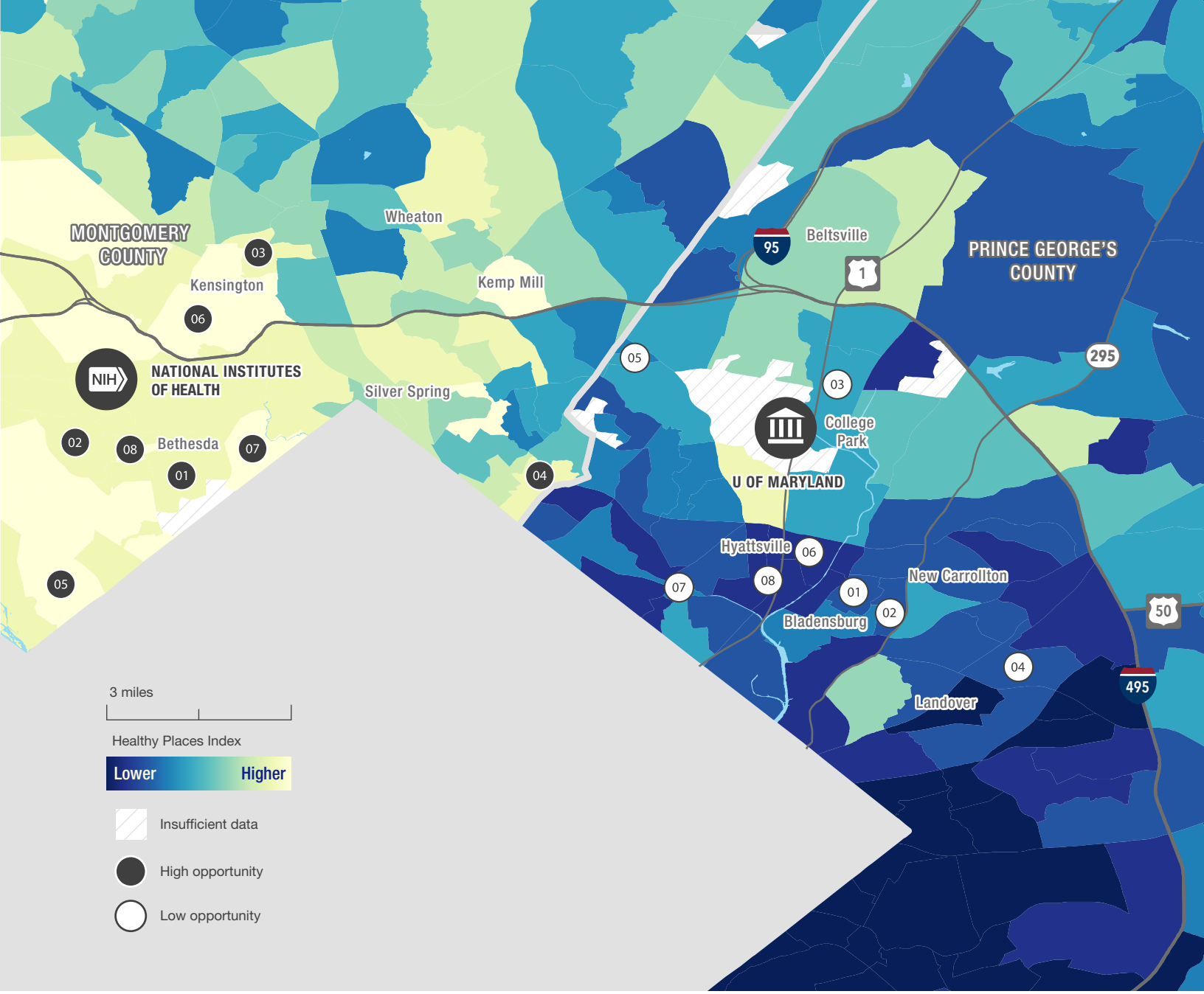


FIGURE 9. EXTREMES IN OPPORTUNITY: MONTGOMERY COUNTY, MD AND PRINCE GEORGE'S COUNTY, MD

Health is about more than health care. Our environment matters: neighborhood conditions affect not only our health but also economic opportunities and social mobility. Statistics that take the average for an entire county mask how conditions vary by neighborhood.

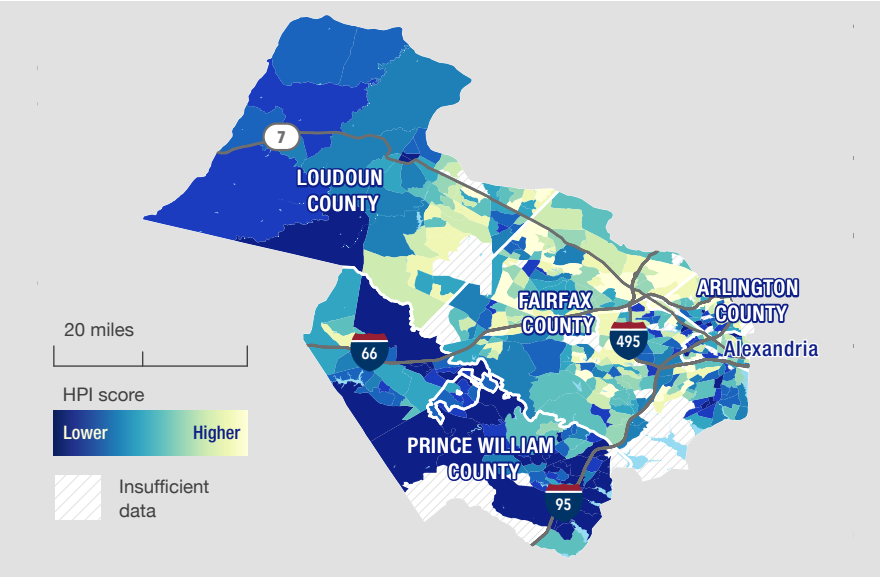
This map contrasts living conditions in nearby neighborhoods of Montgomery County and Prince George's County. Colors depict the Healthy Places Index: yellow reflects high opportunity for health and well-being, dark blue depicts low opportunity. The table contrasts specific living conditions, such as education and housing. Numbered circles in the table refer to census tracts on the map and show how greatly conditions vary across suburban Maryland. For example, the percent of adults with some college was 97% in a high-opportunity tract in Bethesda (01 in darkly shaded circle), whereas the percent in a Bladensburg tract (01 in lightly shaded circle) was 21%.

		High Opportunity		Low Opportunity
SOME COLLEGE	01	97%	01	21%
MEDIAN HOUSEHOLD INCOME	02	$245,208	02	$36,386
ADULT POVERTY	03	0%	03	39%
PUBLIC ASSISTANCE	04	<1%	04	37%
MEDIAN HOME VALUE	05	$991,200	05	$67,200
OVERCROWDED	06	0%	06	21%
UNINSURED ADULTS	07	<1%	07	59%
LIFE EXPECTANCY	08	92 years	08	73 years

See Table 2 for full definitions

FIGURE 10. HEALTHY PLACES INDEX SCORES IN NORTHERN VIRGINIA

HPI = Healthy Places Index. The map shows that opportunities for good health at the census tract level vary greatly across Northern Virginia. Areas in yellow have more healthful conditions (high HPI), whereas dark blue census tracts have less favorable conditions (low HPI). Map colors reflect the range of the HPI observed in Northern Virginia. HPI scores in Northern Virginia ranged from 26 to 98. See Figure 10-A in the appendix for a full-size map.



Northern Virginia

The residents of the Virginia suburbs of Washington, D.C. are among the most affluent in the United States.[27] Yet, closer examination reveals clusters of census tracts where residents live in more difficult conditions. Two prior studies by the VCU Center on Society and Health, supported by the Northern Virginia Health Foundation, have documented in detail Northern Virginia's "uneven opportunity landscape."[29, 30] A 2017 report identified 15 "islands of disadvantage," clusters of census tracts with adverse living conditions. These included tracts in (1) Leesburg, (2) Sterling Park, (3) Herndon-Reston, (4) Centreville-Chantilly, (5) Fair Oaks-Oakton, (6) Springfield-Annandale-Landmark, (7) Seven Corners-Bailey's Crossroads-Alexandria West, (8) Columbia Pike-Douglas Park, (9) Buckingham-Fort Myer, (10) Arlandria, (11) Old Town Alexandria-Huntington, (12) Route 1 Corridor-Fort Belvoir, (13) Bull Run-Manassas, (14) Dale City-Woodbridge, and (15) Dumfries.

This study yielded similar results. As seen in Figure 10, some of the lowest HPI scores in Northern Virginia were in the distant suburbs, such as census tracts in Leesburg (Loudoun County) and areas of Woodbridge and Dumfries (Prince William County), where life expectancy was as low as 75–79 years. Many tracts with low HPI scores were situated in pockets of Fairfax County such as Herndon, Springfield, Annandale, and Columbia Pike. Some of Northern Virginia's lowest HPI scores were in such areas as Columbia Heights in Arlington County, the Arlandria neighborhood of Alexandria, and along the Route 1 corridor in Fairfax County. These areas were surrounded by affluent areas with very high HPI scores including Ashburn, Tyson's Corner, Great Falls, McLean, Franklin Farm, Fair Oaks, and Oakton.

As in Montgomery County, the researchers found stark contrasts in socioeconomic and environmental conditions in Northern Virginia, often

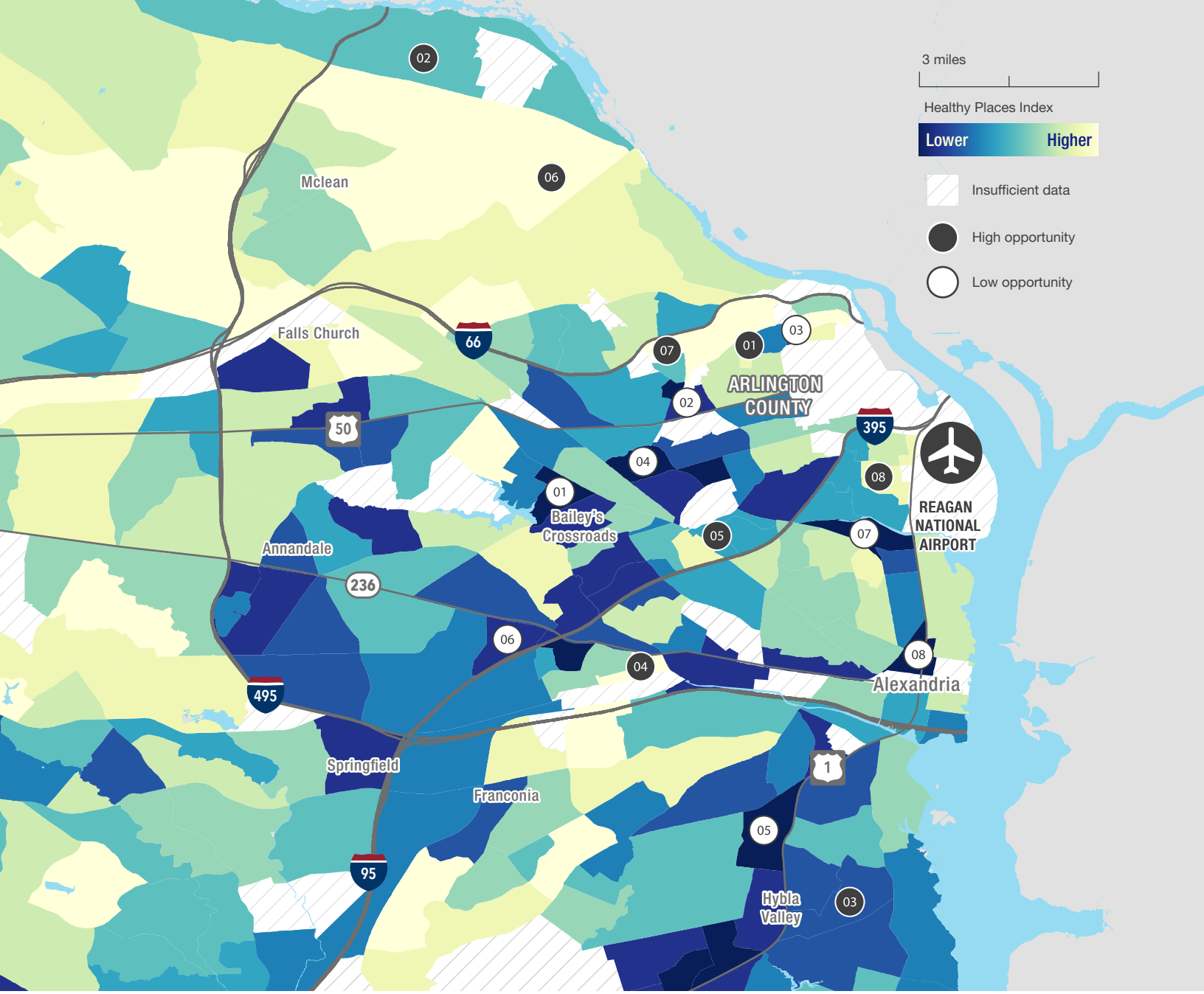


FIGURE 11. EXTREMES IN OPPORTUNITY: NORTHERN VIRGINIA

Health is about more than health care. Our environment matters: neighborhood conditions affect not only our health but also economic opportunities and social mobility. Statistics that take the average for an entire county mask how conditions vary by neighborhood.

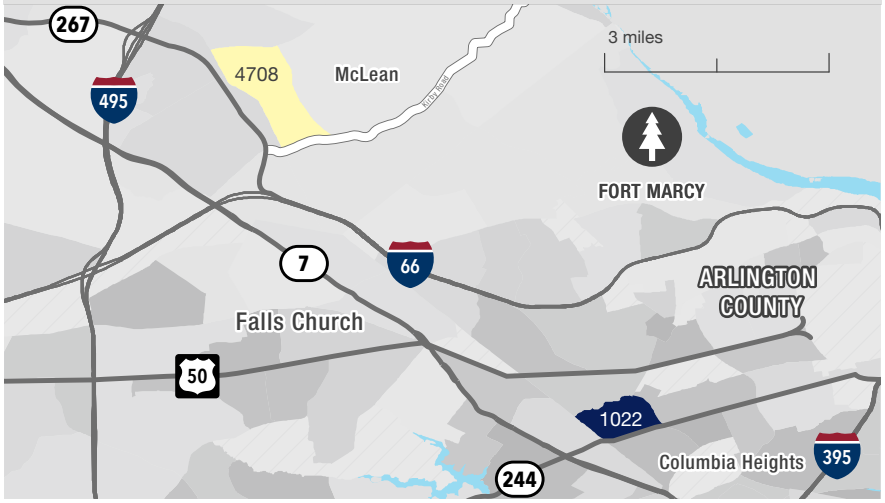
This map contrasts living conditions in areas of Northern Virginia in close proximity. Colors depict the Healthy Places Index: yellow reflects high opportunity for health and well-being, dark blue depicts low opportunity. The table contrasts specific living conditions, such as education and housing. Numbered circles in the table refer to census tracts on the map and show how greatly conditions vary across nearby neighborhoods. For example, the percent of adults with some college was 100% in a high-opportunity tract in Clarendon (01 in darkly shaded circle), whereas the percent in Bailey's Crossroads (01 in lightly shaded circle) was 24%. HPI scores in Northern Virginia ranged from 26 to 98.

	High Opportunity	Low Opportunity
SOME COLLEGE	01 100%	01 24%
MEDIAN HOUSEHOLD INCOME	02 $244,013	02 $38,125
CHILD POVERTY	03 0%	03 66%
ADULT POVERTY	04 0%	04 23%
PRIVATE HEALTH INSURANCE	05 99%	05 39%
UNINSURED ADULTS	06 <1%	06 54%
MODERATE HOUSING COST BURDEN	07 12%	07 58%
LIFE EXPECTANCY	08 88 years	08 78 years

See Table 2 for full definitions

between neighborhoods separated by only a few miles or blocks (Figure 11). Some of the most affluent census tracts in the United States, such as tract 4701 02 in Great Falls—where median household income was $244,013—were only a short drive from tract 1017.01 03 near Fort Myer where 66% of children lived in poverty.

FIGURE 12. A COMPARISON OF CENSUS TRACTS IN MCLEAN AND COLUMBIA HEIGHTS



	TRACT 4708 McLean	TRACT 1022 Columbia Heights
Healthy Places Index	96	41
High school education	97%	79%
Some college education	94%	55%
Limited English	3%	13%
Children in single-parent households	10%	51%
Median household income	$139,773	$42,571
Unemployment	1%	11%
Child poverty	0%	49%
Adult poverty	1%	23%
Income below 200% FPL	3%	49%
Public assistance	2%	14%
Adults without health insurance	3%	45%
Vacant housing	2%	11%
Moderate housing cost burden	24%	56%
Overcrowding	0%	11%
No vehicle	2%	21%

Graphic shows how living conditions vary in an affluent, largely white neighborhood (tract 4708) in McLean and a low-income neighborhood (tract 1022) in Columbia Heights with a large Hispanic and immigrant population. FPL= Federal poverty level. See Table 2 for full definitions.

As was observed elsewhere in the region, people of color were disproportionately exposed to adverse living conditions. Figure 12 poses the contrast between one McLean census tract (4708), where the HPI score was 96, and a tract in Arlington's Columbia Heights (1022), where the HPI score was 41. Whereas the population in the McLean tract was predominately white (70%) and Asian (19%), the population in Columbia Heights was largely Hispanic (51%) and black (19%). More than half was foreign-born, and most immigrated during 2000–2009.

POLICY IMPLICATIONS: WHERE DO WE GO FROM HERE?

This study documents the uneven access to opportunity—and to good health—that characterizes the metropolitan Washington region. The area is home to very healthy communities with high life expectancy, and to socioeconomic and environmental conditions that promote wellness and social mobility. But many neighborhoods—ranging from the "islands of disadvantage" in Northern Virginia to large historically segregated regions such as Southeast D.C. and Prince George's County—continue to struggle with poverty and poor environmental conditions resulting from past social and economic challenges.

