Virgin Islands State Action Plan Table 2025 Application/2023 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Increase the number of women that have well women visits	Emphasize the importance of regular well women visit focusing on self-breast exams, annual gynecological evaluations Encourage more and better quality contacts between women and health care providers	Improve pregnancy and birth outcomes by providing information/facilitation and access to care Remind clients of appointment by sending a friendly text and/or email Promote the importance of prenatal care through education by developing radio and social media ads		SPM 1: Increase the percentage of pregnant women who enroll in prenatal care through the MCH clinic in the first trimester during the calendar year	
Increase the number of women that have well women visits	Improve pregnancy and birth outcomes by providing information to facilitation and access to care Improve overall women's health Increase the number of women who receives an annual and a biannual	Improve quality of visit through education on healthy sexual behavior and habits Emphasize the importance of regular well women visits with a focus on self-breast exams and annual gynecological evaluations Increase access to pre-conceptual care for this population through MCH Provider training	ESM WWV.1 - # of women who receive preconception services through referrals from Title V MCH clinics to Title X sites	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB

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					NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15

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					through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD
Increase the number of women that have well women visits	Encourage more and better quality contacts between women and health care providers	Remind clients of appointment by sending a friendly text and/or email Promote the importance of prenatal care through education by developing radio and social media ads			SOM 1: Percentage of pregnant women who receive prenatal care beginning in the first trimester
Increase the number of women that have well women visits	One hundred percent of women will attend a postpartum checkup within 12 weeks of giving birth.	MCH clinical staff will receive MCH clients discharge information from local hospital after delivery. MCH clinical staff will instruct registration staff to schedule postpartum appointment for new mother. MCH registration staff will place reminder call to new mother at least one day before appointment date. MCH clinical staff will conduct initial visit and give new mother a referral to the Title X Family Planning clinic.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Increase percentage of families that participate in transition planning	Increase the number of children with special health care needs with a medical home by 5%.	MCH clinical staff will maintain a log of children with special health care needs served by the MCH clinics. MCH clinical staff will assure that all parents of children with special health care needs receive appropriate referrals during well-woman visit.			
Perinatal/Infant Health					
Increase the number of families educated on	Increase the number of families that receive educational information of counseling about safe sleep by 6% each year	Continue to educate parents on safe sleep practices at every well-child visit for the first year of life beginning with the post partum visit Provide educational material and training to other Healthcare providers	ESM SS.1 - Percent of families receiving safe sleep educational materials at District	NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B)	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

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safe sleep practices		including FQHCs and Homevisiting Staff on safe sleep practices	birthing hospitals.	Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS	NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID
Increase the number of women breastfeeding up to six months	Increase the number of pregnant women who receive breastfeeding at 6 months up to a year	Assists hospital , WIC program, local clinics and FQHC's to enhance education of mothers and staff on breastfeeding techniques Continue to support breastfeeding initiatives in the hospital via collaboration with the EHDI program	ESM BF.1 - Percent of infants ever breastfed	NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID
Increase the percent of developmental screenings done in the territory	Increase the percentage of parents of children with special health care needs who report that their child has a medical home 5%.	Conduct a survey of parents of children with special health care needs to assess awareness of a medical home. Analyze survey findings and use findings to develop indicated parent education and support services.			
Child Health					
Decrease the number of children with BMI>85%	To promote regular physical activity in children ages 6-11 To encourage healthy eating	To collaborate with sports park and recreation and host out door sporting activities provide educational material to families about the importance of healthy	ESM PA-Child.1 - Physical activity counseling during the well-child visit within	NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day (Physical	NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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	behaviors in children ages 6-11 To reduce sedentary activity (such as watching television and videotapes and playing video games) in children ages 6- 11	eating Partner with the Department of Education to host in school sporting events	the MCH population.	Activity, Formerly NPM 8.1) - PA-Child	 NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS
Increase the percent of developmental screenings done in the territory	To increase the percentage of developmental screening done in the territory for children 9-35 months	Utilize Homevisiting /MIECHV programs to provide Ages and Stages Developmental Screening tool with clients Train medical social workers and childcare providers on developmental screening	ESM DS.1 - Children receiving a developmental screening using a parent-completed screening tool.	NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS	NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Increase access to oral health care for the Maternal Child health population	To increase access to oral health care for the Maternal Child Health population	Utilize home visiting programs to screen for caries and refer to early oral preventative services with recruited dental practices for children over age 6 months Collaborate with Early Head Start and Head Start programs, home visiting programs, and/or WIC clinics to train staff to provide preventative oral health care and referrals to oral health professionals for dental visits	ESM PDV-Child.1 - Percent of Children, ages 5-12 who received a fluoride varnish application in the territory	NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Increase the percent of developmental screenings done in the	Increase the percentage of children with and without special health care needs ages 0 through 17 whose parents report their child has a medical home by 5%.	Conduct a survey about medical home among parents of children ages 0 through 17 with and without special health care needs. Analyze survey findings to assess percentage of parents who report a medical home (baseline).	ESM MH.1 - # of children with special health care needs who receive care coordination through	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care,