Health care is a necessary but insufficient solution to addressing these health inequities. Health is about more than health care. Doctors cannot solve the socioeconomic challenges or improve neighborhood conditions. Impacted areas have large populations that lack health insurance and localized areas have an inadequate number of primary care physicians, mental health professionals, and other clinical services. Policies to improve access to care are vital, and encouraging residents to avoid unhealthy behaviors (e.g., smoking, inactivity) are important. At the same time, creating healthy communities and closing the region's 27-year gap in life expectancy require more fundamental social and economic solutions beyond the world of health care.

The good news is that the solutions to improving public health (Table 4) are also vital to improving the economy and growth of the region. Programs and policies to improve educational opportunities, from preschool to college, will promote the economic mobility of families while also strengthening the competitiveness of the region's workforce. Investments that help alleviate economic stresses on families and create opportunities for social mobility can help reduce demand for social services, discourage crime, and alleviate pressure on law enforcement, courts, and jails. Improving the built environment, expanding green space, and strengthening community services can help attract new businesses to the region, stimulate tourism, and bring other benefits to the public.

In an area that is home to some of the most educated and affluent people in the United States, it is essential that policies, services, and investments be targeted to communities in need. High schools in the region with

well-landscaped campuses and outfitted with the latest technological tools need less assistance than schools with crumbling infrastructure, low-paid teachers, and outdated teaching materials. Tools such as the Healthy Places Index—and similar resources that help pinpoint communities in need—can help identify "hot spots" for targeting efforts at community and economic development. Real solutions require targeted investments in marginalized neighborhoods to improve access to affordable, healthy housing as well as affordable transportation, child care, and health care (e.g., primary care, dental care, behavioral health services). Capital investments in the community, often originating in the private sector, are necessary to create an attractive environment that provides resources (e.g., green space) for physical activity and healthy eating while limiting exposure to harmful pollutants.

As discussed earlier, transformational change in areas that have suffered multi-generational disinvestment requires cross-sectoral partnerships, in which stakeholders from different sectors join hands to make a collective impact. Given the history of the area, it is essential for efforts to be sensitive to the vestiges of institutional racism and to work closely with communities of color and immigrant organizations to pursue trauma-informed policies. Many such efforts are underway in the metropolitan Washington region, including some that have served as models for other U.S. cities. The Metropolitan Washington Council of Governments has embraced a multisector approach in both its *Region Forward* strategic planning and its implementation.

Public health departments can play a major role in coordinating these efforts, beginning with the assessment of community health needs, investigating health effects or hazards, ensuring access to clinical services among at-risk populations, and using data to inform intervention efforts aimed at prevention or control. Increasingly, state and local health departments are helping to conduct health impact assessments (HIAs)[31]—structured processes to forecast the health implications of proposed policies, programs, and projects. HIAs are typically commissioned to examine policies in sectors that have not historically been viewed as health-related (e.g., education, transportation, housing, tax policy, zoning, law enforcement). Beyond this, public health agencies—through their close relationships with other government agencies and with community, business, academic, and philanthropic partners—can serve as backbone organizations for collective impact initiatives, in which stakeholders spanning multiple sectors embrace initiatives to improve the conditions for better health and economic opportunity.

Everyone benefits from this approach, not only the residents in low-income neighborhoods and communities of color, but also the entire regional economy. Economic and racial inequity saps the strength of the economy. Everyone pays a price for inaction: persistent poverty and social isolation fuel discontent, unhealthy behaviors (e.g., drug addiction), crime, and violence.

TABLE 4. STRATEGIES TO REDUCE GEOGRAPHIC DISPARITIES IN HEALTH AND OPPORTUNITY.

Address root causes by improving economic and social conditions for populations in need

- Policy action by government and the private sector to improve job opportunities, increase wages, reduce poverty, and promote economic mobility
- Reforms and investments to improve the quality of education—from preschool through high school—and to improve the affordability of college, vocational training, and professional education
- Cross-racial alliance building to understand and address common causes of health threats facing different racial and ethnic groups, including racism and discrimination

Strengthen the public health system

- Investments in public health agencies to support core functions
- Health needs and health impact assessments to factor in the health implications of policies, programs and projects in all sectors, including education, transportation, housing, and crime

Invest in communities

- Economic development by business, investors, and philanthropy, and the promotion of new industry in marginalized communities
- Civic engagement and cross-sector partnerships to leverage and target resources and expand opportunities to break the cycle of poverty

Ensure access to quality health care services

- Improved access to affordable health insurance and attention to provider shortage areas
- Protecting the quality and cultural competence of health care services

Efforts to promote health and opportunity can produce real-time benefits in the short term for today's families, but our children are perhaps the most important beneficiaries. Improving the living conditions of the region's children, their educational opportunities, and their health care will shape their future health trajectory into adulthood. And conversely, not protecting young people from the chronic stress of adverse childhood conditions will plant the seeds for lasting harm, substance abuse, economic struggles, and adult disease and disability. Today's children will be tomorrow's leaders. They will be the next generation of teachers, doctors, and chief executives. Making our region a place where children in every neighborhood can thrive is perhaps the best guarantee for a bright future.

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APPENDIX

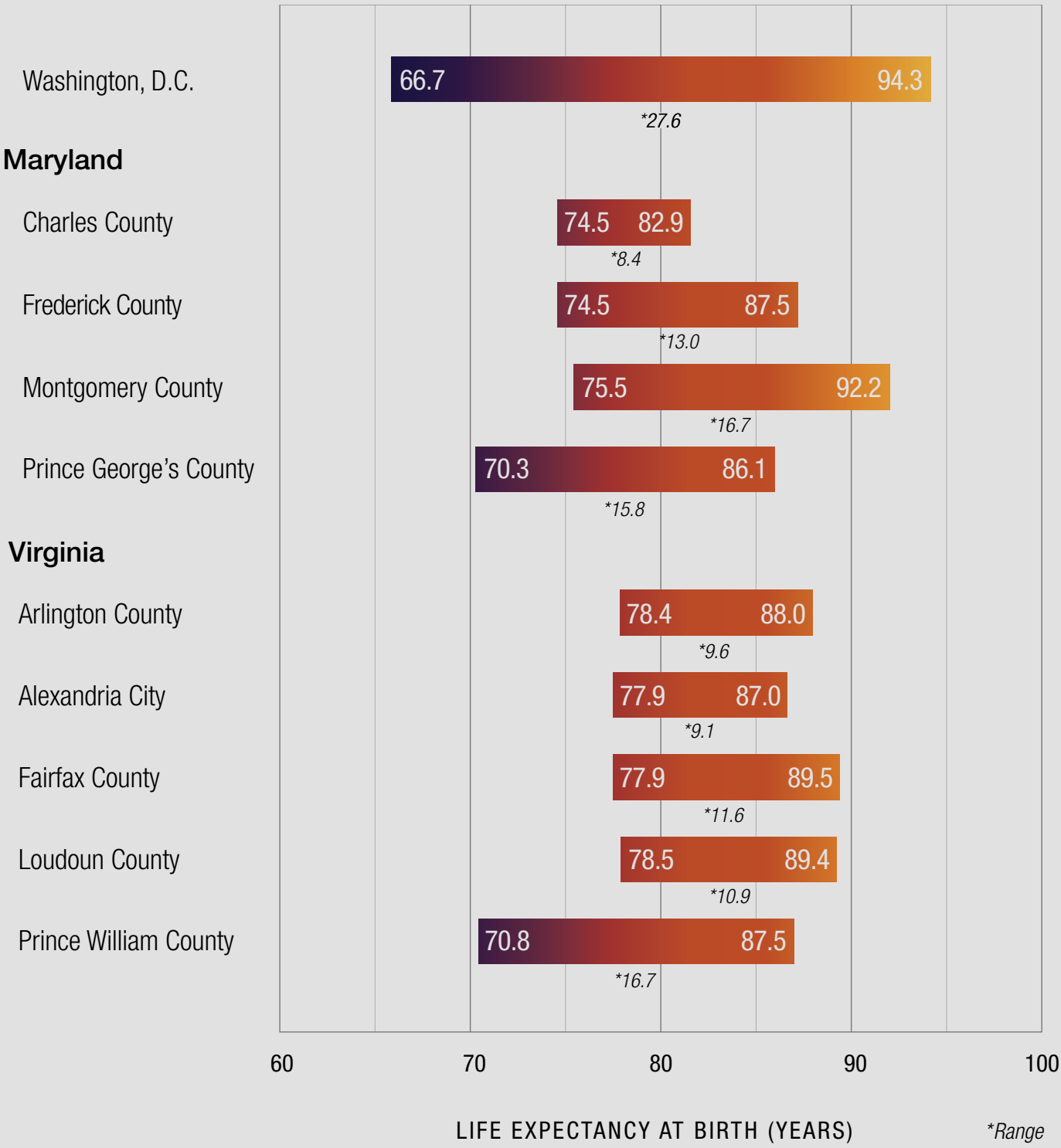


TABLE 1-A. LIFE EXPECTANCY (AT BIRTH) RANGES IN THE METROPOLITAN WASHINGTON REGION

Data for Fairfax County includes Fairfax City and Falls Church, and data for Prince William County includes the cities of Manassas and Manassas Park. Data for Prince George's County includes Bladensburg, Bowie, College Park, and Greenbelt. Data for Frederick County includes the city of Frederick.

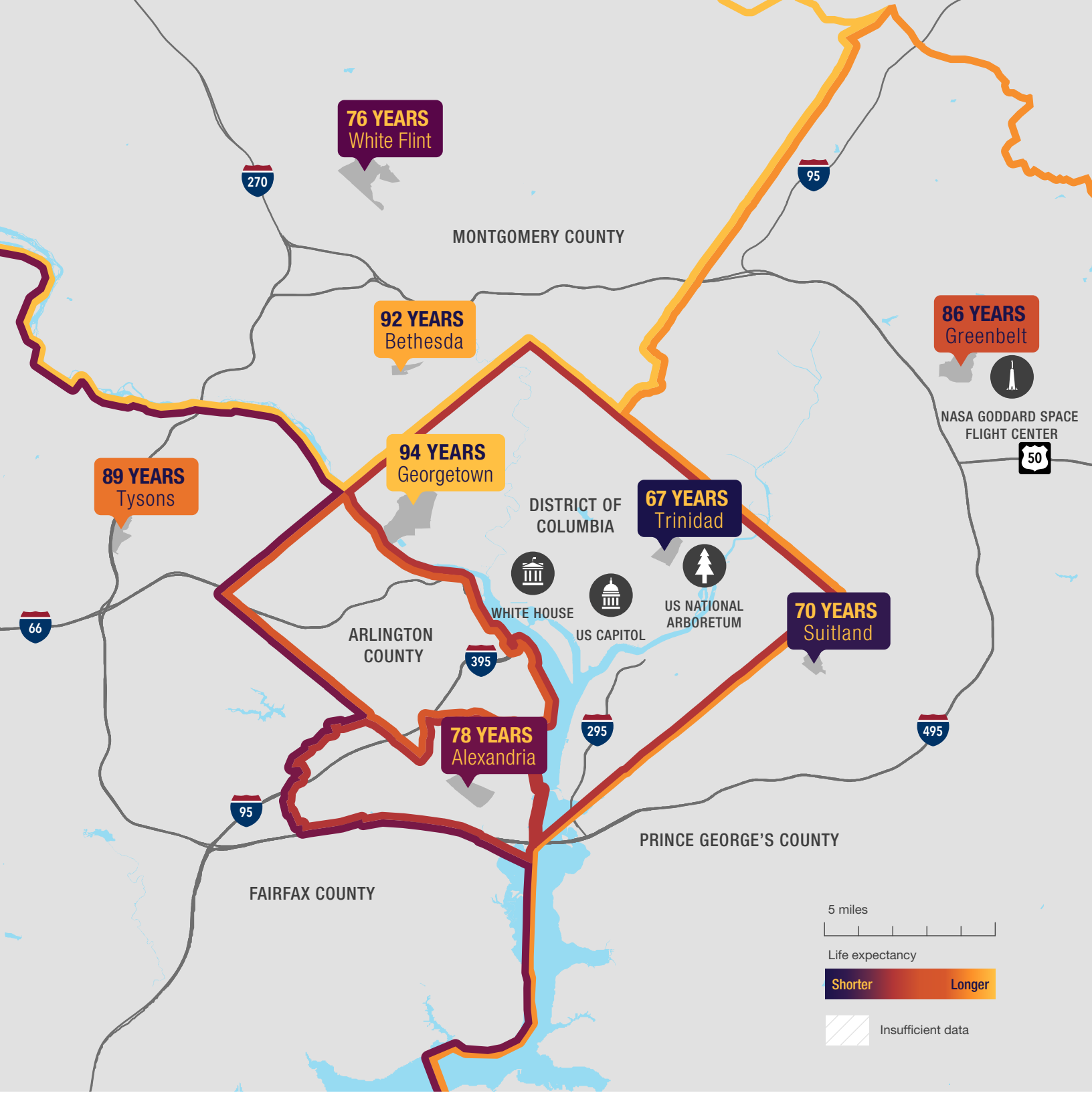


FIGURE 1-A. LIFE EXPECTANCY AT BIRTH IN THE METROPOLITAN WASHINGTON REGION

Life expectancy, how long a newborn can expect to live, varies 27 years across the census tracts of the metropolitan Washington region. Darkly shaded tracts, reflecting lower life expectancy, exist in every jurisdiction—not just the District of Columbia and nearby neighborhoods but also suburban Maryland (Charles County, Frederick County, Montgomery County, Prince George's County) and Virginia (Alexandria, Arlington County, Fairfax County, Loudoun County, and Prince William County). See appendix Table 1-A for life expectancy ranges for individual jurisdictions.

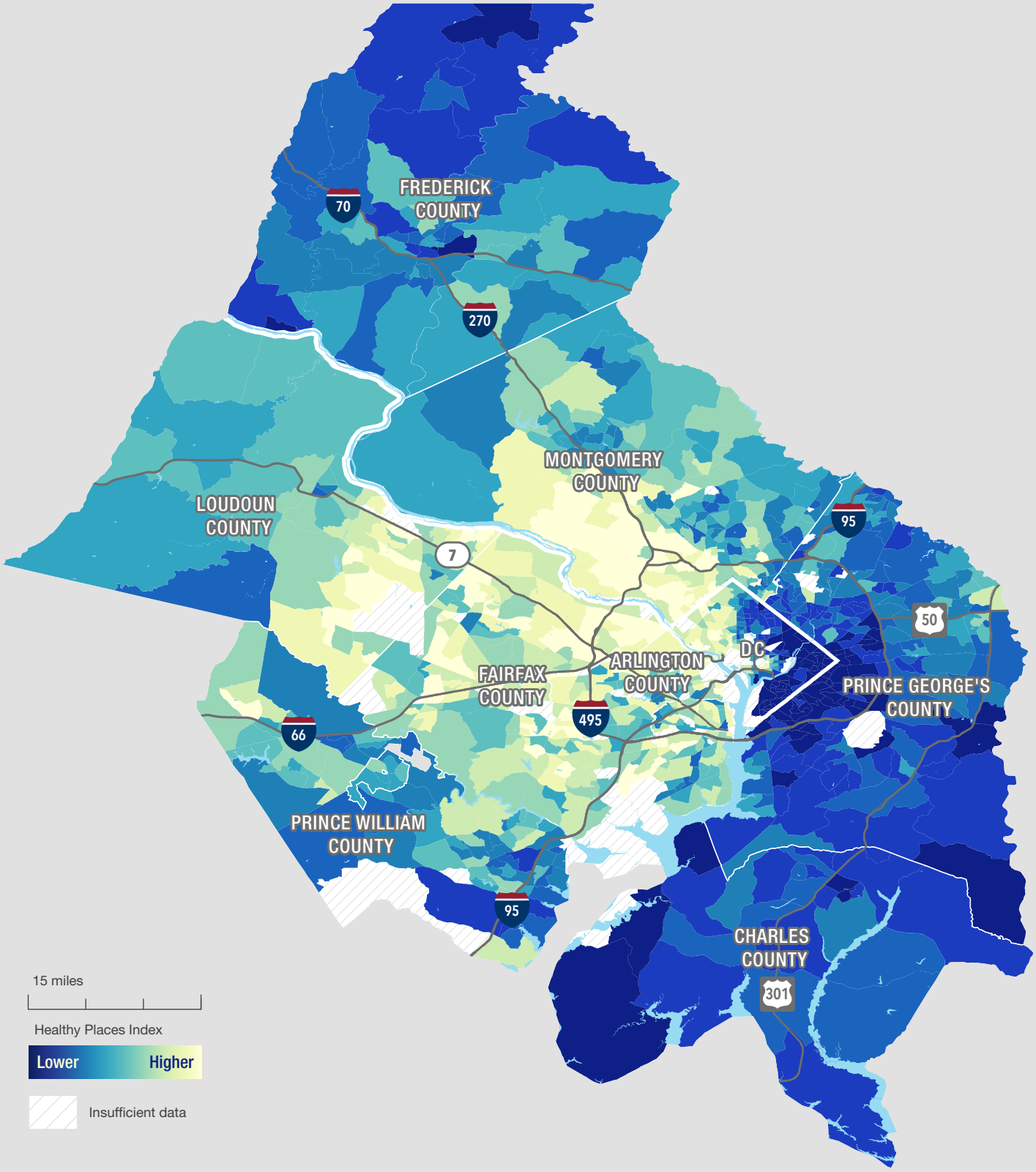


FIGURE 4-A. HEALTHY PLACES INDEX SCORES IN THE METROPOLITAN WASHINGTON REGION

The map shows that opportunities for good health at the census tract level vary greatly across the region. Colors depict how the Healthy Places Index (HPI) varies across the metropolitan Washington region: yellow reflects high opportunity for health and well-being, dark blue depicts low opportunity.

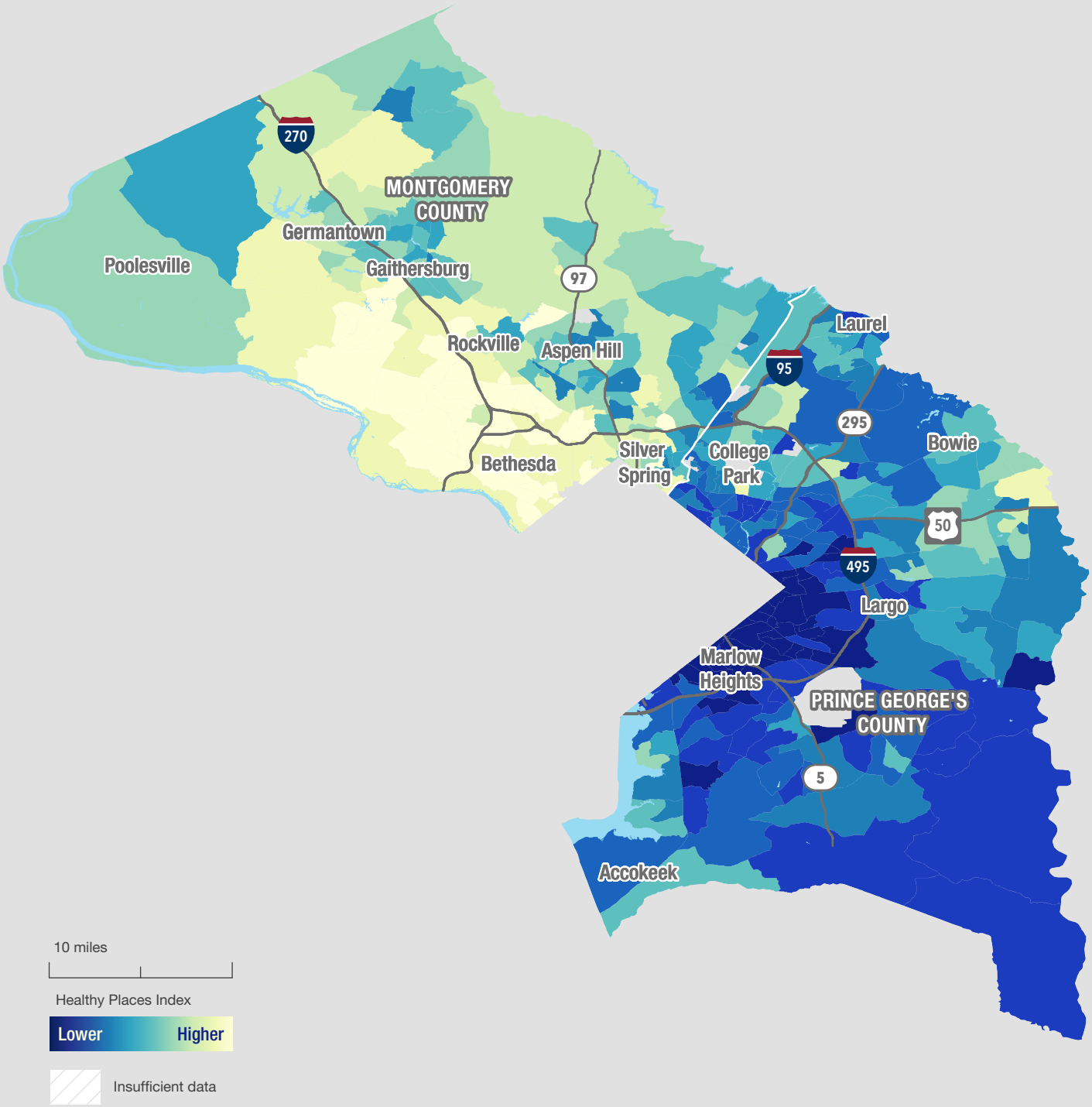


FIGURE 8-A. HEALTHY PLACES INDEX SCORES IN MONTGOMERY COUNTY, MD AND PRINCE GEORGE'S COUNTY, MD

The map shows that opportunities for good health at the census tract level vary greatly across Montgomery County and Prince George's County in Maryland. Colors depict the Healthy Places Index: yellow reflects high opportunity for health and well-being, dark blue depicts low opportunity.

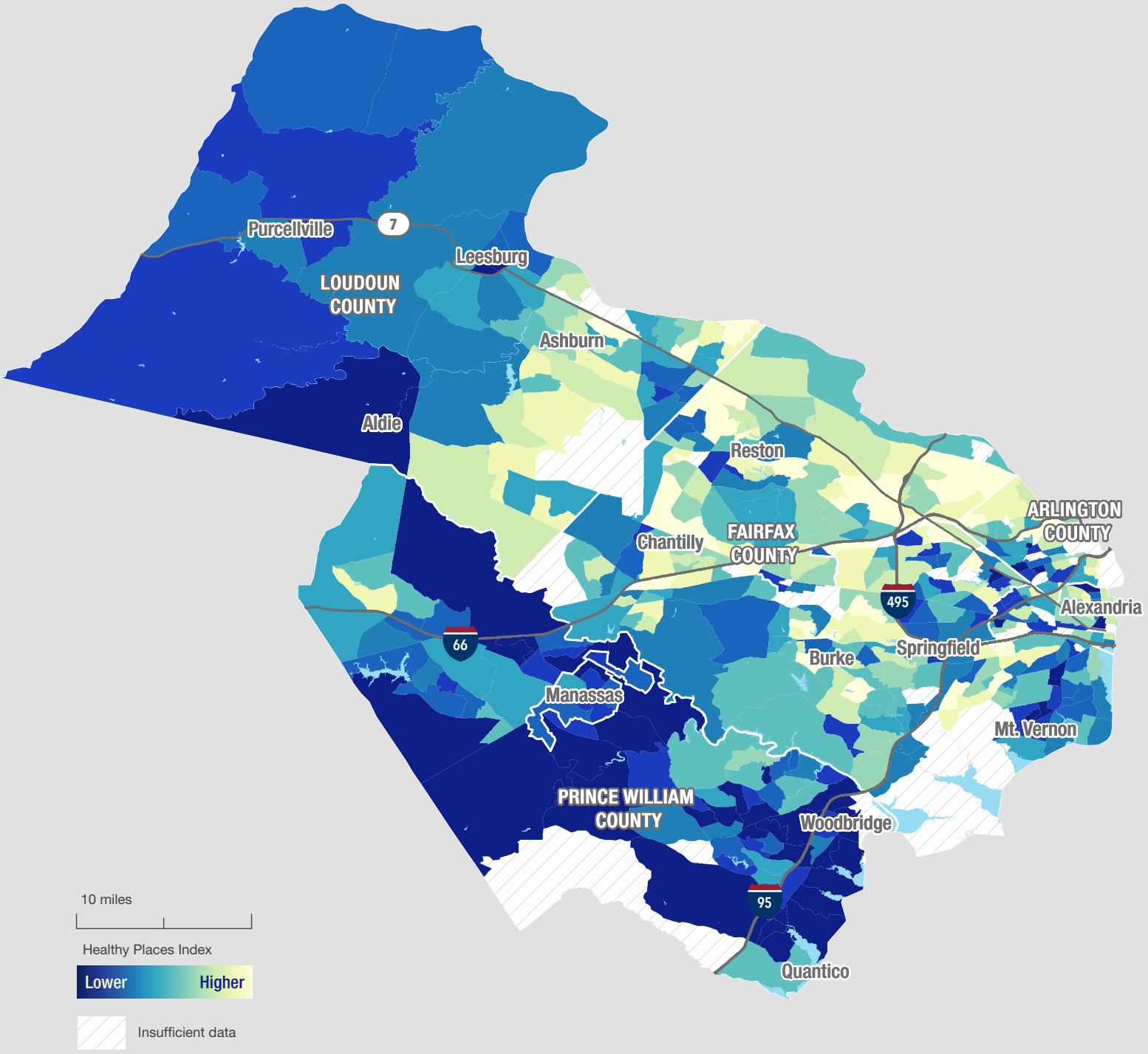


FIGURE 10-A. HEALTHY PLACES INDEX SCORES IN NORTHERN VIRGINIA

The map shows that opportunities for good health for good health vary greatly across census tracts. Colors depict the Healthy Places Index in Northern Virginia: yellow reflects high opportunity for health and well-being, dark blue depicts low opportunity. HPI scores in Northern Virginia ranged from 26 to 98.

AGENDA ITEM #9

REOPENING COORDINATION

Metropolitan Washington Council of Governments

DISTRICT OF COLUMBIA, MARYLAND, AND VIRGINIA REOPENING GUIDELINES

Updated: June 3, 2020

Beginning in late April 2020, the Mayor of the District of Columbia and the Governors of the State of Maryland and the Commonwealth of Virginia, initiated reopening strategies for their respective jurisdictions. To date there have been modifications and clarifications of these plans as conditions and data related to pandemic response continues to evolve.

A review of these plans suggests considerable similarities as the executive leaders of the jurisdictions have publicly noted their ongoing communication and desire for cooperation. The Maryland, Virginia and District of Columbia plans all reflect an emphasis on the following elements:

- Phased, gradual reopening based on data and science;
- Continued social distancing, use of face coverings, and teleworking;
- Application of comparable public health metrics for moving toward reopening;
- Establishment of business and community sector task forces; and
- Alignment with White House guidance.

CURRENT STATUS OF REOPENING STRATEGIES

The two governors revised their emergency orders and related guidance on reopening with their states beginning on Friday, May 15. On May 12, Virginia Governor Ralph Northam issued Executive Order 62 which delays Phase 1 for Northern Virginia localities until May 28. On May 26, Northam announced that Northern Virginia will enter Phase 1 reopening on Friday, May 29. On June 2 Northam issued Executive Order 65 allowing most of Virginia to enter the second phase of reopening; the order excludes Northern Virginia and the City of Richmond. Northam and Northern Virginia officials are working together on when Northern Virginia will enter Phase 2.

On May 15, Maryland Governor Larry Hogan issued Executive Order 20-05-13-01 allowing the reopening of certain businesses and facilities in Maryland. The order also empowers local jurisdictions to determine the timing of their reopening based on their data trends. Executive Order 20-05-27-01 further allows the reopening of certain businesses and activities. As of May 28, jurisdictions in the NCR have announced the implementation of Stage 1, with variations and restrictions, between May 29 and June 1. More detailed information about Maryland jurisdictions reopening decisions and guidance can be found in Appendix A.

On May 13, District of Columbia Mayor Muriel Bowser issued Mayor's Order 2020-066 to extend the public emergency, public health emergency, and Stay at Home Order until June 8. On May 21, Mayor Bowser released a more detailed reopening plan, ReOpen DC: Recommendations to the Mayor, outlining four stages of reopening. On May 27, Mayor Bowser announced the District will begin to lift restrictions on Friday, May 29 and enter Stage 1 of reopening.

Revised guidelines released by Governor Northam, Governor Hogan, and Mayor Bowser are similar and include the following:

- "Stay at Home" order becomes "Safer at Home" order– especially for vulnerable populations;
- No gatherings of more than 10 individuals;

- Continued social distancing, continued teleworking, face coverings recommended in public;
- Easing limits on business and faith communities;
- Outdoor dining with capacity limits and physical distancing protocols;
- Resuming non-emergency/elective surgeries;
- Flexibility for delayed reopening for surge areas (not applicable to the District); and
- Adjusting restrictions to deal with negative metrics, including a surge in new cases and/or hospitalizations.

Table 1: Comparison of Initial Reopening Strategies

	District of Columbia	Maryland	Virginia
Plan Title	ReOpen DC and Mayor's Order 2020-066	Maryland Strong: Roadmap to Recovery; Executive Order 20-05-06-01; Executive Order 20-05-13-01; and Executive Order 20-05-27-01	Forward Virginia Blueprint; Executive Order 61 (amended May 28); and Executive Order 65
Advisory Councils	ReOpen DC Advisory Group	Coronavirus Recovery Team	COVID-19 Task Forces
Phase/Stage I Reopening Guidelines	No gatherings of more than 10 individuals Continued social distancing Continued teleworking Use of face coverings in public Reopening of key low-risk activities, outdoor dining, barber shops and hair salons (by appointment only), outdoor recreation, and businesses with strong safeguards Delivery of inpatient and outpatient care, with providers monitoring and	Safer at Home order – especially for vulnerable populations No gatherings of more than 10 individuals Continued social distancing Continued teleworking Face coverings recommended in public Maximum occupancy is 50% for retail, religious facilities, and hair salons and barber shops by appointment only Restaurants and social organizations may reopen	Safer at Home – especially for vulnerable populations No gatherings of more than 10 individuals Continued social distancing Continued teleworking Face coverings recommended in public; required inside buildings (Executive Order 63) Maximum occupancy is 50% for retail, religious facilities, and hair salons and barber shops by appointment only

	District of Columbia	Maryland	Virginia
	preserving health system capacity Adjusting restrictions to deal with negative metrics, including surge in community transmission and/or hospitalizations	for outdoor dining only with capacity limits Outdoor pools, youth sports, and youth day camps may resume operating under strict safety protocols and capacity limitations Local orders continue to take precedence Adjusting restrictions to deal with negative metrics, including a surge in new cases and/or hospitalizations	Public beaches open to recreational activity, exercise, and fishing Adjusting restrictions to deal with negative metrics, including a surge in new cases and/or hospitalizations
Regional Approach	n/a	Governor Hogan issued Executive Order 20-05-06-01 empowering local jurisdictions to determine reopening timelines and restrictions; Executive Orders 20-05-13-01 and 20-05-27-01 reinforce this approach	Governor Northam issued Executive Order 62 delaying reopening for Northern Virginia; Executive Order 65 delays Phase 2 for Northern Virginia
Status of NCR Jurisdictions	Stage 1 as of May 29	Stage 1 between May 29 – June 1 (see Appendix A)	Phase 1 as of May 29
Next phase for NCR Jurisdictions (Tentative)	Stage 2 – no set date	Stage 2 – no set date and based on locality	Phase 2 – no set date

KEY METRICS FOR REOPENING

The following table outlines the metrics being tracked by the District of Columbia, Maryland, and Virginia to inform initial reopening guidelines. The metrics focus specifically on those being tracked at the state level; some jurisdictions within the NCR are developing additional metrics to inform local

decision-making. The metrics in Table 2 have been reviewed by regional health officials for accuracy.

Table 2: Key Metrics Tracked by the District, Maryland, and Virginia

	District of Columbia	Maryland	Virginia
Cases	Sustained decrease in community spread over 14 days Low transmission rate for three (3) days	Decrease in number of new cases over 14 days	Decrease percentage of positive tests over 14 days
Hospital Capacity	Ability to safely care for all patients without a medical surge 79% hospital capacity, sustained for seven (7) days	Increased hospital surge capacity	Decreased hospitalizations over 14 days Enough hospital beds and intensive case capacity
Testing	Ability to rapidly test all: 1) Symptomatic; 2) At-risk healthcare workers; 3) Essential workers; and 4) Close contacts of all new positive cases Target: 7,500 per day	Expanded testing capability Target: 10,000 per day	Increased testing Target: 10, 000 per day
PPE	Appropriate PPE for all healthcare workers and first responders	Increased supply of PPE	Increasing and sustainable supply of PPE Adequate PPE for hospitals Adequate PPE for outpatient facilities (private practices, long-term care facilities, and first responders)
Contact Tracing	Contact tracing capacity for all new cases within one (1) day and close	Robust contact tracing	Increased contact tracing capacity

	District of Columbia	Maryland	Virginia
	contacts within two (2) days Workforce Target: 900	Workforce Target: 1,000	Workforce Target: 1,000

Appendix A: Maryland Jurisdictions Reopening Decisions and Guidance

Executive Order 20-05-13-01 issued by Maryland Governor Larry Hogan includes a Safer at Home order, moves to Stage One for reopening, and allows local jurisdictions the discretion to review local data and make independent decisions about when it is appropriate to relax certain restrictions. Executive Order 20-05027-01 allows for the resumption of outdoor dining, youth sports, day camps, and outdoor pools. Jurisdictions within and adjacent to the NCR continue to be in various stages of reopening.