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territory		Develop and implement a campaign to educate parents on the concept of a medical home. Survey parents of children with or without special health care needs on the concept of a medical home during well-child visit. Analyze survey results to determine if there was an increase in parents who report their child has a medical home.	medical home model with PCPs in the territory for preventative service	Home, Formerly NPM 11) - MH	Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Adolescent Health					
Increase access to comprehensive primary and preventative health care for adolescents and pre-adolescents	Increase access to comprehensive primary and preventative care for adolescents 10 through 19 Continue outreach activities to parents and school that encourage annual physical exams for adolescents 10 through 19	Develop a State Adolescent Health Care Plan in conjunction with DOH, FQHCs, families and providers Continue to promote education on wellness to adolescents in the community through outreach Continue outreach activities for families and schools that encourage annual exams for this population	ESM AWV.1 - Percentage of adolescents, ages 10 through 19, receiving school-based preventive health services.	NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide NOM - Percent of children with

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					special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents,

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					ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
Children with Special Health Care Needs					
Increase percentage of families that participate in transition planning	Increase the number of families for CSHCN that participate in the transition process by 2%	Train employees in the GOT Transition Model to promote family involvement in a structured manner Utilize GOT Transition Model to promote family involvement in a structured manner Collaborate with other DOH Division and Other Agencies in the transition process, Vocational Rehabilitation, DHS, DOE Special Education, Community Service Providers, UVI and DD Council	ESM MH.1 - # of children with special health care needs who receive care coordination through medical home model with PCPs in the territory for preventative service	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0

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					through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Increase percentage of families that participate in transition planning	Increase the number of clients who access family support services	Collaborate with Birth to 3 and other Early Intervention Programs to ensure Early Intervention is provided for those with developmental delays		SPM 2: The percent of CSHCN clients who access family support services.	
Increase the percent of developmental screenings done in the territory	Increase the percentage of clients who access family support services	Partner with infant and Toddlers to ensure Early Intervention is provided for those with developmental delays	ESM MH.1 - # of children with special health care needs who receive care coordination through medical home model with PCPs in the territory for preventative service	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Cross-Cutting/Systems Building					
Increase access to oral	To establish a systematic methodology to assess the oral	Develop Oral Health Steering Committee		SPM 4: Increase access to oral health care services	

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health care for the Maternal Child health population	health needs of the child/adolescent population in the US Virgin Islands, e.g. the Association of State and Territorial Dental Directors Basic Screening Survey (BSS)."	Train Pediatricians, Nurses and other clinic staff in the process of applying Vanish Add Vanish application as a part of the well children check-up process		for the child and adolescent MCH populations.	
Increase access to oral health care for the Maternal Child health population	Increase the number of children who receive a dental check-up at their annual check-up	Train Providers to apply Vanish to clients during their annual checkup Create PSA and social media ads to promote oral health education			SOM 4: Percentage of Children, ages 5 through 12, who have decayed teeth or cavities in the past year