Table 3: NCR Maryland Counties Reopening Decisions and Guidance

	Charles County	Frederick County	Montgomery County	Prince George's County
Order/ Decision	Phase One Gradual Reopening and May 28 Press Release	Executive Order 02-2020 and May 28 Press Release	May 28 Press Release	Executive Order 10-2020
Effective Date	May 29	May 29	June 1	June 1
Brief Description	Implementation of Maryland's "RoadMap to Recovery" Stage 1 Retail businesses, hair salons and barber shops by appointment only, and indoor religious facilities may open at 50% capacity Outdoor dining only with capacity limits Outdoor pools, youth sports, and youth day camps may resume operating under strict safety protocols and capacity limitations	Implementation of Maryland's "RoadMap to Recovery" Stage 1 Retail businesses, hair salons and barber shops by appointment only, and indoor religious facilities may open at 50% capacity Outdoor dining only with capacity limits	Incremental implementation of Maryland's "RoadMap to Recovery" Stage 1 Retail businesses limited to curbside services only, hair salons and barber shops by appointment only, and full reopening of manufacturing Outdoor dining only with capacity limits Outdoor day camps and youth sports may resume following Maryland Department of Health guidelines	Incremental implementation of Maryland's "RoadMap to Recovery" Stage 1 Retail businesses may open with physical distancing and capacity limits, hair salons and barber shops by appointment only, and full reopening of manufacturing Outdoor dining only with capacity limits

	Charles County	Frederick County	Montgomery County	Prince George's County
Modified from State Guidelines	Yes	Yes	Yes	Yes
Reopening Metrics	State metrics	County metrics (found here)	County metrics (found here)	County metrics (found here)

Table 4: Maryland Counties in Close Proximity to NCR Reopening Decisions and Guidance

	Anne Arundel County	Cecil County	Howard County
Order	Reopening of Certain Businesses (Executive Order 21) and May 28 Press Release	May 28 Press Release	Howard County Executive Order #2020-09
Effective Date	May 29	May 29	May 29
Brief Description	Implementation of Maryland's "RoadMap to Recovery" Stage 1 Incremental reopening of recreation and parks amenities between May 29 and June 1 Outdoor pools opening June 5 after county inspection Modified outdoor day camps open July 6 with capacity limits	Full implementation of Maryland's "RoadMap to Recovery" Stage 1	Implementation of Maryland's "RoadMap to Recovery" Stage 1
Modified from State Guidelines	Yes	No	Yes
Reopening Metrics	State metrics	State metrics	County metrics (found in HoCoRISE framework)

Forward Virginia

MAY 8, 2020

Forward Virginia Phase One

Phase I looks like this:

- Safer at home—especially if you are vulnerable
- No social gatherings of more than 10 individuals
- Continued social distancing
- Continued teleworking
- Face coverings recommended in public
- Revised business limitations

Forward Virginia: Phase One

Here is what changes in Phase One with the Safer at Home order:

	NOW	PHASE ONE
NON-ESSENTIAL RETAIL	Open with 10-person limit	Open with 50 percent capacity
RESTAURANT AND BEVERAGE SERVICES	Takeout and delivery	Takeout and delivery; Outdoor seating at 50 percent capacity
ENTERTAINMENT AND AMUSEMENT	Closed	Closed
FITNESS AND EXERCISE	Closed	Closed (limited to outdoor fitness)
BEACHES	Exercise and fishing only	Exercise and fishing only

Forward Virginia: Phase One

Here is what changes in Phase One with the Safer at Home order:

	NOW	PHASE ONE
PLACES OF WORSHIP	Drive-in services; 10-person limit	Drive-in services 50 percent indoor capacity
PERSONAL GROOMING	Closed	Appointment only Strict social distancing Face coverings required
PRIVATE CAMPGROUNDS	Closed	Open
STATE PARKS	Open to day use only	Day use; Overnight in phases
CHILD CARE	Open for working families	Open for working families
OVERNIGHT SUMMER CAMPS	Closed	Closed

Forward Virginia: Phase One

Here is what changes in Phase One with the Safer at Home order:

	NOW	PHASE ONE
GATHERINGS	10-person limit	10-person limit
TELEWORKING	Strongly encouraged	Strongly encouraged
FACE COVERINGS	Strongly encouraged	Strongly encouraged

Forward Virginia: Phase One

	PHASE ZERO	PHASE ONE
NON-ESSENTIAL RETAIL	Open with 10 person limit	Open with 50% capacity
RESTAURANTS AND BEVERAGE SERVICES	Takeout and delivery	Takeout and delivery; outdoor seating at 50% capacity
ENTERTAINMENT AND PUBLIC AMUSEMENT	Closed	Closed
FITNESS AND EXERCISE	Closed	Closed (limited to outdoor fitness classes)
BEACHES	Exercise and fishing only	Exercise and fishing only
GATHERINGS	10 person limit	10 person limit
TELEWORKING	Strongly encouraged	Strongly encouraged
FACE COVERINGS	Strongly encouraged	Strongly encouraged
CHILDCARE	Open for working families	Open for working families
PLACES OF WORSHIP	Drive-in services; 10 person limit	Drive-in services; 50% capacity
PERSONAL GROOMING	Closed	Appointment only
PRIVATE CAMPGROUNDS	Closed	Open
OVERNIGHT SUMMER CAMPS	Closed	Closed
STATE PARKS	Day use only	Day use; Overnight in phases
SCHOOLS	Closed	Closed

SAFER AT HOME: PHASE TWO

GUIDELINES FOR ALL BUSINESS SECTORS

PHYSICAL DISTANCING BEST PRACTICES:

- ✓ Establish policies and practices for physical distancing between co-workers and between members of the public. (See sector-specific guidelines below for more detailed information on public engagement.)
- ✓ Provide clear communication and signage for physical distancing in areas where individuals may congregate, especially at entrances, in seating areas, and in check-out lines.
- ✓ Limit the occupancy of physical spaces to ensure that adequate physical distancing may be maintained. (See sector-specific guidelines for more detailed information.)
- ✓ Encourage telework whenever possible.
- ✓ For those businesses where telework is not feasible, temporarily move or stagger workstations to ensure six feet of separation between co-workers and between members of the public.
- ✓ Limit in-person work-related gatherings, including conferences, trade shows, and trainings.
- ✓ When in-person meetings need to occur, keep meetings as short as possible, limit the number of employees in attendance, and use physical distancing practices.

ENHANCED CLEANING AND DISINFECTION BEST PRACTICES:

- ✓ Practice routine cleaning and disinfection of high contact areas and hard surfaces, including check out stations and payment pads, store entrance push/pull pads, door knobs/handles, dining tables/chairs, light switches, handrails, restrooms, floors, and equipment. Follow CDC Reopening Guidance for Cleaning and Disinfection and use an EPA-approved disinfectant to clean. For high contact areas, routinely disinfect surfaces at least every 2 hours. Certain surfaces and objects in public spaces, such as shopping carts and point of sale keypads, should be cleaned and disinfected before each use.

- ✓ To the extent tools or equipment must be shared, provide access to and instruct workers to use an EPA-approved disinfectant to clean items before and after use.

- ✓ Provide a place for employees and customers to wash hands with soap and water, or provide alcohol-based hand sanitizers containing at least 60% alcohol. (See sector-specific guidelines for more detailed information.)

- ✓ When developing staff schedules, implement additional short breaks to increase the frequency with which staff can wash hands with soap and water. Alternatively, consider providing alcohol-based hand sanitizers with at least 60% alcohol so that workers can frequently sanitize their hands.

- ✓ Provide best hygiene practices to employees on a regular basis, including washing hands often with soap and water for at least 20 seconds and practicing respiratory etiquette protocols. A CDC training video is available here: https://www.cdc.gov/handwashing/videos.html.

ENHANCED WORKPLACE SAFETY BEST PRACTICES:

- ✓ Prior to a shift and on days employees are scheduled to work, employers should screen employees prior to starting work. Employees should also self-monitor their symptoms by self-taking of temperature to check for fever and utilizing the questions provided in the VDH Interim Guidance for COVID -19 Daily Screening of Employees before reporting to work. For employers with established occupational health programs, employers can consider measuring temperature and assessing symptoms of employees prior to starting work/before each shift. CDC considers a person to have a fever when he or she has a measured temperature of 100.4° F (38° C) or greater, feels warm to the touch, or gives a history of feeling feverish.

- ✓ Implement practices such as those described in VDH Interim Guidance for COVID - 19 Daily Screening of Employees for examples of a screening questionnaire. A sample symptom monitoring log is available in this Interim Guidance.

- ✓ Instruct employees who are sick to stay at home and not report to work. If an employee becomes ill or presents signs of illness, follow CDC What to Do if You Are Sick guidance. Employers should post signage in the common languages of the employees telling employees not to come to work when sick.

- ✓ Develop or adopt flexible sick leave policies to ensure that sick employees do not report to work. Policies should allow employees to stay home if they are sick with COVID-19, if they need to self-quarantine due to exposure, and if they need to care for a sick family member. Employers should recommend that employees follow CDC guidance on If You Are Sick or Caring For Someone.

- ✓ Some employees are at higher risk for severe illness from COVID-19. These vulnerable employees include individuals over age 65 and those with underlying medical conditions. Vulnerable employees should be encouraged to self-identify and employers should take particular care to reduce their risk of exposure, while making sure to be compliant with relevant Americans with Disabilities Act (ADA) and Age Discrimination in Employment Act (ADEA) regulations.

    1. Consider offering vulnerable employees duties that minimize their contact with customers and other employees (e.g., restocking shelves rather than working as a cashier), if agreed to by the employee.

    2. Protect employees at higher risk for severe illness by supporting and encouraging options to telework.

    3. If implementing health checks, conduct them safely and respectfully, and in accordance with any applicable privacy laws and regulations. Confidentiality should be respected.

    4. Other information on civil rights protections for workers related to COVID-19 is available here.

- ✓ Designate a staff person to be responsible for responding to COVID-19 concerns. Employees should know who this person is and how to contact them.

- ✓ Implement staggered shifts for both work periods and break periods. Consider cohort scheduling where groups of employees only work with employees in their group.
- ✓ Limit the number of employees in break rooms and stagger breaks to discourage gatherings.
- ✓ Use messaging boards or digital messaging for pre-shift meeting information.
- ✓ If the building has not been occupied for the last 7 days, there are additional public health considerations that should be considered, such as taking measures to ensure the safety of your building water system. However, it is not necessary to clean ventilation systems other than routine maintenance as part of reducing the risk of coronavirus transmission.
- ✓ Establish a relationship with your local health department and know who to contact for questions.

For healthcare facilities, additional guidance is provided on CDC's Guidelines for Environmental Infection Control in Health-Care Facilities.

RESOURCES TO PRINT AND DISPLAY:

CDC Symptoms English

Spanish CDC Symptoms

CDC Printable Flyer English

CDC Printable Flyer Spanish

CDC Printable Flyer Chinese

CDC Printable Flyer Korean

CDC Printable Flyer Vietnamese

FDA information

What Grocery Store and Food Retail Workers Need to Know about COVID-19

CDC Re-Opening America Cleaning and Disinfecting Public Spaces, Workplaces, Businesses, Schools, and Homes

CDC What You Need to Know About Handwashing VIDEO

GUIDELINES FOR SOCIAL GATHERINGS

BEST PRACTICES:

In addition to the best practices in the "Guidelines for All Business Sectors" document, social gatherings should consider the following best practices:

- ✓ Post signage at the entrance that states that no one with a fever or symptoms of COVID-19, or known exposure to a COVID-19 case in the prior 14 days, is permitted in the establishment.
- ✓ Post signage to provide public health reminders regarding physical distancing, gatherings, options for high-risk individuals, and staying home if sick (samples at bottom of this document).
- ✓ Social gatherings should be limited to 50% occupancy of the event space, if applicable, or 50 participants, whichever is less.
- ✓ Limit the occupancy of spaces to ensure that six feet of physical distance can be maintained between all organizers, staff, volunteers, and attendees who are not members of the same household.
- ✓ Reconfigure seating areas to allow six feet of physical distance between individuals by eliminating or closing select tables or seating areas, or by spreading them out to allow for adequate spacing.
- ✓ Ensure exits are configured to reduce the occurrence of bottlenecks at the conclusion of the event.
- ✓ Practice routine cleaning and disinfection of high contact areas and hard surfaces, including check out stations and payment pads, store entrance push and pull pads, door knobs and handles, dining tables and chairs, light switches, handrails, restrooms, guest lockers, floors, and equipment. Follow CDC Reopening Guidance for Cleaning and Disinfection and use an EPA-approved disinfectant to clean. For high contact areas (e.g., in both public and staff areas), routinely disinfect surfaces at least every 2 hours. Certain surfaces and objects in public spaces, such as point of sale keypads, should be cleaned and disinfected before each use.

- ✓ Social gatherings should not include close contact between gathering organizers, staff, and attendees not from the same household. Discontinue activities such as face-painting, temporary tattoo application, or audience participation with performers.

- ✓ Events that cannot restrict access to the general public should not take place.

- ✓ Where applicable, organizers must create a participant flow plan of modified queue lines to and within the mass gathering. Determine areas likely to become bottlenecks or pinch points and adjust participant flow accordingly.

- ✓ Where applicable, install visible markers for queue lines that separate people by six feet of physical distance. Provide physical guides to seating areas including floor decals, colored tape, or signs to indicate where attendees should not sit, stand, or congregate. Sample markers are available in the VDH Business Toolkit.

- ✓ Do not include side events as part of the gathering. These are events associated with but located outside of the formal gathering location, such as souvenir vending stations, gaming areas, petting zoos, and designated food truck areas.

- ✓ Designate a coordinator who will be responsible for identifying COVID-19 related issues and their impact on the gathering, including coordinating health preparedness for the event and emergency response planning.

- ✓ Develop an emergency and medical response plan for COVID-19. This plan should include information about how attendees should interface with the local healthcare system (who to speak with or call if they feel sick) and procedures for isolating sick attendees and reporting illnesses to event organizers. The response plan must also include a plan for organizers to notify the local health department and all participants if any exposure to COVID-19 occurs at the event.

- ✓ Develop a mitigation plan for COVID-19, to include how all requirements listed here will be met, and how guidelines and requirements will be enforced at the gathering.

- ✓ Consider limiting the duration of the gathering, especially for indoor gatherings and gatherings involving activities that would increase respiration (e.g., cheering, singing).

- ✓ Consider delaying gatherings where the target demographic is persons in high risk populations.

- ✓ Use technology solutions where possible to reduce person-to-person interaction, including contactless payment and ticket scanning.

- ✓ Install physical barriers, such as sneeze guards and partitions, at staffed kiosks.

- ✓ All bathrooms, hand-washing stations, and portable toilets should be placed in a convenient location for use by attendees but away from congregate areas and arranged in a configuration that maintains at least six feet of physical distance.

- ✓ Provide a place for staff and attendees to wash hands with soap and water, or provide alcohol-based hand sanitizers containing at least 60% alcohol.

- ✓ Where applicable, provide best hygiene practices to employees on a regular basis, including washing hands often with soap and water for at least 20 seconds and practicing respiratory etiquette protocols. A CDC training video is available here: https://www.cdc.gov/handwashing/videos.html.

- ✓ Close off areas used by a sick person and do not use them until after cleaning and disinfection. Wait 24 hours before cleaning and disinfecting. If it is not possible to wait 24 hours, wait as long as possible. Ensure safe and correct application of disinfectants and keep disinfectant products away from children.

- ✓ Attendees should leave as quickly as possible following the event in order to limit contact and exposure to themselves and other attendees.

- ✓ Establish relationships with key community partners and stakeholders, such as the local health department, community leaders, hospitals, and law enforcement. Collaborate and coordinate with them on broader planning efforts for the gathering.

- ✓ Identify actions to take if the event needs to be postponed or cancelled.

- ✓ Private events may be held at venues provided they can comply with these guidelines.

RESOURCES TO PRINT AND DISPLAY:

CDC Symptoms English

CDC Symptoms Spanish

CDC Printable Flyer English

CDC Printable Flyer Spanish

CDC Printable Flyer Chinese

CDC Printable Flyer Korean

CDC Printable Flyer Vietnamese

FDA information

RESTAURANT AND BEVERAGE SERVICES

SCOPE: Restaurants, dining establishments, food courts, breweries, cideries, mobile units (food trucks), distilleries, wineries, and tasting rooms.

PHASE 2: Establishments must either implement the following mandatory requirements or close.

MANDATORY REQUIREMENTS:

Businesses must strictly adhere to the physical distancing guidelines, enhanced cleaning and disinfection practices, and enhanced workplace safety practices provided in the "Guidelines for All Business Sectors" document. Virginia Department of Health and Virginia Department of Agriculture and Consumer Services regulated facilities must continue to follow requirements related to prohibiting sick employees in the workplace, strict handwashing practices, and procedures and practices to clean and sanitize surfaces.

During Phase 2, businesses should continue to offer takeout and delivery options. If businesses choose to open to dine-in customers, they may do so in indoor and outdoor spaces and must adhere to the following additional requirements for service:

- ✓ Post signage at the entrance that states that no one with a fever or symptoms of COVID-19, or known exposure to a COVID-19 case in the prior 14 days, is permitted in the establishment.
- ✓ Post signage to provide public health reminders regarding physical distancing, gatherings, options for high risk individuals, and staying home if sick (See samples at the bottom of this document).
- ✓ Occupancy must be limited to no more than 50% of the lowest occupancy load on the certificate of occupancy, if applicable, while maintaining a minimum of six feet of physical distancing between all individuals as much as possible.
- ✓ Provide a minimum of six feet between parties at tables, (i.e., the six feet cannot include the space taken up by the seated guest). If tables are not movable, seat parties at least six feet apart. Spacing must also allow for physical distancing from areas

outside of the facility's control (i.e. provide physical distancing from persons on public sidewalks).

- ✓ All parties, whether seated together or across multiple tables, must be limited to 50 patrons or less.
- ✓ Do not seat multiple parties at any one table unless marked with six foot divisions (such as with tape).
- ✓ Bar seats and congregating areas of restaurants must be closed to patrons except for through-traffic. Non-bar seating in the bar area (i.e., tables or counter seats that do not line up to a bar or food service area) may be used for customer seating as long as a minimum of six feet is provided between parties at tables.
- ✓ Keep game areas, dance floors, and playgrounds closed. If live musicians are performing at an establishment, they must remain at least six feet from patrons and staff.
- ✓ Employees working in customer dining and service areas are required to wear face coverings over their nose and mouth, such as using CDC Use of Cloth Face Coverings guidance.
- ✓ Use single-use disposable menus (e.g., paper) and discard after each customer. Reusable menus are not permitted in Phase 2. Refilling food and beverage containers or implements brought in by customers is not allowed in Phase 2.
- ✓ Prior to each shift, employers should ask that the employee self-measure their temperature and assess symptoms. Please see VDH Interim Guidance for Implementing Safety Practices for Critical Infrastructure Workers During Widespread Community Transmission.
- ✓ No self-service of food (except beverages), including condiments. Condiments must be removed from tables and dispensed by employees upon the request of a customer. Buffets must be staffed by servers. For self-service beverage areas, use beverage equipment designed to dispense by a contamination-free method.
- ✓ Perform thorough cleaning and disinfection of frequently contacted surfaces including digital ordering devices, check presenters, self-service areas, tabletops, bathroom surfaces, and other common touch areas every 60 minutes during operation. Tabletops and credit card/bill folders must be disinfected between patrons.

- ✓ Table resets must be done by an employee who has washed their hands with soap and water for at least 20 seconds just prior to reset activities.
- ✓ Patrons may wait for takeout or for seated dining in the lobby area, but they must maintain six feet of physical distance between parties.

BEST PRACTICES:

In addition to the requirements provided above, establishments are encouraged to utilize the following best practices to the extent they are feasible:

- ✓ Utilize reservations for dining on the premises.
- ✓ Use staff facilitated seating where appropriate. If seating is not staff facilitated and tables cannot be moved to meet the physical distancing requirements outlined above, tables that should not be used must be clearly marked that they are out of service.
- ✓ Assign employee(s) to monitor and clean high touch areas while in operation.
- ✓ Use technology solutions where possible to reduce person-to-person interaction, including mobile ordering and menu tablets, text on arrival for seating, and contactless payment options.
- ✓ Consider methods to make point of sale terminals safer, including use of no contact applications, placement of a glass or clear plastic barrier between the employee and the customer, and providing a hand sanitizer station for customer and employee use after handling credit/debit cards, PIN terminals, or exchange of cash.
- ✓ Servers should avoid touching items on tables while customers are seated. Dedicated staff should remove all items from the table when customer(s) leave.
- ✓ Consider scheduled closure periods throughout the day to allow for cleaning and disinfecting, including bathrooms (i.e., after lunch service).
- ✓ Use separate doors to enter and exit the establishment when possible.
- ✓ When protective equipment such as face coverings are used, launder daily and wash hands after touching/adjusting face covering while working.
- ✓ Single-use items should be discarded. Consider using rolled silverware and eliminating table presets.

- ✓ Consider installing touchless door and sink systems or providing single-use barriers (e.g., deli tissues, paper towels) for use when touching door and sink handles.
- ✓ Implement procedures to increase how often the back-of-house areas are cleaned and sanitized.

ADDITIONAL CONSIDERATIONS:

Take-out and Delivery providers are encouraged to utilize the following recommendations:

- ✓ Notify customers as the delivery is arriving by text message or phone call.
- ✓ Ensure transport containers are cleaned and sanitized between uses.
- ✓ Establish designated pick-up zones for customers, including separate entrances and exits where possible.
- ✓ Offer curb-side pick-up.
- ✓ Encourage cashless transactions where possible.
- ✓ Practice physical distancing by offering to place orders in vehicle trunks.
- ✓ Seal food packages to safeguard the integrity of contents.
- ✓ If an establishment uses a delivery service, implement a contactless pick-up option where drivers do not have to come into the restaurant.

Food Trucks/Mobile Units are encouraged to utilize the following recommendations:

- ✓ Provide signage and aids to help customers maintain six feet of distance while ordering or waiting for an order.
- ✓ Food and other items should not be returned after they are loaded onto the mobile unit.
- ✓ Schedule frequent cleaning and disinfecting of order pick-up areas and other commonly touched surfaces.

RESOURCES TO PRINT AND DISPLAY:

CDC Symptoms English

Spanish CDC Symptoms

CDC Printable Flyer English

CDC Printable Flyer Spanish

CDC Printable Flyer Chinese

CDC Printable Flyer Korean

CDC Printable Flyer Vietnamese

FDA information

What Grocery Store and Food Retail Workers Need to Know about COVID-19

CDC Re-Opening America Cleaning and Disinfecting Public Spaces, Workplaces, Businesses, Schools, and Homes

CDC What You Need to Know About Handwashing VIDEO

FARMERS MARKETS

PHASE 2: Establishments must either implement the following mandatory requirements or close.

MANDATORY REQUIREMENTS:

Businesses must strictly adhere to the physical distancing guidelines, enhanced cleaning and disinfection practices, and enhanced workplace safety practices provided in the "Guidelines for All Business Sectors" document. Virginia Department of Health and Virginia Department of Agriculture and Consumer Services regulated facilities must continue to follow requirements related to prohibiting sick employees in the workplace, strict handwashing practices, and procedures and practices to clean and sanitize surfaces.

During Phase 2, farmers markets should continue to offer order ahead and pickup options. If markets choose to open, they must adhere to the following additional requirements for outdoor service:

- ✓ Post signage at the entrance that states that no one with a fever or symptoms of COVID-19, or known exposure to a COVID-19 case in the prior 14 days, is permitted in the establishment or farmers market.
- ✓ Post signage to provide public health reminders regarding physical distancing, gatherings, options for high risk individuals, and staying home if sick (See samples at the bottom of this document).
- ✓ On-site shopping is allowed, as long as physical distancing guidelines are adhered to. Configure operations to avoid congestion or congregation points.
- ✓ Employees and vendors working at the farmers markets must wear face coverings over their nose and mouth, such as using CDC Use of Cloth Face Coverings guidance.
- ✓ Provide a minimum of six feet between parties at tables, (i.e., the six feet cannot include the space taken up by the seated guest). Spacing should also allow for physical distancing from areas outside of the facility's control (i.e. provide physical distancing from persons on public sidewalks).

- ✓ Provide hand sanitizer stations or hand washing stations for patrons and employees.
- ✓ Vendors must use enhanced cleaning and disinfecting practices to regularly clean and disinfect spaces and equipment.
- ✓ Vendors and employees handling money should wash their hands between each transaction.

BEST PRACTICES:

In addition to the requirements provided above, farmers markets are encouraged to utilize the following best practices to the extent they are feasible:

- ✓ Promote no touch or low touch purchasing opportunities by pre-boxing or pre-bagging food items.
- ✓ Update your website and social media with detailed instructions so patrons understand the expectations while at the market.
- ✓ Discourage vendor sampling.
- ✓ A mobile market could be used to reach communities with low food access but should comply with physical distancing guidelines for customers shopping and follow all recommended hygiene and sanitation protocols.
- ✓ Limit vendors to those selling food and horticultural products, or other handcrafted products critical for hygiene and sanitation such as handmade soaps and face coverings.
- ✓ Encourage touchless payment systems.

RESOURCES TO PRINT AND DISPLAY:

CDC Symptoms English

Spanish CDC Symptoms

CDC Printable Flyer English

CDC Printable Flyer Spanish

CDC Printable Flyer Chinese

CDC Printable Flyer Korean

CDC Printable Flyer Vietnamese

FDA information

What Grocery Store and Food Retail Workers Need to Know about COVID-19

CDC Re-Opening America Cleaning and Disinfecting Public Spaces, Workplaces, Businesses, Schools, and Homes

CDC What You Need to Know About Handwashing VIDEO

SAFER AT HOME: PHASE TWO

BRICK AND MORTAR RETAIL

SCOPE: All non-essential brick and mortar retail establishments.

PHASE 2: Establishments must either implement the following mandatory requirements or close.

MANDATORY REQUIREMENTS:

Businesses must strictly adhere to the physical distancing guidelines, enhanced cleaning and disinfection practices, and enhanced workplace safety practices provided in the "Guidelines for All Business Sectors" document. They must also adhere to the following additional requirements:

- ✓ Post signage at the entrance that states that no one with a fever or symptoms of COVID-19, or known exposure to a COVID-19 case in the prior 14 days, is permitted in the establishment.
- ✓ Post signage to provide public health reminders regarding physical distancing, gatherings, options for high risk individuals, and staying home if sick (samples at bottom of this document).
- ✓ Retailers must limit occupancy to 50% of the lowest occupancy load on the certificate of occupancy.
- ✓ Retailers must assist customers in keeping at least six feet of space between individuals or households while shopping and waiting in line. Mark floors in six-foot increments in areas where customers will be congregating or standing in line such as cashier areas. If six feet of space cannot be maintained between checkout lines, only operate alternate checkout lines.
- ✓ If seating is available, provide a minimum of six feet between tables; if tables are not movable, parties must be spaced at least six feet apart.
- ✓ Meeting rooms and other enclosed spaces such as fitting rooms should be closed to customers.

- ✓ Employees working in customer-facing areas are required to wear face coverings over their nose and mouth, such as using CDC Use of Cloth Face Coverings guidance.
- ✓ Perform a thorough cleaning and disinfection of frequently contacted surfaces including digital ordering devices, self-service areas, countertops, bathroom surfaces, cashier stations, belts, shelves, cash machine pads, keyboards, order separation bars, and other high touch surfaces, at a minimum, every 2 hours.
- ✓ Eliminate stations where food or drink can be sampled. No self-service of food (except beverages), including condiments. Self-service beverage areas must use beverage equipment designed to dispense through a contamination-free method.
- ✓ Ensure there is a way to sanitize shopping cart and basket handles: either make an EPA-approved disinfectant easily accessible to customers or have employees manage the process and sanitize between each customer use.

BEST PRACTICES:

In addition to the requirements provided above, establishments are encouraged to utilize the following best practices to the extent they are feasible:

- ✓ Provide sanitizing stations for customers and staff throughout the store, particularly at entry and exit points.
- ✓ Consider managing customer movement utilizing one-way aisles or other directional instructions.
- ✓ Consider reserving certain hours for senior citizens and other high-risk populations.
- ✓ Provide opportunities to shop and pay online or on the phone whenever possible.
- ✓ Provide options for home delivery, in store pickup, or curbside pickup whenever possible to minimize the number of customers in facilities.
- ✓ When protective equipment such as face coverings are used, launder daily and wash hands after touching/adjusting face covering while working.
- ✓ Use separate doors to enter and exit the establishment when possible.
- ✓ Consider installing touchless door and sink systems or providing single-use barriers (e.g., deli tissues, paper towels) for use in touching door and sink handles.

- ✓ Consider using a reservation system to schedule customer visits, including asking customers to set up a time to visit the showroom or sales floor to limit the number of customers in a facility.
- ✓ Prohibit congregating in break rooms or common areas and limit the capacity of such areas to allow for safe physical distancing of a minimum of six feet whenever possible.
- ✓ If reusable shopping bags are permitted, ask customers to bag their own products/groceries.

RESOURCES TO PRINT AND DISPLAY:

CDC Symptoms English

Spanish CDC Symptoms

CDC Printable Flyer English

CDC Printable Flyer Spanish

CDC Printable Flyer Chinese

CDC Printable Flyer Korean

CDC Printable Flyer Vietnamese

FDA information

What Grocery Store and Food Retail Workers Need to Know about COVID-19

FITNESS AND EXERCISE FACILITIES

SCOPE: Gymnasiums, recreation centers, sports facilities, and exercise facilities.

PHASE 2: Establishments must either implement the following mandatory requirements or close.

MANDATORY REQUIREMENTS:

Businesses must strictly adhere to the physical distancing guidelines, enhanced cleaning and disinfection practices, and enhanced workplace safety practices provided in the "Guidelines for All Business Sectors" document. If businesses choose to offer fitness and exercise services, they must adhere to the following additional requirements for operations:

- ✓ Post signage at the entrance that states that no one with a fever or symptoms of COVID-19, or known exposure to a COVID-19 case in the prior 14 days, is permitted in the establishment.
- ✓ Post signage to provide public health reminders regarding physical distancing, gatherings, options for high risk individuals, and staying home if sick (samples at bottom of this document).
- ✓ Occupancy must be limited to no more than 30% of the lowest occupancy load on the certificate of occupancy, if applicable, while maintaining a minimum of ten feet of physical distancing between all individuals as much as possible.
- ✓ Facilities should separate fitness equipment to ensure ten feet of separation between patrons, members, and guests using such equipment.
- ✓ Facilities should screen patrons for COVID-19 symptoms prior to admission to the facility. Patrons should be asked if they are currently experiencing fever (100.4 degrees Fahrenheit or higher) or a sense of having a fever, a new cough that cannot be attributed to another health condition, new shortness of breath that cannot be attributed to another health condition, new chills that cannot be attributed to another health condition, a new sore throat that cannot be attributed to another health condition, or new muscle aches that cannot be attributed to another health condition or specific activity (such as physical exercise). Anyone experiencing symptoms should

not be permitted in the facility. Screenings should be conducted in accordance with applicable privacy and confidentiality laws and regulations.

- ✓ Instructors and all participants of group exercise and fitness classes must maintain at least ten feet of physical distancing between each other at all times.
- ✓ The total number of attendees (including both participants and instructors) in all group exercise and fitness classes cannot exceed the lesser of 30% of the minimum occupancy load on the certificate of occupancy or 50 persons.
- ✓ Personal trainers must maintain at least ten feet of distance between themselves and their clients.
- ✓ Employees working in customer-facing areas are required to wear face coverings over their nose and mouth, such as using CDC Use of Cloth Face Coverings guidance. Lifeguards responding to distressed swimmers are exempt from this requirement.
- ✓ Provide hand sanitizing stations, including at the entrance/exit and where shared fitness equipment is utilized.
- ✓ Employers must ensure cleaning and disinfection of shared equipment after each use.
- ✓ Facilities must prohibit the use of any equipment that cannot be thoroughly disinfected between uses (e.g., climbing rope, exercise bands, etc.). Facilities must also prohibit the use of equipment requiring more than one person to operate, unless those operating are from the same household (e.g., free weights when it requires a spotter).
- ✓ Hot tubs, spas, saunas, splash pads, spray pools, and interactive play features must be closed. Basketball courts and racquetball courts may operate provided patrons maintain ten feet of physical distancing while utilizing such courts. Swimming pools may operate in accordance with the Guidelines for Swimming Pools.

BEST PRACTICES:

In addition to the requirements provided above, establishments are encouraged to utilize the following best practices to the extent they are feasible:

- ✓ When protective equipment such as face coverings are used, launder daily and wash hands after touching/adjusting face covering while working.

- ✓ Use disposable towels and linens where possible. All reusable towels, linens and other porous fabric should be laundered after single use. Store towels and linens in a closed, covered container prior to use.

RESOURCES TO PRINT AND DISPLAY:

CDC Symptoms English

Spanish CDC Symptoms

CDC Printable Flyer English

CDC Printable Flyer Spanish

CDC Printable Flyer Chinese

CDC Printable Flyer Korean

CDC Printable Flyer Vietnamese

FDA information

SWIMMING POOLS

SCOPE: Indoor and outdoor swimming pools.

PHASE 2: Establishments must either implement the following mandatory requirements or remain closed.

MANDATORY REQUIREMENTS:

Businesses must strictly adhere to the physical distancing guidelines, enhanced cleaning and disinfection practices, and enhanced workplace safety practices provided in the "Guidelines for All Business Sectors" document. If businesses choose to offer fitness and exercise services, they must adhere to the following additional requirements for outdoor operations:

- ✓ Post signage at the entrance that states that no one with a fever or symptoms of COVID-19, or known exposure to a COVID-19 case in the prior 14 days, is permitted in the establishment.
- ✓ Post signage to provide public health reminders regarding physical distancing, gatherings, options for high risk individuals, and staying home if sick (samples at bottom of this document).
- ✓ Hot tubs, spas, saunas, splash pads, spray pools, and interactive play features must be closed.
- ✓ Indoor and outdoor swimming pools may be open for lap swimming, diving, exercise, and instruction only.
- ✓ Lap swimming must be limited to three persons per lane with ten feet of physical distance per swimmer.
- ✓ Diving areas must be limited to three persons per diving area with ten feet of physical distance per diver.
- ✓ Swimming instruction and water exercise classes must be limited to allow all participants to maintain ten feet of physical distance at all times.
- ✓ Seating may be provided on pool decks with at least ten feet of spacing between persons who are not members of the same household.

- ✓ All seating (including lifeguard stations) must be cleaned and disinfected between uses.
- ✓ Employees working in customer-facing areas are required to wear face coverings over their nose and mouth, such as using CDC Use of Cloth Face Coverings guidance. Lifeguards responding to distressed swimmers are exempt from this requirement.
- ✓ Provide hand sanitizing stations, including at the entrance/exit and where shared equipment is utilized.
- ✓ Facilities should screen patrons for COVID-19 symptoms prior to admission to the facility. Patrons should be asked if they are currently experiencing fever (100.4 degrees Fahrenheit or higher) or a sense of having a fever, a new cough that cannot be attributed to another health condition, new shortness of breath that cannot be attributed to another health condition, new chills that cannot be attributed to another health condition, a new sore throat that cannot be attributed to another health condition, or new muscle aches that cannot be attributed to another health condition or specific activity (such as physical exercise). Anyone experiencing symptoms should not be permitted in the facility. Screenings should be conducted in accordance with applicable privacy and confidentiality laws and regulations.

RESOURCES TO PRINT AND DISPLAY:

- ✓ CDC Symptoms English
- ✓ CDC Printable Flyer English
- ✓ CDC Printable Flyer Chinese
- ✓ CDC Printable Flyer Vietnamese

Spanish CDC Symptoms
CDC Printable Flyer Spanish
CDC Printable Flyer Korean
FDA information

RECREATIONAL SPORTS

SCOPE: Indoor and outdoor recreational sports activities

PHASE 2: Recreational sports activities must either implement the following mandatory requirements or must not take place.

MANDATORY REQUIREMENTS:

Participants and organizers of recreational sports activities must strictly adhere to the physical distancing guidelines, enhanced cleaning and disinfection practices, and enhanced workplace safety practices provided in the "Guidelines for All Business Sectors" document. Participants and organizers of recreational sports activities must adhere to the following additional requirements for such activities:

- ✓ Post signage at the entrance that states that no one with a fever or symptoms of COVID-19, or known exposure to a COVID-19 case in the prior 14 days, is permitted in the establishment.
- ✓ Post signage to provide public health reminders regarding physical distancing, gatherings, options for high risk individuals, and staying home if sick (samples at bottom of this document).
- ✓ Indoor and outdoor recreational sports may occur if ten feet of physical distance can be maintained by all instructors, participants, and spectators, with the exception of incidental contact or contact between members of the same household. This applies during instruction and practice and during competitive events. Competition that involves close contact with other athletes must be avoided.
- ✓ The total number of attendees (including both participants and spectators) of outdoor recreational sports cannot exceed the lesser of 50% of the occupancy load on the certificate of occupancy, if applicable, or 50 persons.
- ✓ The total number of attendees for indoor recreational sports cannot exceed the lesser of 30% of the lowest occupancy load on the certificate of occupancy or 50 persons. For indoor recreational sports, spectators may not be present except parents, guardians, or caretakers who are supervising children.

- ✓ Ensure anyone who has symptoms of, has tested positive for, or has been exposed to COVID-19 follows appropriate guidelines for quarantine or isolation. Persons with symptoms should stay home until CDC criteria for ending isolation have been met. Persons with severe symptoms may need to be evaluated by a healthcare provider. Establish procedures for safely transporting anyone who is sick to their home or to a healthcare facility. If you are calling an ambulance or bringing someone to the hospital, try to call first to alert them that the person may have COVID-19.

- ✓ Conduct daily screening of coaches, officials, staff, and players for COVID-19 symptoms prior to admission to the venue/facility. Children should be screened per the CDC guidance for screening children. Adults should be asked if they are currently experiencing fever (100.4o or higher) or a sense of having a fever, a new cough that cannot be attributed to another health condition, new shortness of breath that cannot be attributed to another health condition, new chills that cannot be attributed to another health condition, a new sore throat that cannot be attributed to another health condition, or new muscle aches that cannot be attributed to another health condition or specific activity (such as physical exercise). Anyone experiencing symptoms should not be permitted in the venue/establishment. Screenings should be conducted in accordance with applicable privacy and confidentiality laws and regulations.

- ✓ All shared items must be disinfected between each use to the extent practicable.

RESOURCES TO PRINT AND DISPLAY:

- ✓ CDC Symptoms English
- ✓ CDC Printable Flyer English
- ✓ CDC Printable Flyer Chinese
- ✓ CDC Printable Flyer Vietnamese

Spanish CDC Symptoms
CDC Printable Flyer Spanish
CDC Printable Flyer Korean
FDA information

PERSONAL CARE AND PERSONAL GROOMING SERVICES

SCOPE: Beauty salons, barbershops, spas, massage centers, tanning salons, tattoo shops, and any other location where personal care or personal grooming services are performed.

PHASE 2: Establishments must either implement the following mandatory requirements or remain closed.

MANDATORY REQUIREMENTS:

Businesses must strictly adhere to the physical distancing guidelines, enhanced cleaning and disinfection practices, and enhanced workplace safety practices provided in the "Guidelines for All Business Sectors" document. They must also adhere to the following additional requirements:

- ✓ Post signage at the entrance that states that no one with a fever or symptoms of COVID-19, or known exposure to a COVID-19 case in the prior 14 days, is permitted in the establishment.
- ✓ Post signage to provide public health reminders regarding physical distancing, gatherings, options for high-risk individuals, and staying home if sick (samples at bottom of this document).
- ✓ Occupancy may not exceed 50% of the lowest occupancy load on the certificate of occupancy with at least six feet of physical distancing between work stations.
- ✓ Services must be provided by appointment only, with no more than two appointments per service provider at a time.
- ✓ Stagger stations with at least six feet of separation.
- ✓ Maintain physical distancing between clients of at least six feet within the waiting area.
- ✓ Staggered appointments must be utilized to minimize the number of individuals congregating in a waiting area and allow time to disinfect work stations and tools in between clients.

- ✓ Employees and service providers working in customer-facing areas are required to wear face coverings over their nose and mouth, such as using CDC Use of Cloth Face Coverings guidance.
- ✓ Provide face coverings for clients or ask that clients bring a face covering with them that they must wear during the service. Limit services to only those that can be completed without clients removing their face covering.
- ✓ Wash hands with soap and water for at least 20 seconds after each service is performed, and, when gloves are worn, change gloves after each client's service.
- ✓ Perform thorough cleaning and disinfection of frequently contacted surfaces every 60 minutes; clean and disinfect all personal care and personal grooming tools after every use or discard.
- ✓ Employers must maintain a list of the names and contact information for all clients, to include the date and time services are received.

BEST PRACTICES:

In addition to the requirements provided above, establishments are encouraged to utilize the following best practices to the extent they are feasible:

- ✓ Provide hand sanitizer at the reception area and all stations for employee and client use.
- ✓ Remove commonly touched non-essential items such as magazines, self-serve coffee, and candy jars.
- ✓ Where possible use disposable towels, capes, and linens. All reusable towels, capes, linens and other porous fabric should be laundered after single use. Non-porous capes (e.g., plastic, vinyl) should be cleaned and disinfected after single use or discarded. Towels, capes, and linens should be stored in a closed, covered container prior to use.
- ✓ When capes are used on clients, use a freshly laundered or disposable cape for each client.
- ✓ Minimize to the greatest degree possible close, direct face-to-face contact with clients, such as allowing clients to be seated prior to approaching to perform a service.

- ✓ When protective equipment such as face coverings are used, launder daily and wash hands after touching/adjusting face covering while working.
- ✓ Use separate doors to enter and exit the establishment when possible.
- ✓ Consider installing touchless door and sink systems or providing single-use barriers (e.g., deli tissues, paper towels) for use in touching door and sink handles.
- ✓ Consider limiting the maximum time of services (e.g., no more than 1 hour).

RESOURCES TO PRINT AND DISPLAY:

CDC Symptoms English

CDC Symptoms Spanish

CDC Printable Flyer English

CDC Printable Flyer Spanish

CDC Printable Flyer Chinese

CDC Printable Flyer Korean

CDC Printable Flyer Vietnamese

FDA information

SAFER AT HOME: PHASE TWO

CAMPGROUNDS AND OVERNIGHT SUMMER CAMPS

SCOPE: Private campgrounds and overnight summer camps.

PHASE 2: Private campgrounds must either implement the following mandatory requirements or close. Overnight summer camps must remain closed in Phase 2.

MANDATORY REQUIREMENTS:

Businesses must strictly adhere to the physical distancing guidelines, enhanced cleaning and disinfection practices, and enhanced workplace safety practices provided in the "Guidelines for All Business Sectors" document. They must also adhere to the following additional requirements:

- ✓ Post signage at the entrance that states that no one with a fever or symptoms of COVID-19, or known exposure to a COVID-19 case in their prior 14 days, is permitted in the establishment.
- ✓ Post signage to provide public health reminders regarding physical distancing, gatherings, options for high risk individuals, and staying home if sick (samples at bottom of this document).
- ✓ All lots rented for short term stays of less than 14 nights (and not owned by individuals) must maintain a minimum of 20 feet between units.
- ✓ No physical sharing of recreation or sports equipment unless it is cleaned and disinfected with an EPA-approved disinfectant.
- ✓ No gatherings of greater than 50 people in one location.
- ✓ On site retail, recreation and fitness, cabins, and food establishments must follow the requirements and guidelines specific to those establishments.
- ✓ Employees working in customer-facing areas are required to wear face coverings over their nose and mouth, such as using CDC Use of Cloth Face Coverings guidance.
- ✓ Provide hand washing in bath houses or sanitizing stations for guests and employees.

- ✓ It is recommended that campgrounds must strongly encourage customers to wear face coverings over their nose and mouth.

RESOURCES TO PRINT AND DISPLAY:

CDC Symptoms English

CDC Symptoms Spanish

CDC Printable Flyer English

CDC Printable Flyer Spanish

CDC Printable Flyer Chinese

CDC Printable Flyer Korean

CDC Printable Flyer Vietnamese

FDA information

ENTERTAINMENT AND PUBLIC AMUSEMENT

SCOPE: Outdoor performing arts venues, outdoor concert venues, outdoor movie theaters, drive-in entertainment, outdoor sports venues, museums, botanical gardens, aquariums, zoos, and public and private social clubs.

PHASE 2: Outdoor performing arts venues, outdoor concert venues, outdoor sports venues, outdoor movie theaters, museums, botanical gardens, aquariums, zoos, and public and private social clubs must either implement the following mandatory requirements or closed.

The indoor locations of all theaters, performing arts centers, concert venues, sports venues (except for recreational sports at such facilities), and other indoor entertainment centers must remain closed to the public in Phase 2.

Historic horse racing facilities, bowling alleys, skating rinks (except for recreational sports at such facilities), arcades, amusement parks, trampoline parks, fairs, carnivals, arts and craft facilities, escape rooms, trampoline parks, and all other places of indoor public amusement must remain closed to the public in Phase 2.

MANDATORY REQUIREMENTS:

Businesses must strictly adhere to the physical distancing guidelines, enhanced cleaning and disinfection practices, and enhanced workplace safety practices provided in the "Guidelines for All Business Sectors" document. They must also adhere to the following additional requirements:

- ✓ Post signage at the entrance that states that no one with a fever or symptoms of COVID-19, or known exposure to a COVID-19 case in their prior 14 days, is permitted in the establishment.

- ✓ Post signage to provide public health reminders regarding physical distancing, gatherings, options for high risk individuals, and staying home if sick (samples at bottom of this document).
- ✓ Create a guest flow plan of modified queue lines to and within the facility. Determine areas likely to become bottlenecks or pinch points and adjust guest flow accordingly.
- ✓ Install visible markers for queue lines that separate people by six feet of physical distance. Sample markers are available in the VDH Business Toolkit.
- ✓ Create and display physical distancing communication tools, including static signs, kiosks, audio announcements, or video announcements. Signage should include the requirement to wear face coverings at all times and to maintain six feet of physical distance between people who do not reside in the same household. Sample signage is available in the VDH Business Toolkit.
- ✓ Reconfigure seating areas to allow six feet of physical distance between individuals by eliminating and closing select tables or seating areas, or by spreading them out to allow for adequate spacing.
- ✓ Ensure facility exits are configured to reduce the occurrence of bottlenecks and large gatherings.
- ✓ Where possible, install sneeze guards in front of commonly used point-of-sale or guest service stations.
- ✓ On site retail, recreation and fitness, cabins, and food establishments must follow the requirements and guidelines specific to those establishments.
- ✓ Employees working in customer-facing areas are required to wear face coverings over their nose and mouth, such as using CDC Use of Cloth Face Coverings guidance.
- ✓ Provide hand washing or sanitizing stations for guests and employees.

ADDITIONAL MANDATORY REQUIREMENTS:

OUTDOOR PERFORMING ARTS, OUTDOOR CONCERT VENUES, AND OUTDOOR MOVIE THEATERS (EXCLUDING DRIVE-IN ENTERTAINMENT):

- Ten feet of physical distance must be maintained between all performers, participants, and patrons who are not members of the same household.
- Occupancy cannot not exceed the lesser of 50% of the lowest occupancy load on the certificate of occupancy, if applicable, or 50 patrons.
- All shared items must be cleaned and disinfected between uses.

DRIVE-IN ENTERTAINMENT:

- Properly permitted businesses may operate a drive-in model.
- Participants must remain in their vehicle at all times, except as necessary to visit a restroom.
- All vehicles must be parked to ensure at least six feet of physical distance between all patrons. Lowering of vehicle windows is permitted.
- Limit interaction between employees and patrons as much as possible.
- Any equipment used by patrons must be cleaned and disinfected between each use with an EPA-approved disinfectant.

OUTDOOR PROFESSIONAL SPORTS:

- All participants and patrons must maintain ten feet of physical distance, with the exception of incidental contact or contact between members of the same household.
- All shared items must be disinfected between uses.
- If open to spectators, the total number of patrons and spectators cannot exceed the lesser of 50% of the lowest occupancy load on the certificate of occupancy or 50 persons.
- If not open to spectators, attendees may only participate as part of their employment.

MUSEUMS, BOTANICAL GARDENS, AQUARIUMS, ZOOS, AND PUBLIC AND PRIVATE SOCIAL CLUBS:

- Occupancy must be limited to no more than 50% of the lowest occupancy load on the certificate of occupancy.
- Public and private social clubs cannot exceed the lesser of 50% of the occupancy load on the certificate of occupancy, if applicable, or 50 persons.
- Remove or deactivate all shared objects and interactive exhibits/events to discourage congregating and reduce contact with high-touch surfaces.

- Outdoor queue lines should follow physical distancing guidelines, allowing for six feet of separation between persons who are not members of the same household.

WALKING OR MOTORIZED GROUP TOURS:

- Reduce walking tour group sizes to maintain six feet of physical distance between all individuals who are not members of the same household. Walking tours must be limited to no more than ten persons (including the guide and customers) per tour.
- Require all customers to sign a waiver (online, if possible) that states they are healthy and have not exhibited any signs of illness (COVID-19) in the last 14 days. Customers should be asked if they are currently experiencing fever (100.4o or higher) or a sense of having a fever, a new cough that cannot be attributed to another health condition, new shortness of breath that cannot be attributed to another health condition, new chills that cannot be attributed to another health condition, a new sore throat that cannot be attributed to another health condition, or new muscle aches that cannot be attributed to another health condition or specific activity (such as physical exercise). Anyone experiencing symptoms should not be permitted to attend a tour.
- Shared equipment (e.g., Segways) must be cleaned and disinfected between uses.

BEST PRACTICES:

In addition to the requirements provided above, establishments are encouraged to utilize the following best practices to the extent they are feasible:

- ✓ Practice routine cleaning and disinfection of high contact areas and hard surfaces, including check out stations and payment pads, store entrance push/pull pads, door knobs/handles, dining tables/chairs, light switches, handrails, restrooms, guest lockers, floors, and equipment. Follow CDC Reopening Guidance for Cleaning and Disinfection and use an EPA-approved disinfectant to clean. For high contact areas (e.g., in both public and staff areas), routinely disinfect surfaces at least every 2 hours. Certain surfaces and objects in public spaces, such as point of sale keypads, should be cleaned and disinfected before each use.

- ✓ Sanitizing wipes should be made available throughout the facility for guests to use on high-touch surfaces.

- ✓ Determine appropriate guest capacity levels for each facility to ensure compliance with physical distancing requirements, taking into account facility size, layout, and operational needs.
- ✓ Employers should remain cognizant of the potential for outdoor staff to experience overheating or breathing difficulties caused by using facial coverings. When developing staff schedules, implement additional short breaks to increase the frequency with which staff can cool off indoors.

RESOURCES TO PRINT AND DISPLAY:

CDC Symptoms English

CDC Symptoms Spanish

CDC Printable Flyer English

CDC Printable Flyer Spanish

CDC Printable Flyer Chinese

CDC Printable Flyer Korean

CDC Printable Flyer Vietnamese

FDA information

RELIGIOUS SERVICES

SCOPE: Religious services.

PHASE 2: Religious services must be conducted according to the following requirements.

Given the public health implications of the 2020 global pandemic, the Commonwealth's diverse faith community quickly adjusted in response to this unprecedented crisis.

Therefore, it is important that the diverse faith communities in Virginia stay informed with local, state, and national officials using the links below:

CDC's main COVID-19 Web page: https://www.cdc.gov/coronavirus/2019-ncov/index.html

Virginia Department of Health COVID-19 Web page: http://www.vdh.virginia.gov/coronavirus/

Virginia Governor's COVID-19 Web page: https://www.virginia.gov/coronavirus/

MANDATORY REQUIREMENTS:

Religious services must strictly adhere to the following requirements:

- ✓ Occupancy shall be limited to no more than 50% of the lowest occupancy load on the certificate of occupancy of the room or facility in which the religious services are conducted.
- ✓ Individuals attending religious services must be seated at least six feet apart at all times and must practice physical distancing at all times. Family members, as defined in Executive Order 61, Order of Public Health Emergency Three, may be seated together. Mark seating in six-foot increments.
- ✓ Attendees shall not pass items to other attendees, who are not family members, as defined above.
- ✓ Any items used to distribute food or beverages must be disposable and used only once and discarded.

- ✓ A thorough cleaning and disinfection of frequently contacted surfaces must be conducted prior to and following any religious Post signage at the entrance that states that no one with a fever or symptoms of COVID-19, or known exposure to a COVID-19 case in the prior 14 days, is permitted in the establishment.

- ✓ Post signage to provide public health reminders regarding social distancing, gatherings, options for high risk individuals, and staying home if sick (samples at the bottom of this document).

- ✓ If any place of worship cannot adhere to the above requirements, it must not conduct in-person services.

BEST PRACTICES: In addition to the requirements provided above, faith communities are encouraged to utilize the following best practices to the extent they are feasible:

- ✓ Designate a health coordinator and/or health equity team who will be responsible for COVID-19 planning and preparation for your place of worship.

- ✓ *For the **building**:*

    - Conduct thorough cleaning before and between services.

    - Use separate doors to enter and exit the establishment when possible.

    - Allow interior doors to remain open to limit touching of door handles.

    - Provide sanitizing stations throughout the building, particularly at entry and exit points.

    - Consider installing touchless door entry systems or providing single-use barriers (i.e., paper towels) for use in touching door and sink handles in bathroom facilities.

    - Use messaging boards or digital messaging and social media for announcements to eliminate use of bulletins and handouts.

- ✓ *For weekly **religious services**:*

    - Members are safer at home. Continue to provide and encourage use of online streaming and drive-in options for people who can utilize these options. No

place of worship should feel obligated to return to in-person worship before they are ready to do so.

- Consider holding multiple services, with time for thorough cleaning in between each service, to allow for greater distancing during services.
- Suspend the choir as part of services.
- Consider shorter services to avoid the need for people to use bathroom facilities.
- Consider limiting or suspending youth services until a safer time.
- Consider holding small group or separate services for senior citizens and other high-risk populations.
    - Consider making this the first service of the week, after thorough cleaning and disinfection of facilities have been performed.
    - Ensure social distancing in parking lots or common areas.

✓ Consider discontinuing use of common items (e.g., microphones, books, hymnals, scriptural texts) that may be shared between people and are difficult to clean. Consider assigning religious books to a family or individual that they can bring to each service, or use a projector for the display of sacred texts, scriptures, and songs.

✓ When oils, water, ashes, or other materials are applied to a person's forehead, self-application should be used, to the extent possible.

✓ Discontinue shared meals and other activities where people may gather in groups (e.g., limit or suspend coffee stations, shared food, meet and greet time before and after services etc.), with the exception of essential food services for low-income residents.

✓ *Possible methods for religious services:*

1. **Drive-in/parking lot church:** This is the safer model of religious service where social distancing may be maintained.
2. **Sign-up worship services:** This will limit the number of live worship services. Ask members, visitors, or guests to sign up for one live service per month, or every other week. If needed, members can take turns between online and in-person

worship services during this interim time. Allow space for impromptu visitors by registering fewer people (for each worship or religious service) than the maximum allowed per the occupancy restrictions.

3. **Multiple gatherings during the week:** A place of worship may divide the number of congregants by the maximum occupancy level and offer worship services at that level. Consider adding online services, multiple services on one day, or alternative services during the week and/or on Saturdays and Sundays.

4. **Utilize multiple methods:** As a result of the COVID-19 crisis, most places of worship lost the ability to gather in-person, but many gained a stronger online presence. Consider nurturing both aspects for at-risk individuals, as well as for the increased capacity to reach and serve those outside of the walls of the faith organization.

5. **Adult-only services:** This method asks parents of young children to alternate worship attendance (naturally reducing attendance, as one parent stays home with children).

6. **Online-only:** Take this approach if you are in a high-risk area, your place of worship is not yet prepared with the conditions outlined in the state guidelines for opening, you or a member of your family has COVID-19 symptoms, or the governing authorities have requested additional measures in the interest of public health.

COMMUNICATION RESOURCES:

Members and leaders of the diverse faith communities and funeral homes around the Commonwealth can receive a signage tool-kit and register to receive updated information from the Governor's Office of Diversity and Partners in Prayer and Prevention from the Virginia Department of Health by contacting DEIDirector@governor.virginia.gov or OHE@vdh.virginia.gov

RESOURCES TO PRINT AND DISPLAY:

CDC Symptoms English

CDC Symptoms Spanish

CDC Printable Flyer English

CDC Printable Flyer Spanish

CDC Printable Flyer Chinese

CDC Printable Flyer Korean

CDC Printable Flyer Vietnamese

FDA information

MARYLAND **STRONG**

ROADMAP TO RECOVERY

RELEASED APRIL 24, 2020

GOVERNOR
LARRY HOGAN

MARYLAND STRONG: ROADMAP TO RECOVERY

STAGE ONE

ADDITIONAL REOPENINGS EFFECTIVE FRIDAY, MAY 29 AT 5 PM

Outdoor dining at restaurants and social clubs will be permitted with strong safety protocols in place.

Other activities include outdoor pools with limited capacity and drive-in movie theaters.

Outdoor youth sports & outdoor activities at youth day camps may resume with safety protocols in place.

Marylanders must continue to practice physical distancing and wear masks in indoor public areas.

Jurisdictions are empowered to make decisions regarding the timing of Stage One reopenings.

READ THE ROADMAP: GOVERNOR.MARYLAND.GOV/RECOVERY
FIND HEALTH RESOURCES: CORONAVIRUS.MARYLAND.GOV

VIII. OUR ROADMAP TO RECOVERY

1. The **Maryland Strong Roadmap to Recovery** is divided into three stages:

    a. **Low Risk**
    b. **Medium Risk**
    c. **High Risk**

2. These stages are broad in character and contemplate being multi-phased within each stage. These sub-phases will be announced when the Governor determines gating benchmarks for the safe rollout of additional openings exist. Changes will necessarily be made to the plan throughout the implementation, in a safe manner, as warranted by public health and economic conditions.

3. The Roadmap contemplates offering some flexibility to health officers of county and municipal governments, and considering regional differences in COVID conditions, but within the parameters set forth by the Governor and his Administration for each stage and particular sub-phase.

    a. In each stage, the State will evaluate which localities meet appropriate gating criteria based upon COVID+ rate in the jurisdiction and/or region.

    b. In the event a locality has satisfied the gating criteria, county health officers will be permitted to expand the permitted activities and businesses under parameters of the current stage identified by the State. Note: the Roadmap also contemplates that county health officers may order local businesses and gathering places to restrict service or close if deemed to be operating in a manner dangerous to the public health, regardless of whether said business falls within a category generally opened statewide.

4. The Low/Medium/High delineation divides activities and businesses into categories designated by the AEI's *Guidance for Governors* report (and as adopted in the NGA's *Roadmap to Recovery: A Public Health Guide for Governors*) as having Medium or High "Modification Potential" to mitigate the risk of infection to protect individuals, and Low or Medium "Number of Contacts" or "Contact Intensity." Copies of both the AEI and NGA reports are incorporated herein as general guidance as appendices to this Roadmap.

5. The Governor will receive industry-specific input on an ongoing basis from the Commerce Secretary's various Industry Recovery Advisory Groups, the religious institution advisory group, the nonprofit advisory group, and from his own team of medical, business and economic experts.

6. The Governor will continue consulting with the State Superintendent of Schools, as well as area school superintendents, to evaluate the safe use of educational and child care facilities throughout Maryland.

7. As stated above, the Roadmap expects that people currently teleworking shall continue to telework for the duration of the State of Emergency. The Roadmap also expects that physical distancing and masking requirements shall continue until the lifting of the State of Emergency

8. Low, Middle and High Risk stages:

A. LOW RISK

This is the first stage of the recovery, and involves business, community, religious, and quality of life improvements. Once the Governor determines that Maryland has a sufficient foundation using the Building Blocks and other benchmark metrics, the Governor will announce that Maryland is moving to this initial recovery stage.

The decisions on what "Low Risk" activities can resume will not be announced in whole as one package, but rather as a phased rollout over a period of time using the White House's recommended gating protocols.

While these first steps might feel slow, they are being made both with the input of business and medical leaders, and also designed to make sure that we are not recklessly exposing Marylanders to undue risk. These initial steps will focus on the broad category of "quality of life" improvements and will involve the lifting of the Governor's "Stay at Home" Order (and transitioning to encouraging a voluntary "Safer-at-Home" guidance).

It is important for Marylanders to realize that these lists are non-exclusive, and subject to change depending upon COVID conditions in the state.

1. Beyond lifting the "Stay-Home" Order, other examples of changes that could be implemented in this stage:
    a. Small shops and certain small businesses
    b. Curbside pickup and drop-off for businesses
    c. Elective medical and dental procedures at ambulatory, outpatient, and medical offices
    d. Limited attendance outdoor religious gatherings
    e. Recreational boating, fishing, golf, tennis, hiking, and hunting
    f. Car washes
    g. Limited outdoor gym and fitness classes
    h. Outdoor work with appropriate distancing measures
    i. Some personal services

2. "Stop Signs"[40] requiring the easing to slow, stop, or even be reversed:
    a. An unexpected increase in hospitalizations or a sustained increase in cases requiring intensive care.[41]
    b. Indications that Marylanders are disregarding physical distancing guidelines. If people can maintain physical distancing for this period while we ramp-up testing and contact tracing, we have a much higher chance to open without a spike in cases.
    c. Significant outbreaks of community transmission (not clusters or outbreaks in particular nursing homes or vulnerable communities) where contact tracing cannot establish the route of the spread. A sustained increase in cases over a period of five or more days may require the reimposition of some prior restrictions.[42]

B. MEDIUM RISK

This will likely be a longer stage of the initial recovery, but will also be the stage when a large number of businesses and activities come back online. Any businesses that reopen during this period will need to comply with strict physical distancing and appropriate masking requirements. The stage includes numerous steps over many weeks towards recovery.

[40] Note: The "Stop Signs" are applicable throughout all phases of the recovery roadmap.
[41] Three days of current COVID hospitalization rate percentage increases over the seven-day rolling average of current hospitalizations.
[42] AEI, *Roadmap*, at 7-8.

CORONAVIRUS

(COVID-19)

Situational Update

Wednesday, May 27, 2020

CORONAVIRUS.DC.GOV

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

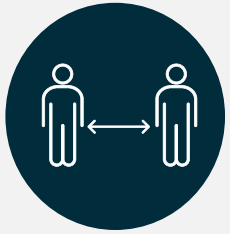
On Friday, May 29, 2020, the District's Stay-at-Home Order will be lifted.

The Public Health Emergency is still in effect and gatherings of more than 10 people are still prohibited.

Our Shared Responsibility. Our Special Responsibility.

As we begin a phased reopening,

masks



social distancing

frequent handwashing

will be critical for keeping our community safe.

We have a **shared responsibility** to do all that we can to stop the spread of the coronavirus.

We also have a **special responsibility** to protect those who are vulnerable because of age, underlying conditions, or health disparities.

Retail

Nonessential retail businesses can operate with:

- **Curbside** or **front door pickup** by customers for items ordered online or over the phone
- **Delivery of items** ordered online or over the phone
- **No customers allowed inside**

Barbershops and Hair Salons

Barbershops and **hair salons** may operate as follows:

- ✓ Services may be provided by **appointment only**
- ✓ Stations must be at least **six feet apart**
- X **No waiting inside the shop**

The following services are still prohibited:

- Waxing
- Electrolysis
- Threading
- Nail Care

Hair-related products may be sold to customers immediately before or after appointments, but otherwise only through delivery or curbside-pickup.

Restaurants

In addition to **takeout, delivery, and grab and go**, restaurants that already have **outdoor seating** can begin using that space.

- ✓ All outdoor dining **customers must be seated**, and patrons must place orders and be served while sitting at tables.
- ✓ All tables must be **at least six feet apart**.
- ✗ **No more than six people seated at a table.**

Parks and Recreation

Reopening:

- ✓ Dog parks
- ✓ Golf courses
- ✓ Parks
- ✓ Tennis courts
- ✓ Tracks and fields

Still closed:

- X Playgrounds
- X Public pools
- X Recreation centers
- X Other indoor DPR facilities

Contact sports are still prohibited:

- Basketball
- Football
- Soccer

Further guidance on parks and recreation can be found on coronavirus.dc.gov

Public Space: Restaurants, Retail & Recreation

The Mayor's Special Events Task Group, in conjunction with the District Department of Transportation, will identify public space, including sidewalks, roads, and alleys, or any portions thereof, **to be closed to vehicular traffic** for specific days and times to allow for expanded pedestrian and bicycle usage and outdoor customer seating for Phase One licensed food or retail establishments consistent with public safety.

Elective Surgeries

During Phase One, health care providers may continue to offer, or resume offering, outpatient or other surgical procedures that will not unduly burden hospital capacity or COVID-19 related resources.

Further guidance on elective surgeries can be found on **coronavirus.dc.gov**

Additional Guidance

Today, additional guidance will be posted on coronavirus.dc.gov for:

- Barbershops and hair salons
- Childcare centers
- Dentists
- Elective Surgery
- Individuals with chronic health conditions
- Older adults
- Parks and open spaces
- Restaurants
- Rideshare operators
- Schools

Phase One Website

coronavirus.dc.gov/phaseone

Mayors and Chairs of the Counties of Arlington, Fairfax, Loudoun and Prince William, and the City of Alexandria

May 10, 2020

The Honorable Ralph S. Northam
Governor of Virginia
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, Virginia 23219

Dear Governor Northam:

Thank you for your leadership during this extraordinary time for our Commonwealth. We appreciate your partnership with local governments in addressing the public health crisis, the human crisis and the economic crisis that this outbreak has caused in our jurisdictions. This partnership will be critical as we address the decisions in the weeks and months ahead.

We appreciate that you took the time to speak with us this week and solicit our perspectives on the reopening decisions that you must make. As you know, together our jurisdictions represent half of the Commonwealth's COVID-19 cases, hospitalizations and deaths. As we make local decisions during this time, we understand that confidence in public health is a foundation for restoring commerce. We appreciate your thoughtful and data-driven approach to striking the correct balance.

As you make the decision as to when Phase 1 should commence, we offer the following input:

1) The threshold metrics that you provided in the *Forward Virginia* plan should guide any transition to Phase 1.
2) We believe the industry-specific guidelines that you provided for Phase 1 are appropriate and prudent.
3) The transition to Phase 1 in Northern Virginia should occur when our region has achieved the threshold metrics.

Two weeks ago, you released your *Forward Virginia* blueprint for the easing of the public health restrictions currently in place. You provided five threshold metrics for a transition to Phase 1:

- Downward trend of positive tests over a period of 14 days
- Downward trend of hospitalizations over a period of 14 days
- Enough hospital beds and intensive care capacity
- Increasing and sustainable supply of PPE
- Increased testing and tracing

On Friday, you provided additional detail as to what an easing of public health restrictions would look like in Phase 1. Sharing the specific industry guidelines greatly assists our small businesses in determining how they will operate during this important transitional phase.

While it is certainly useful to examine statewide metrics as we gauge the success of current public health policies, we feel strongly that any changes to current policies be guided by what is occurring in our region. We eagerly wish to rebuild our economy and help our residents recover. It is only through our regional achievement of these milestones that we will be positioned to avoid a more damaging return to business closures later in the summer.

We have attached a memo provided to the State Health Commissioner by our public health directors with their analysis of the region's achievement of the threshold metrics.

We thank you for your consideration of our views during this time.

Sincerely,

Libby Garvey, Chair
Arlington County Board

Jeff McKay, Chair
Fairfax County Board of Supervisors

Phyllis Randall, Chair
Loudoun County Board of Supervisors

Ann Wheeler, Chair
Prince William County Board of Supervisors

Justin Wilson, Mayor
Alexandria City Council

Enclosure: As Stated

May 9, 2020

To: Dr. M. Norman Oliver, State Health Commissioner, Virginia Department of Health
Mark Jinks, Alexandria City Manager
Mark Schwartz, Arlington County Manger
Bryan Hill, Fairfax County Executive
Tim Hemstreet, Loudoun County Administrator
Christopher Martino, Prince William County Executive

Dear Dr. Oliver and Chief Administrative Officers,

Governor Northam issued Executive Orders 53 and 55 that closed businesses in the Commonwealth to help maintain the public's health in the face of the COVID-19 pandemic. Various criteria have been provided for determining when entering into Phase 1 of re-opening could be safely accomplished. Executive Order 61 was issued on May 8, 2020, to provide for the Phase 1 easing of certain temporary restrictions due to COVID-19.

The Northern Virginia Health Directors were asked to assess the status of the Northern Virginia region against the metrics. **Based on our assessment, we do not believe that the Northern Virginia region has met the criteria for moving into Phase 1 at this time**. We recommend continuing current community mitigation strategies and reassessing this on a regular basis to determine when Northern Virginia can move into Phase 1 according to these criteria (and any additional agreed upon criteria).

The following table is our assessment against the metrics issued on April 24:

Metric	**Met or Unmet**	**Health Directors' Comments**
Moving downward: Percentage of positive tests over 14 days	**Unable to assess**	As of May 4 the data shows that Northern Virginia (NOVA) is higher than the rest of Virginia: 27% for NOVA and 18% for all of Virginia (the latter is inclusive of NOVA) Without additional information, we cannot assess whether it has gone down over the past 14 days We have asked Virginia Department of Health for this data (including past data)

Moving downward: Hospitalizations over 14 days	**Unmet**	* See chart below: "Hospitalizations over the14 day period for NoVa, Outside of NoVA and All of VA" (See suggestion below)
Increased testing	**Unable to assess**	Currently only have baseline We have asked Virginia Department of Health for this data (including past data)
Increased (contact) tracing (capacity)	**Unmet**	Infrastructure is not yet in place to respond to every new case, trace and actively monitor their close contacts, and coordinate testing for symptomatic contacts
Enough hospital beds and intensive care capacity	**Unable to assess**	Available critical care beds continue to decrease but still fall within normal operating capacity Note: there is 20% surge capacity that is not yet utilized (See suggestion below)
Increasing and sustainable supply of PPE	**Unmet**	Met: PPE for hospitals appears to be adequate at this time Unmet: PPE for outpatient facilities (private practices, long-term care facilities and first responders) continues to be a challenge

* COVID-19 Hospitalizations over the past 14 Days - Northern Virginia, Outside of Northern Virginia and All of Virginia

INPATIENT		Northern Virginia		Outside Northern Virginia		ALL Virginia	
14-Day Period	Date	Inpatient	Ratio Inpatient to Prev Day	Inpatient	Ratio Inpatient to Prev Day	Inpatient	Ratio Inpatient to Prev Day
1	7-May	670	0.99	**943**	1.03	1613	1.01
2	6-May	676	1.03	918	1.09	1594	1.07
3	5-May	654	1.09	**842**	0.97	1496	1.02
4	4-May	598	1.03	865	1.04	1463	1.04
5	3-May	580	1.03	**833**	0.96	**1413**	0.99
6	2-May	**561**	0.94	865	1.04	**1426**	1.00
7	1-May	596	1.01	**835**	0.87	**1431**	0.92
8	30-Apr	589	1.03	**961**	0.97	**1550**	0.99
9	29-Apr	571	1.00	995	1.06	1566	1.04
10	28-Apr	569	1.03	939	1.04	1508	1.04
11	27-Apr	553	1.03	902	1.00	1455	1.01
12	26-Apr	**538**	0.99	898	1.04	1436	1.02
13	25-Apr	**543**	0.99	862	1.02	1405	1.00
14	24-Apr	551	1.05	**848**	0.99	1399	1.01

Suggestions Regarding Metrics

1) Regarding Hospital Beds and ICU Capacity: should indicate whether hospitals are able to double the number of patients treated in ICUs from current census (including staffing)
2) Regarding Increasing and Sustainable Supply of PPE: clarification needed about the meaning of "sustainable" (e.g. "assured resupplies available from vendors within 2 weeks"?)
3) Additional Metrics: need to be considered for Phase 2 and Phase 3, including Contact Tracing indicators, Availability of Facilities for Non-hospitalized Persons Needing Isolation and/or Quarantine, Long-Term Care Facility metrics, etc.

Note: all metrics need to be measured using an equity perspective

Sincerely,

Stephen A. Haering, MD, MPH, FACPM
Director, Alexandria Health Department

Reuben K. Varghese, MD, MPH
Director, Arlington Health District

Gloria Addo-Ayensu, MD, MPH
Director of Health, Fairfax County Health Department

David Goodfriend, MD, MPH
Director, Loudoun County Health Department

Alison Ansher, MD, MPH
Director Prince William County Health District

Mayors and Chairs of the Counties of Arlington, Fairfax, Loudoun and Prince William, the Cities of Alexandria and Fairfax, and the Towns of Dumfries, Herndon, Middleburg and Vienna

May 25, 2020

The Honorable Ralph S. Northam
Governor of Virginia
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, Virginia 23219

Dear Governor Northam:

We continue to value your leadership during these extremely challenging times for our Commonwealth and our nation. We appreciate your increased communication with local governments in the Northern Virginia region, and we stand with you and all Virginians during this historic health and economic crisis.

We had hoped, based on the data, the Northern Virginia region would have been ready to ease the public health restrictions with the rest of the Commonwealth on May 15th. Unfortunately, the data, as assessed by the five public health directors serving our region, did not support a transition to Phase 1 on that date.

We have enclosed the updated May 24th assessment by the five public health directors. They have noted the regional attainment of four of the critical metrics and assessed the need for continued focus on expanding our contact tracing capacity and developing sustainable supplies of PPE.

We appreciate the increased testing capacity the Commonwealth has provided for our region and realize that your assistance with testing and tracing in the future will be important to assist us as we move into subsequent phases.

Each of our jurisdictions have been making preparations to support a transition into Phase 1 at midnight on May 28th. We do have two requests for your consideration:

1) As you have stated, we believe there is value for the Commonwealth moving forward together. If the data supports it, we would like the Northern Virginia region to move to Phase 2 in concert with the rest of the Commonwealth when that date is established.

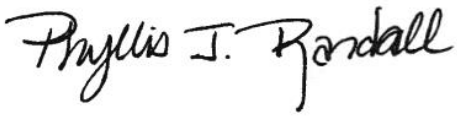
2) The “Stay-at-Home” phase has been especially hard on Virginians with Mental Health Diagnoses, particularly veterans. We ask that you establish distinct, accelerated availability of those services immediately for this group.

Thank you, Governor Northam, and we hope you, your family and your staff remain safe.

Respectfully,

Libby Garvey, Chair
Arlington County Board of Supervisors

Jeff McKay, Chair
Fairfax County Board of Supervisors



Phyllis J. Randall, Chair
Loudoun County Board of Supervisors

Ann B. Wheeler, Chair
Prince William County Board of Supervisors

Justin Wilson, Mayor
Alexandria City Council

David L. Meyer, Mayor
City of Fairfax

Derrick Wood, Mayor
Town of Dumfries

Lisa Merkel, Mayor
Town of Herndon

Bridge Littleton, Mayor
Town of Middleburg

Laurie A. DiRocco, Mayor
Town of Vienna

Enclosure: As Stated

May 24, 2020

To: Dr. M. Norman Oliver, State Health Commissioner, Virginia Department of Health
Mark Jinks, Alexandria City Manager
Mark Schwartz, Arlington County Manger
Bryan Hill, Fairfax County Executive
Tim Hemstreet, Loudoun County Administrator
Christopher Martino, Prince William County Executive

Dear Dr. Oliver and Chief Administrative Officers,

Governor Northam issued Executive Orders 53 and 55 that closed businesses in the Commonwealth to help maintain the public's health in the face of the COVID-19 pandemic. Various metrics have been provided for determining when entering into Phase 1 of re-opening could be safely accomplished. Executive Order 61 was issued on May 8, 2020, to provide for the Phase 1 easing of certain temporary restrictions due to COVID-19. Executive Order 62 was subsequently issued on May 12, 2020, maintaining Phase 0 through May 28, 2020 for the Northern Virginia region.

The Northern Virginia Health Directors assessed the status of the Northern Virginia region against the April 24 Forward Virginia metrics on May 9 and recommended Northern Virginia continue existing community mitigation strategies. We have now reassessed the status of the metrics on May 24. We appreciate the efforts of the Virginia Department of Health to provide the key metrics by the Northern Virginia region (https://www.vdh.virginia.gov/coronavirus/key-measures/#northern). **Based on our May 24 assessment, our region has met four (4) of the six (6) April 24 metrics for moving into Phase 1 at this time**.

We recommend that policymakers continue to consider the status of these Forward Virginia metrics when contemplating moving into various phases of reopening. In addition, we suggest additional public health metrics for moving into subsequent phases of reopening (see "Requests Regarding Metrics" below).

The following table is our May 24, 2020, assessment against the metrics issued on April 24:

Metric	**Met or Unmet**	**Health Directors' Comments**
Moving downward: Percentage of positive tests over 14 days	**Met** (previously "unable to assess")	* See chart below: "Testing Measures"
Moving downward: Hospitalizations over 14 days	**Met** (previously unmet)	** See chart below: "Hospital Measures"

Increased testing	**Met** (previously "unable to assess")	* See chart below: "Testing Measures"
Increased (contact) tracing (capacity)	**Unmet** (previously unmet)	Infrastructure is currently being put into place, with sequential increased capacity anticipated in the coming weeks
Enough hospital beds and intensive care capacity	**Met** (previously unable to assess)	** See chart below "Hospital Measures"
Increasing and sustainable supply of PPE	**Unmet** (previously unmet)	Met: PPE for hospitals appears to be adequate at this time Unmet: PPE for outpatient facilities (private practices, long-term care facilities and first responders) continues to be a challenge - although there is increased supply for these entities, there is not a sustainable supply through non-government sources.

Requests Regarding Metrics

1) Refinements of Existing Metrics
    a) Regarding Hospital Beds and ICU Capacity: should indicate whether hospitals are able to double the number of patients treated in ICUs from current census (including staffing).
    b) Regarding Increasing and sustainable supply of PPE: clarification needed about the meaning of "sustainable" (e.g. "assured resupplies available from vendors within 2 weeks"). The metric of "Sustainable supply of PPE" should include entities other than hospitals and that all entities can readily obtain PPE supplies from non-government sources.
2) Additional Metrics: need to be considered for Phase 2 and Phase 3, including Contact Tracing indicators, Availability of Facilities for Non-hospitalized Persons Needing Isolation and/or Quarantine, Long-Term Care Facility metrics, etc.
3) VDH and the Office of the Governor
    a) Use indicators, thresholds and triggers developed by national public health experts such as
        i) CDC Activities and Initiatives Supporting the COVID-19 Response
        ii) Resolve to Save Lives'
            (1) COVID-19 Vital Strategies
            (2) When and How to Reopen
            (3) When and How to Close
    b) Coordinate indicators, thresholds and triggers for the National Capital Region with DC and Maryland because of the unique dynamics of the region, including Northern Virginia.
4) The status of all existing and additional metrics be publicly posted on the VDH website for the Commonwealth and by VDH regions.
5) All metrics need to be examined using an equity perspective.

Sincerely,

Stephen A. Haering, MD, MPH, FACPM
Director, Alexandria Health Department

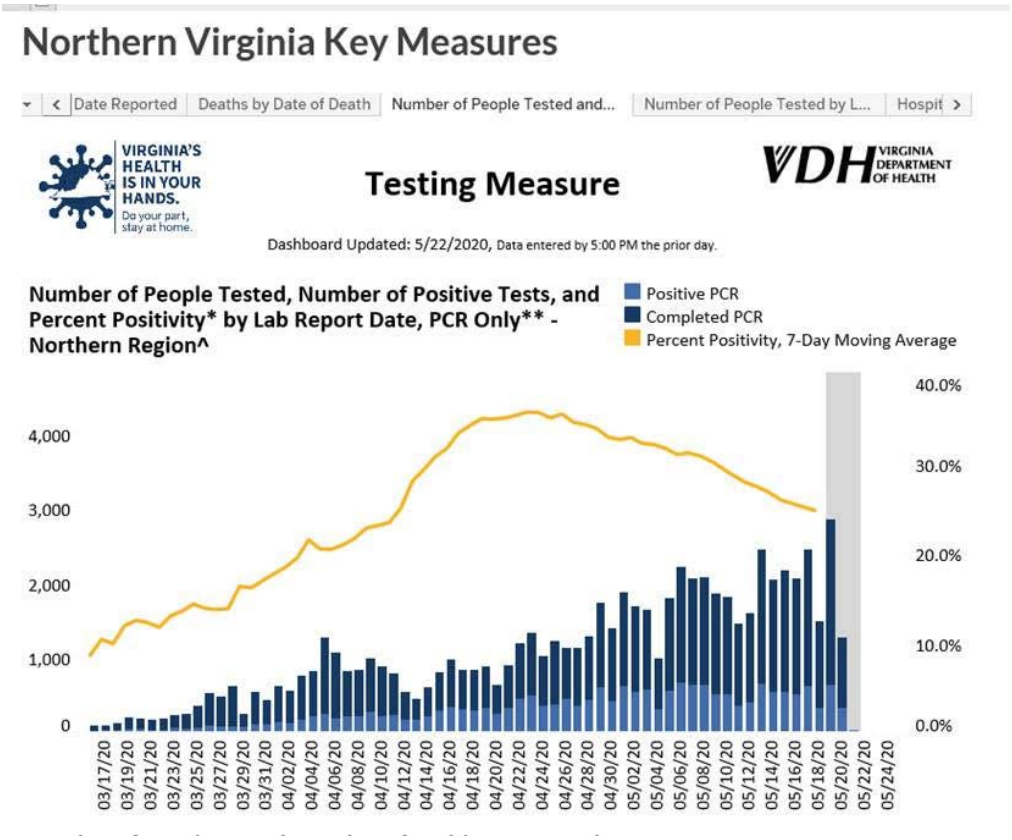
Reuben K. Varghese, MD, MPH
Director, Arlington Health District

Gloria Addo-Ayensu, MD, MPH
Director, Fairfax Health District

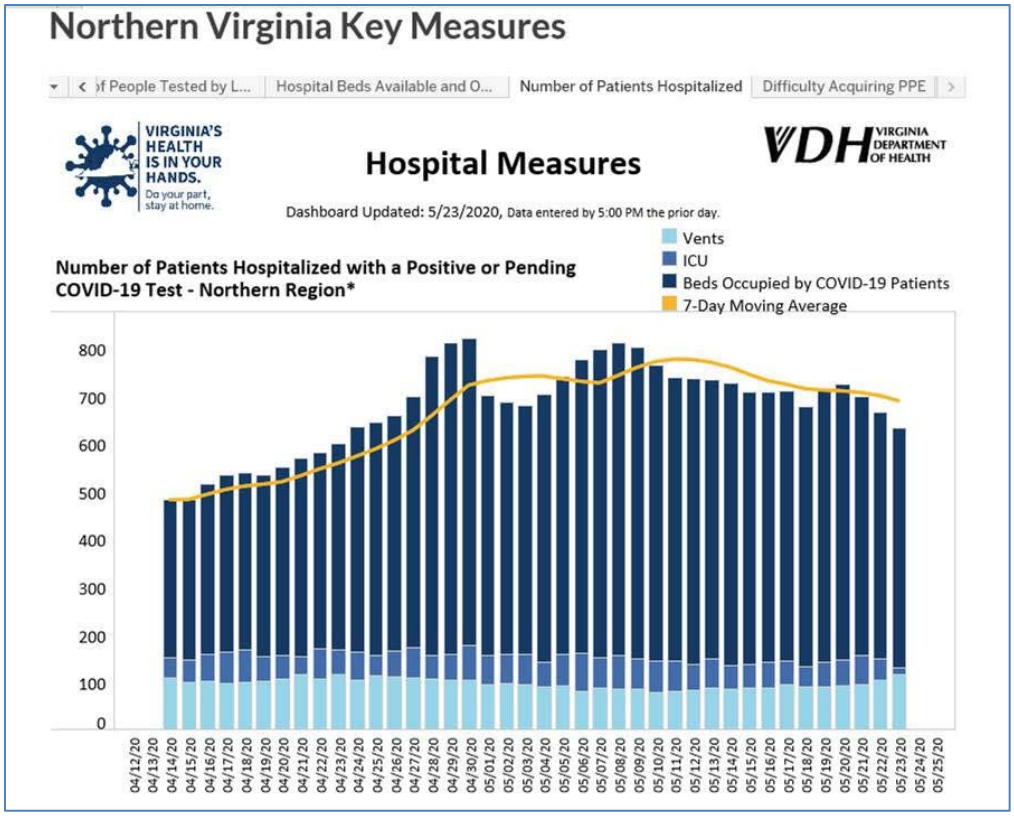
David Goodfriend, MD, MPH
Director, Loudoun County Health Department

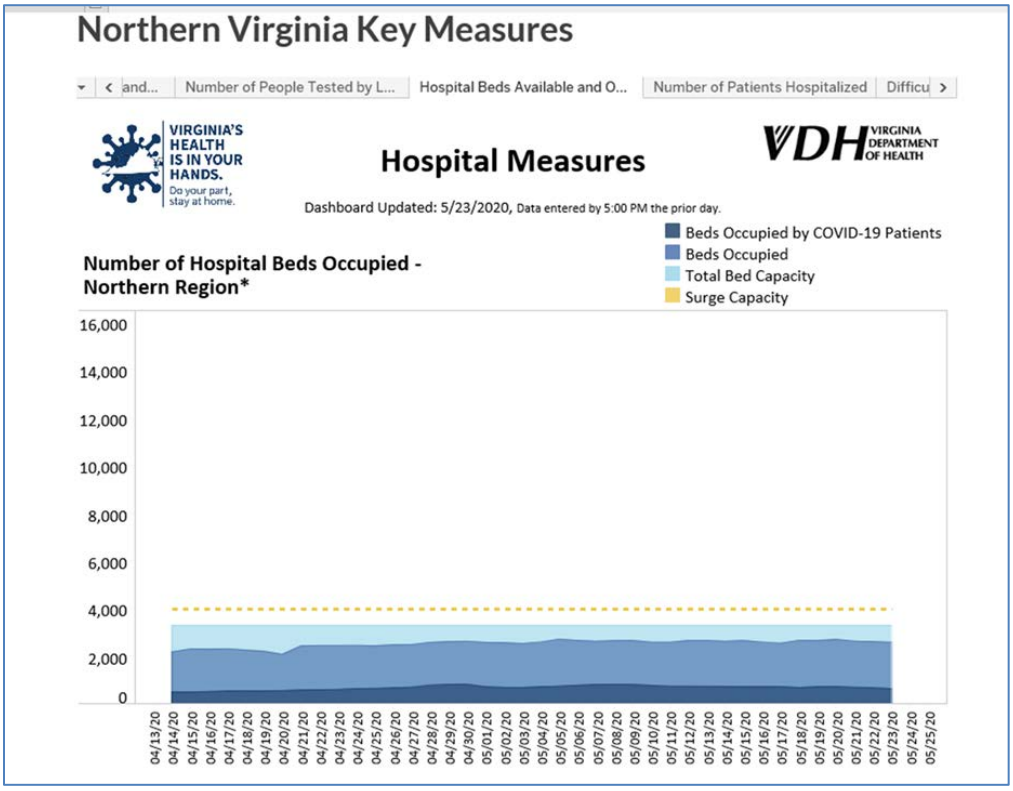
Alison Ansher, MD, MPH
Director, Prince William Health District

***Testing Measures (https://www.vdh.virginia.gov/coronavirus/key-measures/#northern)**



****Hospital Measures (https://www.vdh.virginia.gov/coronavirus/key-measures/#northern)**





REOPENING MONTGOMERY

PHASE 1 GUIDELINES

Effective Monday, June 1 | 6 a.m.

RETAIL	RESTAURANTS	CHILDCARE
Curbside Only	Outdoor Dining (Curbside Pickup Still in Effect)	Open for Children of Essential Employees and Phase I Opening Employees

OUTDOOR YOUTH SPORTS	PERSONAL SERVICES	OUTDOOR DAY CAMPS
Limited, Low-Contact Outdoor Practices	Hair Salons and Barbers by Appointment for Select Hair Services Only	9 or Fewer Campers with 1 Counselor

CAR WASHES	MANUFACTURING
Exterior Cleaning Only	Open for Operations

Face coverings to be worn in all public spaces where physical distancing can't be maintained. (Except when seated at outdoor restaurant tables).

Our Road to Reopening

Angela D. Alsobrooks
County Executive

COVID-19 (Coronavirus)
Prince George's County Modified Phase One Reopening

Prince George's County, MD Proud
Get to Know Us

The Stay-At-Home Order will be lifted for Prince George's County
JUNE 1, 2020.

We are encouraging all residents to continue to stay home as much as possible and use good judgment.

What is Now Open with Modifications:

Barbershops/Hair Salons
(hair services only,
by appointment only)

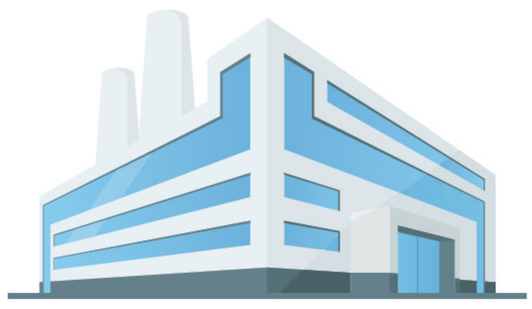
Retail Stores
(curbside pickup only)

Restaurants
(outside seating only,
max 6 people per table)

Houses of Worship
(10 people or less)

Farmer's Market

Farmer's Markets
(carryout only)



Manufacturing
(must follow CDC guidelines)

Car Washes with Automated
Systems (stay in your vehicle)

Golf Courses &Tennis Courts

Child Care

Childcare Facilities
(for essential workers and phase
one employees returning to work)

What Remains CLOSED/Activities not Permitted:

- Nail salons
- Pools
- Contact sports such as basketball or soccer
- Playgrounds
- Fitness centers
- County Government buildings
- Theaters
- Gatherings of more than 10 people

AGENDA ITEM #10

OTHER BUSINESS

AGENDA ITEM #11

ADJOURN